STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

(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 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015		11/26/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/22/2021

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E 015	Continued From page 1 hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update the subsistence needs for food, water, medical and pharmaceutical supplies for staff and residents whether they evacuated or sheltered in place since July 2019. Findings included: A review of the facility ' s emergency preparedness plan in section E0015 for subsistence needs to include food, water, medical and pharmaceutical supplies for the staff and resident revealed the date recorded as last updated was July 2019. An interview was conducted with the Maintenance Supervisor (MS) on 10/21/21 at 5:00 PM. The MS revealed it was his responsibility to update the subsistence needs for the staff and residents and he must have overlooked it when he was updating the emergency preparedness plan in August of 2021.	E 015	E015: Subsistence Needs for Staff and Residents Residents effected: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice No resident was identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice The Emergency Preparedness manual was reviewed and updated on 11/5/21, by the Administrator and Maintenance Supervisor. Systemic measures implemented to ensure the same practice does not recur: The Administrator received re-training from the Regional Director of Operations (RDO) on 10/20/21, related to the	

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E 015	Continued From page 2 An interview was conducted with the Administrator on 10/21/21 at 5:00 PM. The Administrator stated he had only been the Administrator at this facility since October 7 and confirmed when the emergency preparedness manual was updated in August of 2021 it should have included updating the subsistence needs for staff and residents for food, water, medical and pharmaceutical supplies.	E 015	Emergency Preparedness Plan (EPP) and timely updating of the information. The Administrator and/or maintenance director will review the EPP Manual weekly for 4 weeks, then monthly to ensure all updates have been made timely. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Emergency Preparedness Manual will be reviewed with the Quality Assurance Performance Improvement (QAPI) Committee annually and when changes occur to ensure the manual is updated and approved to ensure sustained compliance. Compliance date 11/26/21	
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the	E 030		11/26/21

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E 030	Continued From page 3	E 030		

following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [facilities].
(v) Volunteers.

*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [hospitals and CAHs].
(v) Volunteers.

*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Next of kin, guardian, or custodian.
(iv) Other RNHCIs.
(v) Volunteers.

*[For ASCs at §416.45(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Volunteers.

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E 030	Continued From page 4 *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update the names and contact information of the current administrative staff for the communication plan since July 2019. Findings included: A review of the facility ' s emergency	E 030	E030 Names and Contact Information Residents effected: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice No Resident identified.	

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E 030	Continued From page 5 preparedness plan in section E0030 for names and contact information for the communication plan revealed the contact information documented was for the previous Administrator and previous Director of Nursing. The communication plan was not updated to reflect the new Administrator or Director of Nursing since July 2019. An interview was conducted with the Administrator on 10/21/21 at 5:00 PM. The Administrator stated he had only been the Administrator at this facility since October 7, 2021 and confirmed when the emergency preparedness manual was updated in August of 2021 it should have included updating the contact information in the communication plan with the current Administrator and the current Director of Nursing at that time.	E 030	Address how the facility will identify other residents having the potential to be affected by the same deficient practice Any resident had the potential to be affected. The communication plan was reviewed and updated by the Administrator and Maintenance Director on 11/5/21 to include updating the facility contact list and phone numbers. Systemic measures implemented to ensure the same practice does not recur: The Administrator received re-training from the Regional Director of Operations (RDO) on 10/20/21, related to the Emergency Preparedness Plan (EPP) and timely updating of the information. The Administrator and/or maintenance director will review the EPP Manual weekly for 4 weeks, then monthly to ensure all updates have been made timely. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Emergency Preparedness Manual will be reviewed with the Quality Assurance Performance Improvement (QAPI) Committee annually and when changes occur to ensure the manual is up to date, to include name and number of Department Managers and approved to ensure sustained compliance. Compliance date 11/26/21	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 6 An unannounced recertification survey was conducted on 10/17/21 through 10/21/21. Additional information was obtained from the facility on 10/26/21. Therefore, the exit date was 10/26/21. Event ID# TQT211.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, Physician and Psychiatric Physician Assistant interviews the facility failed to protect a residents right to be free from sexual abuse when a cognitively impaired resident (Resident #28) was observed in a resident's room (Resident #7) who was also cognitively impaired, masturbating to the point of ejaculation for 1 of 3 residents reviewed for abuse. Findings included: Resident # 28 was admitted to the facility on	F 600	F600 – Free from Abuse, Neglect, and Exploitation Residents effected: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #7 and resident # 28 were immediately separated. Resident #7 was no longer at the facility. Resident # 28 was relocated to a different hall. Address how the facility will identify other	11/26/21

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F 600	Continued From page 7 03/23/21. His diagnoses included; Delusional Disorder and Dementia with behavioral disturbances. The Minimum Data Set (MDS) quarterly assessment dated 06/07/21 revealed Resident #28 was severely cognitively impaired. He required limited assistance with bed mobility, transfers and activities of daily living. A wanderguard was used daily. Resident #7 was admitted to the facility on 03/15/20. His diagnoses included; Traumatic Brain injury, Delusional Disorder, and Cerebral Vascular Accident with Hemiplegia. The MDS quarterly assessment dated 07/24/21 revealed Resident #7 had moderately impaired cognition. He required extensive assistance with bed mobility, transfers and activities of daily living. He exhibited physical behaviors directed toward others on 1-3 days. A wanderguard was used daily. A progress note dated 08/31/21 at 8:40 PM documented by Nurse #2 revealed Resident (#28) was found making sexual actions, he became very agitated. The Psychiatric Physician Assistant was notified. An order for Ativan (used to treat anxiety) 1 milligram (mg) every 8 hours as needed for agitation was received. An interview was conducted on 10/19/21 at 9:42 AM with Nurse #2. She stated on 08/31/21 Resident #28 was found in Resident #7's room by Nurse Aide #10 who observed Resident #28 ejaculating while Resident #7 watched. She stated Nurse Aide #10 reported to her that she did not observe any physical contact between the	F 600	residents having the potential to be affected by the same deficient practice Regional Clinical Nurse and Director of Nursing completed a review of current resident medical record over the previous 60 days on 10/20/21, to identify any resident behaviors that would need to report as indicated in F 600. The facility Social Worker completed interviews with residents and resident representatives to identify any resident behavior that should have been reported. Results of this audit identified no new behaviors. No other behaviors were identified. Systemic measures implemented to ensure the same practice does not recur: The Regional Clinical Nurse completed a re-training with Facility Administrator, Director of Nursing, Administrative Nurses, and Leadership team on 11/17/21, related to the facility Abuse Policy protocol, including identifying resident to resident altercations & timely reporting, required for F 600. Current facility employees, including agency/contract employees, will be educated on the “Abuse Policy” by the Administrator, Director of Nursing or Administrative Nurse by 11/26/21. New hires will be educated during orientation. Any employee who was not present for training will not be allowed to work until training is complete. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Interviews will be conducted with five	

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F 600	Continued From page 8 two residents. She stated Nurse aide #10 immediately removed Resident #28 from the room and reported the incident to her. She stated she went to Residents #28's room immediately, and he became very agitated and commented he would knock the hell out of her which was out of character for him, so she notified the Psychiatric Physician Assistant who ordered her to administer a dose of Ativan 1mg. She stated she notified the (previous) Director of Nursing (DON) and the (previous) Administrator. She stated she also talked with the Social Worker about the incident and about Resident #28's Responsible Party wanting him in a locked unit because he constantly roamed around the facility. She stated he had a wander guard in place. She stated his family was concerned about him roaming, and the family told the nurse (#2) that sexual actions were not normal for him. Nurse #2 stated she only worked in the facility two days a week, but she never witnessed Resident (#28) having any physical or sexual contact with any resident. An interview was conducted on 10/19/21 at 10:19 AM with Nurse Aide #10. She stated she was the nurse aid that walked by Resident #7's room and saw Resident #28 standing in the room ejaculating. She stated Resident #7 was sitting in his wheelchair and she did not observe them having any physical contact. She stated she entered the room immediately and told them that was inappropriate and told Resident #28 to leave the room. She stated after that incident she continually had to redirect Resident #28 to keep him from going back into Resident #7's room. She reported they were both on the 400 hall at that time and staff kept a constant watch on the two residents because she didn't think any sexual acts were appropriate and she wanted to make	F 600	residents weekly X 4 weeks and 4 residents monthly for 2 months by the Social Worker to ensure they do not have any complaints regarding abuse or neglect. Any negative findings will be reported to the Administrator and/or Director of Nursing for the determination of reporting. If deemed necessary, the reporting process will be implemented within 2 hours of notification of such information. Results of the weekly audits will be reviewed at the morning meeting. The Quality Assurance Performance Improvement (QAPI) Committee will review the results of all audits results during the QAPI meeting monthly for 3 months. The QAPI Committee will determine if the plan is effective. Additional intervention may be implemented by the Committee to ensure sustained compliance. Compliance date 11/26/21	

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F 600	Continued From page 9	F 600		

sure the two of them were kept apart. She stated she didn't think Resident #28 was aware of his actions, but he could voice his needs and stated Resident #7 constantly made inappropriate sexual remarks to staff and she wanted to make sure Resident #28 wasn't around him. She reported she never witnessed any physical contact between the two residents. She stated she immediately went to the previous Administrator and told him about the incident, and stated she also reported to the previous DON. She stated Resident #7 was not currently in the facility and was discharged to the hospital last week. She added that Resident #28 was friendly and had no behaviors since that time but thought when he had any behaviors such as increased agitation that it was related to his blood sugar fluctuating. She stated Resident #28 was typically calm and cooperative with care and she didn't think he was a threat to any other residents.

An interview was conducted on 10/19/21 at 10:37 AM with the Medical Director. She indicated Resident #28 was severely cognitively impaired, he could be redirected but had no insight into what he did or said. She stated Resident #7 was also cognitively impaired and had a history of inappropriate behaviors attributed to TBI (traumatic brain injury), and stroke. She stated Resident #7 could not control his behaviors, had no impulse control, he did not know boundaries, and he could be redirected but the behaviors may still happen again later. She stated Resident #7 was also followed by the Psychiatrist. She stated Resident #28, and Resident #7 were not capable of making sound decisions or judgements.

A phone interview was conducted on 10/21/21 at 3:30 PM with the Psychiatric Physician Assistant

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F 600	Continued From page 10 that evaluated Resident #28 on 09/02/21 following the incident that occurred 08/31/21. She stated she was aware of Resident #28 having hypersexual behaviors and was aware of Resident #7 having inappropriate sexual behaviors.	F 600		
F 607 SS=E	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 by: Based on observations, record review, resident, staff and physician interviews, the facility failed to implement their abuse policy by not: 1) reporting allegations of sexual abuse to the Health Care Personnel Registry (HCPR) within 2 hours for 2 of 3 residents (Res #7, #28); 2) failed to conduct a thorough investigation for allegations of sexual abuse and submit an investigation report to the HCPR within 5 days for 1 of 3 residents (Resident #28); 3) failed to report allegations of resident to resident physical abuse with no serious bodily injury to the HCPR within 24 hours and failed to submit an investigation report to the HCPR within 5 days for resident to resident physical abuse for 1 of 1 residents (Resident #38).	F 607	F607 Develop/Implement Abuse/Neglect Policies Residents effected: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #38 and resident #27 were immediately separated; Resident #7 & #14 was an unwitnessed event but at the time Resident #7 reported incident, interventions were implemented. The facility did notify family and physician and interventions were started by the facility.	11/26/21

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F 607	Continued From page 11 Findings included: The facility's Abuse Policy dated November 2016 Section V.6 (b) stated, in part, it is our policy that reports of "abuse" to include mistreatment, abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of property are promptly and thoroughly investigated. The facility will conduct investigations in accordance with federal requirements and state law. All alleged violations involving abuse are reported immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury to the Administrator of the facility and to other officials including to the State Survey Agency in accordance with state law through established procedures; and Section V.6 (p) (ii) states the Administrator provides a written report of the result of the investigation and action taken to the State Survey Agency within the required time frame. 1) Resdient #7 was admitted to the facility on 3/15/20 with diagnoses that included Traumatic Brain Injury (TBI), brain aneurysm, neurocognitive disorder, delusional disorders, mood disorder, and hemiplegia and hemipresis following a cerebral infarction (stroke). A progress note written by Nurse #5 on 10/16/21 at 6:41 AM documented: "Resident continues on 15 min checks for behaviors. Resident across the hall from him room 407 voiced a complaint to the med tech on the hall early in the evening stating	F 607	Address how the facility will identify other residents having the potential to be affected by the same deficient practice Regional Clinical Nurse and Director of Nursing completed a review of current resident medical record over the previous 60 days on 10/20/21, to identify any resident-to-resident behaviors that would need to report as indicated in F 600. The facility Social Worker completed interviews with residents and resident representatives to identify any resident behavior that should have been reported. Results of this audit identified no new behaviors. No other behaviors were identified. Systemic measures implemented to ensure the same practice does not recur: During the morning clinical meeting, Monday thru Friday, residents medical record will be reviewed by the Director of Nursing, Assistant Director of Nursing and Administrative Nurses to identify residents with new behaviors. Interventions will be developed and implemented by the Interdisciplinary Team and Care Planned, when necessary, by the Minimum Data Set nurse. This meeting will begin by 11/26/21. The Regional Clinical Nurse completed a re-training with Facility Administrator, Director of Nursing, Administrative Nurses, and Leadership team on 11/17/21, related to the facility Abuse Policy protocol, including identifying resident to resident altercations & timely reporting. Current staff will be educated on the	

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F 607	Continued From page 12 that he had exposed his body parts to her and she was very offended and afraid of him. Med tech stated to this nurse that he redirected him to his room and told him he had to put pants on, resident stated ok." In an interview with Resident #14 on 10/18/21 at 2:35 PM she stated she witnessed Resident #7 disrobe in his doorway across the hall but "did not want to talk about it." She became tearful. In an interview with the Regional Clinical Nurse Consultant on 10/18/21 at 3:00 PM she stated the administrative staff (herself, the Administrator, the DON, and the Regional Director of Operations) had met on 10/16/21 and concluded this incident was not reportable because there had been no contact between the residents, Resident #7 had not sought out Resident #14, and Resident #7 could not remember not to act in this manner due to a history of a TBI and a stroke. In an interview with the facility Administrator on 10/18/21 at 3:30 PM he stated the administrative staff met on 10/16/21 and discussed the incident. He concluded the group decided because there had been no contact between the two residents that abuse had not occurred and no 24 hour report was sent to the State Survey Agency. An action plan was developed on 10/16/21 to address the incident that included a full investigation with details of the incident, corrective action and identification of others at risk, and systemic changes and monitoring. In an interview with Unit Manager #2 on 10/18/21 at 4:30 PM she stated when she learned of the incident on 10/16/21 at 1:15 PM, she immediately notified the DON and started an investigation.	F 607	"Abuse Policy" by the Administrator, Director of Nursing or Administrative Nurse by 11/26/21. New hires will be educated during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Interviews will be conducted with five residents weekly X 4 weeks and 4 residents monthly for 2 months by the Social Worker to ensure they do not have any complaints regarding abuse or neglect. Any negative findings will be reported to the Administrator or Director of Nursing for the determination of reporting. If deemed necessary, the reporting process will be implemented and timely. Results of the weekly audits will be reviewed at the morning meeting. Social Worker will complete a summary of these interviews and present at the monthly Quality Assurance Performance Improvement (QAPI) to ensure continued compliance Compliance date 11/26/2021	

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In an interview with Nurse #5 on 10/22/21 at 6:00 PM she stated she was the nurse on duty on 10/15/21 when Resident #7 exposed himself in his doorway. She learned of the incident at 9:00 PM from Medication Aide #2. She conveyed she had not contacted her supervisor regarding abuse because Resident #7 had not touched Resident #14 and she did not feel his exposure was directed at Resident #14 although Resident #14 had seen it. She stated she was covering Medication Aide #2 but that she was on the locked dementia unit and had not seen the incident. She recalled she passed on the information in morning report to the oncoming shift.

2) Resident # 28 was admitted to the facility on 03/23/21. His diagnoses included; Delusional Disorder and Dementia with behavioral disturbances.

An interview was conducted on 10/19/21 at 9:42 AM with Nurse #2. She stated on 08/31/21 Resident #28 was found in Resident #7's room by Nurse Aide #10 who observed Resident #28 ejaculating while Resident #7 watched. She stated Nurse Aide #10 reported to her that she did not observe any physical contact between the two residents. She stated Nurse aide #10 immediately removed Resident #28 from the room and reported the incident to her. She stated she went to Residents #28's room immediately, and he became very agitated and commented he would knock the hell out of her which was out of character for him, so she notified the Psychiatric Physician Assistant who ordered her to

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administer a dose of Ativan 1mg. She stated she notified the (previous) Director of Nursing (DON) and the (previous) Administrator. She stated she also talked with the Social Worker about the incident and about Resident #28's Responsible Party wanting him in a locked unit because he constantly roamed around the facility. She stated he had a wander guard in place. She stated his family was concerned about him roaming, and the family told the nurse (#2) that sexual actions were not normal for him. Nurse #2 stated she only worked in the facility two days a week, but she never witnessed Resident (#28) having any physical or sexual contact with any resident. She stated she did not feel Resident (#28) was a threat in any way to other residents.

An interview was conducted on 10/19/21 at 10:19 AM with Nurse Aide #10. She stated she was the nurse aid that walked by Resident #7's room and saw Resident #28 standing in the room ejaculating. She stated Resident #7 was sitting in his wheelchair and she did not observe them having any physical contact. She stated she entered the room immediately and told them that was inappropriate and told Resident #28 to leave the room. She stated after that incident she continually had to redirect Resident #28 to keep him from going back into Resident #7's room. She reported they were both on the 400 hall at that time and staff kept a constant watch on the two residents because she didn't think any sexual acts were appropriate and she wanted to make sure the two of them were kept apart. She stated she didn't think Resident #28 was aware of his actions, but he could voice his needs and stated Resident #7 constantly made inappropriate sexual remarks to staff and she wanted to make sure Resident #28 wasn't around him. She

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reported she never witnessed any physical contact between the two residents. She stated she immediately went to the previous Administrator and told him about the incident, and stated she also reported to the previous DON. She stated Resident #7 was not currently in the facility and was discharged to the hospital last week. She added that Resident #28 was friendly and had no behaviors since that time but thought when he had any behaviors such as increased agitation that it was related to his blood sugar fluctuating. She stated Resident #28 was typically calm and cooperative with care and she didn't think he was a threat to any other residents.

An interview was conducted on 10/21/21 at 2:40 PM with the Clinical Corporate Nurse Consultant along with the DON and Unit Manager #2. The Clinical Corporate Nurse Consultant stated there was no record of the previous Administrator or the previous DON investigating or reporting this incident to the State Agency. She acknowledged an investigation was warranted for this incident to assure safety for all residents.

3. Resident #38 was admitted to the facility on 08/31/21. Diagnoses included progressive neurological conditions, Non-Alzheimer ' s dementia, anxiety, and delusional disorders.

The MDS dated 10/14/21 revealed the resident was severely cognitively impaired with poor decision making and an inattention behavior that was continuously present and did not fluctuate.

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Resident #38 demonstrated behavioral symptoms directed toward others such as hitting, pushing, and grabbing, verbal behavioral symptoms directed toward others such as threatening, screaming and cursing, and rejection of care. Resident #38 required limited assistance with one staff physical assistance with bed mobility, transfers, and walking in room, extensive assistance with one staff physical assistance with dressing, eating, and personal hygiene and two staff physical assistance with toileting. Resident #38 was steady at all times, had no impairments, and did not use a mobility device.

A review of a progress note written by Nurse #9 on 09/27/21 at 2:20 PM revealed, in part, Resident #38 hit Resident #27 on the right side of her face while trying to take something away from Resident #27.

The facility was not able to provide the initial allegation report which should have been filed with HCPR within 24 hours of a resident-to-resident abuse on 09/27/21. The facility provided the facsimile transaction form dated 09/27/21 indicating "the following data could not be sent and that the line was busy," but they did not provide the initial allegation report.

Review of the investigation report which was required to be completed and filed with the HCPR within 5 days of the alleged incident was filed on 10/05/21 at 8:35 AM as evidenced by the electronic time and date stamp on the facsimile transaction report.

An interview was conducted with Nurse #9 on 10/21/21 at 11:45 AM. Nurse #9 reported on 09/27/21 the staff and residents were in the

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dining room area having snacks and drinks. Resident #38 reached for Resident #27 ' s drink. Resident #27 said "no" to Resident #38 and tried to stop her from taking her drink. Resident #38 slapped Resident #27 with an open hand to the right side of her face. Nurse #9 stated she immediately separated the two residents and notified the Director of Nursing (DON), the Physician, and the responsible parties of both residents. Nurse #9 stated Resident #27 stated "ouch" and continued on with drinking her drink. Nurse #9 stated there was no apparent harm. Nurse #9 stated she recognized this as resident-to-resident abuse and immediately reported it to the DON who was employed at that time as she had been educated to do. Nurse #9 stated Resident #38 had been assigned to have one staff member with her at all times as a result of this altercation.

An interview was conducted with the current Administrator on 10/21/21 at 12:00 PM. The Administrator stated he had just started working at this facility on 10/07/21 and he did not know why the initial report was not completed for the resident-to-resident abuse on 09/27/21, nor did he know why the investigation report for this incident was not filed within 5 working days but was submitted late on 10/05/21 by the previous Administrator or DON.

An interview was conducted with the Clinical Corporate Nurse Consultant (CCNC) on 10/21/21 at 5:55 PM. The CCNC reported she did not know why the initial report for the resident-to-resident abuse on 09/27/21 had not been completed or filed but stated she believed it was due to the former DON who was terminated as a result of not reporting abuse. The CCNC

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F 607	Continued From page 18 stated the investigation report should have been submitted within 5 days and it seemed as though the previous Administrator or DON attempted to send the initial report on 09/27/21 but the facsimile transaction report revealed "the following data could not be sent and that the line was busy." The CCNC stated an investigation report also was attempted to be sent, although late, on 10/04/21 but the facsimile revealed "the following data could not be sent and that the line was busy." The CCNC stated the DON and the Administrator should have followed up on this to ensure the reports were sent to the HCPR in the time they were required to be sent.	F 607		
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 resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of falls for 1 of 6 residents reviewed for accidents (Resident #26). Findings included: Resident #26 was admitted to the facility on 09/04/20 with multiple diagnoses that included difficulty walking, muscle weakness, pain in the right knee and lack of coordination. Review of a nursing progress note dated 07/25/21 revealed Resident #26 had fallen in her bathroom and was transferred to the emergency	F 641	F641 – Accuracy of Assessments Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #26 electronic medical record was reviewed by the corporate MDS Nurse, modifications were completed and accurate MDS was transmitted on 10/20/21. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was completed on current	11/26/21

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F 641	Continued From page 19 room for evaluation. An annual MDS assessment dated 08/27/21 documented the resident had intact cognition. The assessment documented Resident #26 had not had any falls since admission, reentry or the prior assessment (of 05/28/21). In an interview with Resident #26 on 10/20/21 at 1:15 PM she stated she had fallen in July while taking herself to the bathroom. In an interview with the Regional Clinical Nurse Consultant on 10/21/21 at 5:58 PM she stated the MDS assessment completed in August 2021 was incorrect. She confirmed the assessment should have reflected Resident #26 had fallen since the prior assessment.	F 641	resident Material Data Set (MDS), by Corporate MDS Coordinator, to ensure that those residents who had experienced a Fall with injury did have an accurate MDS. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. During the morning clinical meeting, Monday thru Friday, residents medical record will be reviewed by the Director of Nursing, Assistant Director of Nursing and Administrative Nurses to review any residents who may have experienced a fall over the past 24 hours. Interventions will be developed and implemented by the Interdisciplinary Team and Care Planned as needed by the MDS Nurse and/or Administrative Nurse. This meeting will begin by 11/26/21. Corporate Nurse Consultant completed education with facility traveler MDS relating to the coding of Section J1900. This was completed on 11/18/21. Facility Care manager/MDS Coordinator will audit 5 resident MDS assessments to ensure coded correctly weekly for 4 weeks, then monthly for 3 months. The MDS Nurse and/or Administrative Nurse will create a summary of these monitoring results and present at the facility monthly QAPI to ensure continued compliance.	

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F 641	Continued From page 20	F 641	Include dates when corrective action will be completed: 11/26/21	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to carry out orders consistent with the physician's written order by administering 1 Milligram (MG) of Clonazepam instead of 0.25 MG as ordered by the physician on two separate occasions for 1 of 1 resident's (Resident #43). Findings included: Resident #43 was admitted to the facility most recently on 01/31/18 with diagnoses that included anxiety disorder, major depression, insomnia, chronic pain syndrome and polyneuropathy. Review of physician orders for October 2021 revealed the following orders: 1) Clonazepam 1 MG-take on tablet by mouth every morning for anxiety (started 01/04/20); 2) Clonazepam 0.25 MG-take one tablet by mouth at 5 PM daily for anxiety (started 12/06/19); and 3) Clonazepam 1 MG-give 2 tablets (2 MG) by mouth at bedtime for anxiety (started 03/21/21). A quarterly Minimum Data Set (MDS) assessment dated 09/16/21 documented Resident #43 had intact cognition. She had	F 658	F658 Services Provided Meet Professional Standards Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #43□s attending physician was contacted for a clarification of current orders for Clonazepam, by unit manager. Resident #43 is currently receiving their medications accurately based on physician orders, as of 10//21. Nurse #6 no longer works at this facility. MA #3 received re-training by the director of nursing regarding the 10 rights of medication administration, this was completed on 11/23/21. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was completed on 10/18/21 for	11/26/21

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F 658	Continued From page 21 reported trouble sleeping and feeling tired on 2 to 6 days during the assessment look back period. She was able to stabilize without staff assistance and used a walker for ambulation. She was occasionally incontinent of bladder and always continent of bowel. She had received antianxiety and antidepressant medications on 7 of the days during the assessment period. A care plan for Resident #43 started on 02/14/21 had the following focus area: (Resident #43) is currently being treated for depression, anxiety, and insomnia. The goal was for her to display no decline in mood and no increase in anxiety with no adverse effects from the medications. Interventions included to administer medication as ordered and monitor for effectiveness or adverse effects. Review of the Controlled Drug Receipt Record/Disposition Form for Resident #43 revealed Clonazepam 1 mg was removed from the locked drawer on 10/07/21 by Nurse #6 at 5:30 PM and again on 10/11/21 at 4:15 PM by Medication Aide #3. (The dose ordered by the physician for 4 PM daily was 0.25 MG not 1 MG). Review of the nursing progress notes revealed no entries were made for Resident #43 on either 10/7/21 or 10/11/21. Review of the vital signs between 10/06/21 and 10/12/21 for Resident #43 revealed no abnormalities in her blood pressure, heart rate, or respirations. In an interview with Unit Manager #3 on 10/20/21 at 4:00 PM, after she reviewed the narcotic documentation record, she stated that on both	F 658	current residents comparing physician orders to actual narcotics by the DON and Unit manager. No further negative issues were identified. Current resident's orders will be reviewed to ensure the are accurately reflected on the Medication Administration record (MAR) by the Director of Nursing, Administrative Nurses and/or Unit Managers. Once validated for accuracy, there will be a cross reference with the medications ordered ti the the medications available in the medication cart. Negative findings will be addressed if noted, by the Director of Nursing and/or Unit manager, This will be completed by 11/26/21. Current Licensed Nurses and Medication Aides will be educated on the "ten rights of medication administration" by the Director of Nursing and/or Unit Managers by 11/26/21. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. During, the morning meeting the new orders for current residents and new admissions will be reviewed by the Director of Nursing, Administrative Nurses and Unit Managers. The new and/or admission orders will be compared to the MAR and then to the medication received from pharmacy. If medications are not	

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F 658	Continued From page 22 days (10/07/21 and 10/11/21) the wrong dose of Clonazepam had been removed from the locked drawer at 4:00 PM for Resident #43. The Director of Nursing was present and stated she expected the nursing staff to administer medications as ordered by the physician. In an interview with Medication Aide #3 on 10/20/21 at 4:15 PM she stated she had asked the nurse what to do on 10/11/21 because the bubble pack for the 0.25 MG dose had not been refilled by the pharmacy. She reported the nurse had told her to give the 1 MG dose instead. She confirmed she had given Resident #43 the 1 MG dose in lieu of the correct dose ordered by the physician on 10/11/21. She could not remember the name of the nurse who told her to give the incorrect dose. In an additional interview with Medication Aide #3 on 10/21/21 at 3:45 PM she stated on 10/11/21 when she gave the 1 MG dose of Clonazepam to Resident #43 she had not become lethargic or act any different. Medication Aide #3 declared she knew it was not okay to give the increased dose without a physician's order. In an interview with Nurse #6 on 10/21/21 at 10:44 AM she stated she did not remember Resident #43 and did not remember giving the medication to the resident. She reported she had only worked at the facility about a month and only worked on the 400 hall once. She remembered on 10/07/21 she would have passed the medications to Resident #43 at 4:00 PM but had no specific memory of giving any particular medication or dosage. She was no longer employed at the facility. In an interview with Resident #43 on 10/21/21 at 2:15 PM she stated she had no concerns	F 658	accurate and/or not received, the pharmacy will be notified by the Director of Nursing and/or designated nurse to ensure the accurate medication is received, this review will begin by 11/26/21 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing and/or Unit Managers will audit orders, MAR to the medications available for 5 residents weekly for 4 weeks and the 10 residents monthly for 2 months. Negative findings will be addressed if noted and audits reviewed weekly during the morning meeting. A summary of audit results will be completed and presented by the DON to QAPI monthly x 3 months Include dates when corrective action will be completed; 11/26/21	

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F 658	Continued From page 23 regarding her care. She commented she liked to keep moving so she always made her own bed and dusted her room herself. She attributed her longevity to working all her life. She was well groomed, dressed appropriately for the season and conversed easily in relevant conversation.	F 658		
F 689 SS=D	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 record review and staff interviews the facility failed to provide the assessed level of supervision for Resident #38 for 1 of 6 residents reviewed for accidents. Findings included: Resident #38 was admitted to the facility on 08/31/21. Diagnoses included progressive neurological conditions, Non-Alzheimer ' s dementia, anxiety, delusional disorders, and psychophysiological insomnia. The Minimum Data Set admission assessment dated 09/09/21 revealed the resident was moderately cognitively impaired and demonstrated behaviors of verbal abuse toward others, rejection of care, wandering, and behavioral symptoms that put residents at risk for	F 689	F689 Free of Accident hazards/Supervision/Devices: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Director of Nursing and Regional Nurse Consultant completed a fall assessment for Resident #38, for risk for falls, implemented falls interventions and updated care plan 11/17/21. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Director of Nursing and/or Administrative Nurses completed a review of current residents falls from the past 30 days to	11/26/21

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F 689	Continued From page 24 illness/injury. Resident #38 required limited assistance with one staff physical assistance with bed mobility and transfers and walking in and out of the room, extensive assistance with one staff physical assistance with all other activities of daily living. Resident #38 was steady at all times, had no impairments, and did not use a mobility device. Resident #38 received 7 days of an antidepressant and had no falls during this assessment. A care plan review revealed the resident had a plan of care updated on 09/09/21 for at risk for falls related to cognitive deficits, wandering and bladder incontinence. Interventions included to provide frequent staff observations of resident, observe resident routinely for needs, and rearrange environment to remove barriers for resident. A progress note written on 09/24/21 revealed, in part, Resident was being provided 1:1 care and was trying to escape through the window but was unable to get it open. The 1:1 sitter was trying to redirect the resident when she pinched and slapped the 1:1 staff member in the face and then pushed her away. The resident was placed on acute charting to monitor behaviors every shift. A record review of a psychiatric evaluation written by the Psychiatric Physician Assistant on 10/07/21 revealed Resident #38 continued with ongoing aggressive behavior and combativeness and continued to require a 1:1 due to her dangerous behaviors as she will hit and become violent with staff and residents. A progress note written on 10/17/21 at 10:22 AM revealed at 8:05 AM another resident yelled for	F 689	ensure interventions are current and implemented. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur During the morning clinical meeting, Monday thru Friday, residents medical record will be reviewed by the Director of Nursing, Assistant Director of Nursing and Administrative Nurses to review any residents who may have experienced a fall over the past 24 hours. Interventions will be developed and implemented by the Interdisciplinary Team and Care Planned as needed by the MDS Nurse and/or Administrative Nurse. This meeting will begin by 11/26/21. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Regional Clinical Nurse completed re-education for the Director of Nursing and Administrative Nurses on fall policy and review/intervention process, as of 11/26/21. During the morning Clinical meeting the Director of Nursing and Administrative Nurses will review any resident who had a fall the previous 24 hours to ensure interventions are appropriate and are in place. They will also ensure that the resident care plan us updated timely. The resident falls will be reviewed 5x week for 4 weeks, then weekly for 4 weeks. Director of Nursing and/or Administrative Nurses will complete a summary of	

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F 689	Continued From page 25	F 689		

this nurse; "Help!" Resident #38 was observed lying on the floor outside her room on her right side. It was unknown if she hit her head, neuro checks were started. Range of motion (assessing limbs) was within normal limits and no new bruising present. No discomfort noted or voiced. Two staff assisted with standing Resident #38. She was able to ambulate with assistance and unsteady gait. Unit Manager, Physician, and Nurse Practioner made aware of the fall.

An interview was conducted with Nurse #9 on 10/17/21 at 1:20 PM. Nurse #9 reported Resident #38 has had increased behaviors including hitting staff and other residents, attempting to climb on the dining room tables, increased inability to redirect, and after she had had a resident-to-resident altercation, she had required a 24 hour per day 1:1 sitter on 09/24/21. Nurse #9 stated there was usually 2 nurse aides and a nurse on the 500 hall for first shift, but on the morning of 10/17/21, there was only one nurse aide and herself assigned to the 500 hall. Nurse #9 stated she did not know why there was no staff member to be a 1:1. She stated at 8:00 AM the resident had a fall in the hallway outside of her room. Nurse #9 stated she was not sure what Resident #38 was doing prior to the fall because at the time NA #5 was assisting other residents and she was passing medications and she felt that if Resident #38 had a staff member assigned to her as the 1:1, she would not have fallen. Nurse #9 stated she was not steady when ambulating and moved very quickly and if a staff member was with her, the fall could have been prevented. Nurse #9 stated she and NA #5 were trying to keep an eye on her but it was a very hectic time with getting the residents up and ready for breakfast. Nurse #9 stated she notified

monitoring results and present at the monthly facility QAPI meeting to ensure continued compliance.

Compliance date 11/26/21

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F 689	Continued From page 26	F 689		

the Unit Manager of the fall and stated emphatically that she needed a staff person on the unit to be a 1:1 for Resident #38. Nurse #9 stated the Unit Manager came to the 500 hall and stated she would be the 1:1 until NA #11 came at 11:00 AM. Nurse #9 stated Resident #38 needed to have this constant 1:1 given her combative behaviors, impulses, and lack of safety awareness and constant wandering.

An interview was conducted with Unit Manager #2 (UM #2) on 10/21/21 at 11:10 AM. UM #2 reported Nurse #9 had called her and was very upset because Resident #38 had fallen and they needed a staff member to be the 1:1 for her. UM #2 went to the 500-hall unit and noticed Resident #38 was very busy and moving about the unit constantly with another staff member. UM #2 stated she had no signs or symptoms of pain or injury related to the fall. She stated the resident could ambulate on her own, but she was very much a fall risk and with her increased behaviors, should not be left alone. The UM #2 stated she believed the staff member that was assigned to the 500 hall to be the 1:1 was sent to another hall to work due to a call out.

An interview was conducted with the Director of Nursing (DON) on 10/21/21 at 1:57 PM. The DON reported Resident #38 was a 1:1 for a reason and that was to keep herself and others safe due to her behaviors. The DON reported if she was assigned a 1:1, then a staff member should have been assigned to the Resident for her safety and the safety of others as directed.

An interview was conducted with the Clinical Corporate Nurse Consultant on 10/21/21 at 6:30 PM. She stated her expectation of the nursing

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F 689	Continued From page 27 staff was to ensure that if the resident required a 1:1 assistance, then someone should have been assigned to her 24 hours a day, 7 days a week until the 1:1 was no longer required.	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 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 observations, record review and staff interviews, the facility failed to obtain a physician ordered weight for a resident who was having weight loss for 1 of 3 residents (Resident #63) observed for nutrition. Findings included:	F 692	F692 Nutrition/Hydration Status Maintenance Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	11/26/21

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F 692	Continued From page 28 Resident #63 was admitted to the facility on 05/03/19. Diagnoses included stroke with left sided weakness, diabetes, Non-Alzheimer ' s dementia, seizures, and depression. The Minimum Data Set quarterly assessment dated 10/03/21 revealed the resident was severely cognitively impaired and demonstrated some moods but no behaviors. Resident #63 required extensive assistance with one staff physical assistance with eating. Resident #63 ' s in Section K indicated the resident ' s weight was 157 lbs. A review of Resident #63 ' s care plan updated on 10/03/21 revealed an ongoing plan of care was in place for Nutrition with a goal to maintain current weight. Interventions included to weigh monthly, refer to Dietician for evaluation of current nutritional status and assist with meals as needed. Review of the weights recorded revealed on 09/17/21 resident ' s weight was 157 lbs. There were no other weights recorded after 09/17/21. On 08/18/21 her weight was 162 lbs. and on 07/05/21 her weight was 167 lbs. On 09/23/21 Resident #63 was seen by the Psychiatric Nurse Practioner (NP) for behaviors and weight loss. The NP ' s progress note revealed, in part, Resident #63 was recently sent out to the hospital due to a change in her mental state. She was having trouble holding a spoon and required assistance with eating and was noted to be having some right sided weakness. At the hospital they determined she was quite possibly having seizures or TIAs (mini strokes). Since the Resident ' s return, she had been weak	F 692	Resident #63 weight was obtained by facility staff on 10/20/21. Regional Clinical Nurse and Registered Dietitian completed an assessment and implemented interventions for resident #63. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 10/29/21, current residents were re-weighted to ensure accurate weights were recorded in resident electronic medical record, by the designated certified nursing assistant. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Residents will be weighed by the 12th of the month each month; New admissions and any resident identified with a significant weight loss within 30 days will be weighted weekly for 4 weeks, then monthly there after if weight gain resumes. DON, unit managers, dietary manager, and MDS Nurse will review resident weights during weekly weight meeting, to ensure interventions are in place, and notification of physician and resident representative. Regional Clinical Nurse completed re-training with the Administrative Nurses and DON on the importance of ensuring that accurate weights are entered into the resident medical record.	

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F 692	Continued From page 29 and required assistance to eat and it had appeared she had lost a significant amount of weight. I did ask the staff to get another weight on the resident as her appearance had changed so drastically. A Physician order was written on 10/01/21 to obtain weekly weights for 4 weeks as well as an order for mechanical soft diet with nectar thick liquids and magic cup (nutritional supplement) with lunch and dinner. A review of the Medication Administration Record (MAR) for October 2021 revealed there was no weight recorded on 10/06/21, the weight for 10/13/21 was recorded as 151 lbs., and there was no weight recorded for 10/20/21. An observation of Resident #63 during lunch time on 10/18/21 from 12:10 - 12:30 PM revealed the resident was being supervised with meals and being encouraged to eat her meal. The resident consumed about 75% of her meal including the magic up ice cream supplement. An observation of Resident #63 during lunch time on 10/20/21 from 12:15-12:40 PM revealed the resident was not being supervised or encouraged to eat and was sitting in front of her plate without eating. At 12:40 PM, Nurse Aide (NA) #8 was noted to start encouraging the resident to eat. The resident consumed about 25% of her meal and ate all of her magic cup ice cream supplement. An interview was conducted with NA #8 on 10/20/21 at 1:00 PM. NA #8 stated the resident could eat independently and some days she would eat better than others and she usually	F 692	Monthly weights will be reviewed, by the facility director of nursing and administrative nurses, at the facility Weight Meeting weekly for 4 weeks, then monthly for 2 months. Include dates when corrective action will be completed; 11/26/21	

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F 692	Continued From page 30 always consumed her magic cup. NA #8 stated the resident need to be encouraged and queued to eat and stated today was one of those days she did not eat much at lunch. An interview was conducted with Nurse #10 on 10/20/21 at 1:15 PM. Nurse #10 reviewed the MAR and stated the resident had an order to obtain weekly weights for 4 weeks. Nurse #10 did not know why the weight was not obtained on 10/06/21 as ordered. Nurse #10 stated Resident #63 needed assistance with meals and she had good days and bad days but generally would eat about 50% of her meal. An interview was conducted with Nurse #9 on 10/21/21 at 11:45 AM. Nurse #9 reviewed the Electronic medical administration record (E-Mar) and reported the order was written on 10/01/21 by the previous Director of Nursing (DON) and it read to obtain a weight weekly for 4 weeks and start on 10/06/21. Nurse #9 stated they typically did weights on Wednesdays so the DON scheduled the first weight to be on Wednesday, 10/06/21. Nurse #9 stated if there was an order to obtain a weekly weight, the nurses should be obtaining the weight and recording it on the MAR. Nurse #9 stated she would obtain a weight now. The current weight was obtained and was recorded in the MAR as 157 lbs. An interview was conducted with the NP via phone on 10/21/21 at 2:18 PM and she reported if there was an order to obtain weekly weights then the order should have been carried out so that the Resident ' s weight could be monitored.	F 692		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		11/26/21

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F 725	Continued From page 31 §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 by: Based on record review and staffing interviews the facility failed to maintain adequate staffing to meet a residents' (Resident #38) assessed level of supervision for 1 of 22 residents observed for staffing. Findings included: This tag is cross-referred to:	F 725	F 725 Sufficient Nursing Staff: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Director of Nursing and Scheduler reviewed the current nurse staffing to ensure that Resident #38 was provided 1:1 supervision as of 10/18/21.	

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F 725	Continued From page 32 F689: Based on record review and staff interviews the facility failed to provide the assessed level of supervision for Resdient #38 for 1 of 6 residents reviewed for accidents. A review of the staffing assignment sheet on 10/17/21 for the first shift revealed there was one nurse aide assigned to the 100 hall, 200 hall, 300 hall, 400 hall (assigned to NA #6) and 500 hall. The record indicated in the corner of the assignment sheet NA #6 was scheduled to be the 1:1 until 11:00 AM and NA #11 was the 1:1 starting at 11:00 AM. The 400 hall was noted to have a name of a nurse aide crossed out and NA #6 ' s name was written beside it to work 7:00 AM - 3:00 PM. An interview was conducted with Nurse #9 on 10/17/21 at 1:20 PM. Nurse #9 reported when she arrived for her shift on the 500 hall there was only one aid and she was told the nurse aide that was assigned to be the 1:1 for Resident #38 until 11:00 AM had been assigned to another floor and that a 1:1 staff member would be there at 11:00 AM. Nurse #9 stated the 500-hall was usually staffed with 2 nurse aides and the 1:1 staff member and a nurse especially on the first and second shift due to level of care that needed to be provided in a memory care/Alzheimer ' s unit and a total of 18 residents. Nurse #9 stated Resident #38 sustained a fall without injury during this time that she had no 1:1 supervision despite her and NA #5 trying to keep an eye on her. An interview was conducted with Nurse Aide #6 on 10/17/21 at 1:45 PM. NA #6 reported when she arrived this morning she was scheduled to work on the 400 hall and that was usually where	F 725	Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On, 10/20/21, Staffing schedule was reviewed for the remainder of the week by the Director of Nursing and scheduler to ensure adequate nursing coverage was available throughout all shifts Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The facility Administrator and Director of Nursing and Scheduler will have a Daily Labor Meeting, starting 11/19/21. This meeting will be held to review current/upcoming nursing schedule to include staffing levels for week, including agency usage, /needs, and recruiting activity. Facility Administrator provided re-training for the Director of Nursing and Staffing Coordinator on the requirements of F725, including emphasis on importance of allocating sufficient nursing staff to provided resident 1:1 coverage. Daily Labor Meetings will continue to be held daily (M-F) x 4 weeks, then monthly for for 3 months, to ensure continued compliance. Include dates when corrective action will be completed; 11/26/21	

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she worked. She was not aware she was supposed to be a 1:1 on the 500 hall.

An interview was conducted with Nurse Aide #5 on 10/17/21 at 2:10 PM. NA #5 reported she worked on the 500 hall all the time. She stated this hall was a secured memory care unit and needed to have 2 nurse aides and a nurse due to the cognition of the residents and the care and attention they required. NA #5 stated on the morning of 10/17/21, it was just herself and Nurse #9 on the unit and there was supposed to be a 1:1 assigned to Resident #38. She stated Resident #38 had a fall at around 8:00 AM and it was a very chaotic time with just herself and the Nurse trying to get the residents up and ready for breakfast and it was very difficult to keep an eye on Resident #38.

An interview with the Unit Manager (UM) #2 on 10/21/21 at 11:10 AM revealed Nurse #9 had called her that morning stating she did not have the 1:1 coverage for Resident #38 and was very upset because she had a fall. The UM #2 stated she went to the 500 hall to assess Resident #38 and informed Nurse #9 she would stay as the 1:1 coverage for the resident until NA #11 arrived at 11:00 AM. UM #2 was not certain but she believed the staff member assigned to be the 1:1 on the 500 hall until 11:00 AM was sent to the 400-hall due to a call out.

An interview was conducted with the Director of Nursing (DON) on 10/21/21 at 1:57 PM. The DON stated a staff member should have been assigned to the Resident as directed for her safety and the safety of others.

An interview was conducted with the Staffing

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F 725	Continued From page 34 Coordinator (SC) on 10/21/21 at 4:10 PM. The SC stated in looking at the staffing assignment sheet for 10/17/21, NA #6 was supposed to be the 1:1 from 7:00 AM - 11:00 AM until NA #11 came in at 11:00 AM through 11:00 PM. She stated in looking at the assignment sheet there must have been a call out from the aid who worked on the 400 hall because they had to pull the NA #6 to that hall.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		11/26/21

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F 732	Continued From page 35 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to post accurate nurse staffing information for 21 out of 21 days reviewed for staffing. Findings included: A review of the nursing staff posting (report of nursing staff directly responsible for resident care) from 10/01/21 through 10/21/21 was conducted. The staff posting included the day shift 7:00 AM - 3:00 PM, the evening shift 3:00 PM - 11:00PM and the night shift 11:00 PM - 7:00 AM. Each shift listed the category for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nurses (CNAs), the census (# of residents in the facility), a column for FTE (full time employees), and a column for total hours. A review of the actual working assignment sheets compared to the daily staff posting sheets from 10/01/21 through 10/21/21 revealed the staff posting sheets were noted to have discrepancies of actual nursing staff that was physically in the facility working including the RNs, LPNs, and CNAs.	F 732	F732 Posted Nurse Staffing Information: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Current staff postings have been reviewed by facility Director of Nursing and are correct as of 10/20/21 No resident was named. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Any resident had a potential of being affected. Administrative nurses and scheduler were educated on completing staff postings on 11/18/2021, by the Regional Clinical Nurse. on completing the Daily Staff posting Sheets to ensure they accurately reflect current staffing. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	

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F 732	Continued From page 36 An interview was conducted with the Director of Nursing (DON) on 10/21/21 at 1:17 PM. The DON reported she was ultimately responsible for ensuring the accuracy of the staff posting assignments and should have been making sure it was filled out accurately each day. The DON stated the nursing staff posting should accurately reflect the same number of staff that the working staff assignments indicate. An interview was conducted with Regional Clinical Coordinator (RCC) on 10/21/21 at 5:00 PM. The discrepancies were reviewed with the RCC and she reported that further education was needed to make sure the daily staff postings were filled out currently. She stated the daily staff postings should be an accurate picture of how many nursing staff are in the building each day.	F 732	The scheduler and/or Weekend Supervisor, will review the nursing schedule/assignment sheets daily and complete Staff Posting. This Staff Posting will be compared to the daily assignment's sheets by the Director of Nursing and/or Administrator to ensure accuracy, at the daily AM meeting daily (M-F) x 4 weeks, then weekly. Daily staff postings will be compared to actual assignment sheets and reviewed for accuracy by the scheduler and DON 5x/week x 12 weeks or until compliance achieved. The Scheduler will complete a summary report of audit results and present to the facility monthly QAPI meeting Include dates when corrective action will be completed; 11/26/21	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		11/26/21

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F 758	Continued From page 37 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and the Pharmacy Clinical Director's interview the facility failed to ensure an as needed (PRN) psychotropic medication (medications used to	F 758	F758 □ Free from Unec Psychotropic Meds /PRN Use: Address how corrective action will be	

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F 758	Continued From page 38 manage behaviors and psychiatric symptoms) was limited to 14 days or document the continued use with a rationale and duration for 1 of 24 residents whose Medication Administration Record (MAR) was reviewed. Findings included: Resident # 54 was admitted to the facility on 11/08/19. Her diagnoses included; Non-Alzheimer's Dementia, Depression, and Psychotic Disorder. The Minimum Data Set (MDS) annual assessment dated 09/28/21 revealed Resident #54 had severely impaired cognition. She exhibited no behaviors, and no rejection of care. She required extensive assistance with activities of daily living. She received an antidepressant on 7 of 7 days and did not receive antianxiety medications during the assessment period. She was not receiving Hospice care. A review of the physician orders dated 09/30/21 revealed an order for Ativan (antianxiety medication) 0.5 mgs (milligrams) subcutaneously every 4 hours as needed for shortness of breath or wheezing for Resident # 54. The order did not include a 14-day limited duration. A review of the physician orders for Resident #54 revealed Ativan 0.5 mgs subcutaneously every 4 hours as needed for shortness of breath and wheezing remained an active order on 10/21/21. A review of the Medication Administration Record (MAR) for Resident #54 dated September 2021 through October 2021 revealed Ativan 0.5 mgs was not administered to the resident during that	F 758	accomplished for those residents found to have been affected by the deficient practice. Res #54 has been reevaluated and PRN Ativan discontinued, as of 10/27/21 by facility nurse practitioner Address how the facility will identify other residents having the potential to be affected by the same deficient practice. A review of current residents with orders for psychotropic medication was completed on 11/17/2021, by the Regional Clinical Nurse and Director of Nursing, to ensure that any residents with an order for psychotropic medication included a stop date. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All psychotropic medications will be reviewed for PRN usage and stop dates in weekly clinical QA meeting, held by the facility Director of nursing and Administrative Nurses, these meeting will be weekly for 4 weeks, then monthly. The Director of Nursing and/or Administrative Nurses will provide re-training on the intent of F758 and process of clarification of any PRN psychotropic orders to ensure the physician gives a stop date. This training will be completed by 11/26/21.	

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F 758	Continued From page 39 time. A review of the nursing progress notes from 10/01/21 through 10/21/21 revealed Resident #54 had no documented signs or symptoms of shortness of breath or wheezing. An interview was conducted on 10/19/21 at 3:36 PM with Unit Manager #1. She confirmed Ativan 0.5 mgs was an active order for Resident # 54. She stated the order should have had a 14 day stop date and indicated the nurse who entered the order should have clarified the stop date with the physician or Nurse Practitioner. An interview was conducted on 10/21/21 at 4:00 PM with the Clinical Corporate Nurse Consultant along with the Director of Nursing (DON) and Unit Manager #2. The Clinical Corporate Nurse Consultant indicated she was aware of the 14-day time limit on prn psychotropic medications. She stated the nurse should have clarified the stop date prior to entering the prn Ativan order. A phone interview was conducted on 10/26/21 at 5:05 PM with the Pharmacy Clinical Director. She stated the Consultant Pharmacist who completed the facility's monthly review was unavailable for interview. She stated the pharmacist addressed limited duration times on psychotropic medications during the monthly pharmacy review and made recommendations to the physician when a psychotropic medication was identified without a 14-day limited duration.	F 758	Include dates when corrective action will be completed; 11/26/21	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		11/26/21

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F 760	Continued From page 40 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, and the Consultant Pharmacist Clinical Director's interview the facility failed to prevent significant medication errors by 1) not following the physicians order to increase Zoloft (used in treatment of major depressive disorder) from 50 mgs (milligrams) to 75 mgs daily for Resident # 39 and discontinued the order resulting in failure to administer 41 doses of Zoloft 75mgs. 2) not following the physicians order to hold 10 units of Novolog insulin 100 units/ml (milliliter) for blood glucose less than 300 mg/dl (deciliters) resulting in 4 doses of Novolog insulin 10 units administered to Resident #28 when blood glucose was less than 300 mg/dl for 3 of 24 residents whose Medication Administration Record (MAR) was reviewed. Findings included: 1.Resident #39 was admitted to the facility on 03/18/19. His diagnoses included: Major Depressive Disorder, Generalized Anxiety Disorder, Delusional Disorder, and Alzheimer's. A care plan dated 04/02/21 revealed Resident #39 was at risk for side effects from antidepressant and antipsychotic medications. The goal of care indicated Resident #39 would have no injury related to usage or side effects of medications. Interventions included to administer medications as ordered, monitor vital signs, and assess for adverse side effects and report to physician.	F 760	F760 Residents are Free of Significant Med Errors: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Unit Manager completed a review of Res #39, #28, and #42's electronic medical record and contacted attending physician. On 10/22, the attending physician clarified #39's order for Zoloft for 75mg. Resident #28's attending physician was contacted on 10/22/21 by unit manager, and clarification of insulin parameters were obtained. Resident #42's attending physician was contacted on 10/20, by the unit manager to clarify an insulin dosage. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of all MD orders for accuracy was completed by 11/17/2021, by the Unit Manager, which included a review of the last 30 days of physician progress notes to ensure that current orders were correct. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	

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F 760	Continued From page 41 A review of the physician's order dated 07/02/21 revealed an order for Zoloft 50 mgs daily for depression for Resident #39. The Minimum Data Set (MDS) quarterly assessment dated 09/09/21 revealed Resident #39 had severely impaired cognition. He exhibited behaviors not directed toward others on 1-3 days, and rejection of care 1-3 days. He was independent with bed mobility, transfers, and activities of daily living (ADL's). He received antidepressants on 7 of 7 days during the assessment period. A psychiatric evaluation dated 09/10/21 documented by the psychiatric physician assistant revealed Resident #39 continued with recurrent severe major depressive disorder without psychosis. Resident was isolative and withdrawn to his room, however crying spells had reduced with the start of Zoloft (50 mgs). A review of the physician assistants order dated 09/10/21 indicated to increase Zoloft to 75 mgs daily. A review of the Medication Administration Record (MAR) for Resident #39 dated September 2021 revealed Zoloft 50 mgs was discontinued on 09/10/21. There was no order implemented on the MAR for Zoloft 75 mgs. A review of the MAR dated October 2021 revealed no order for Zoloft 75 mgs for Resident #39. A review of the nursing progress notes dated 09/10/21 through 10/21/21 revealed Resident #39 exhibited no abnormal behaviors and no	F 760	Director of Nursing and/or Unit Managers will be reviewing physician orders for the previous 24 hours, including admission order will be reviewed for accuracy/clarification daily (M-F) in clinical meeting. Regional clinical Nurse completed re-training, on 11/18/21 with unit managers and director of nursing. Current licensed nurses will receive training by the DON and/or unit manager on the order entry and clarification process. This training will be completed by 11/26/21, and included in the orientation for any new licensed nurse, including agency. Any licensed nurse, include agency who does not complete this training will not be allowed work until the training is completed The Director of Nursing will complete a summary of audit results and present at the monthly facility QAPI meeting, to ensure continued compliance. Include dates when corrective action will be completed; 11/26/21	

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documented adverse signs or symptoms during that time.

An interview was conducted on 10/20/21 at 2:30 PM with Nurse #8. She stated she was familiar with Resident #39's care. She reported Resident #39 was cognitively impaired but could communicate his needs. She stated he was independent with ambulation but typically stayed in his room. He was cooperative but would refuse care at times which was typical behavior. She stated she had not observed any decline in his mood or behaviors over the past month.

An interview was conducted on 10/21/21 at 12:00 PM with Medication Aide #4. She stated she was familiar with Resident #39 and indicated she had not observed any change in his mood or behaviors over the past month.

A phone interview was conducted on 10/21/21 at 3:30 PM with the Psychiatric Physician Assistant that evaluated Resident #39 on 09/10/21. She stated she was not aware the residents Zoloft had been discontinued until the nurse notified her of the medication error on 10/21/21. She stated Zoloft should have been increased from 50 mgs to 75 mgs per her order on 9/10/21 and not discontinued. She stated (Resident #39) had been on a low dose of 50 mgs of Zoloft for only 1-2 months and therefore she would not expect the resident to have any significant or detrimental effects from abruptly stopping the medication. She stated potential effects for abruptly stopping Zoloft could include signs and symptoms such as headache, nausea, dizziness, or fatigue. She stated staff had not reported any adverse signs or symptoms to her since 9/10/21. She reported once the facility made her aware of the

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medication error on 10/21/21 she instructed the nurse to resume the order for Zoloft 75 mgs daily.

An interview was conducted on 10/21/21 at 4:00 PM with the Clinical Corporate Nurse Consultant along with the Director of Nursing (DON) and Unit Manager #2. The DON stated she clarified the order with the Psychiatric Physician Assistant and the order was corrected for Zoloft 75 mgs in the resident's electronic medical record as of 10/21/21. The Clinical Nurse Consultant and the DON indicated the nurses were responsible for entering physician orders accurately.

A phone interview was conducted on 10/21/21 at 4:30 PM with Nurse #1 who discontinued the order on 09/10/21 for Zoloft 50 mgs daily. She reported she was not currently in the facility to review the order and stated she could not recall the details of the order. She stated if she discontinued Resident #39 's Zoloft 50 mgs instead of increasing the dose to 75 mgs according to the physicians order that it was done in error.

A phone interview was conducted on 10/26/21 at 3:00 PM with the Medical Director. She stated she was not aware of the medication error related to Resident #39 's Zoloft. She indicated if Resident #39 had not exhibited increased behaviors after discontinuing the Zoloft order then she would reassess the resident and communicate with the Psychiatric Physician Assistant to consider decreasing the dose.

A phone interview was conducted on 10/26/21 at 5:05 PM with the Consultant Pharmacist's Clinical Director. She indicated stopping Zoloft abruptly may result in withdrawal symptoms such as mood

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swings, or nausea, and vomiting. She stated Zoloft 50 mgs was considered a low dose and therefore she would not expect Resident #39 to have severe effects from abruptly stopping the medication.

2.) Resident # 28 was admitted to the facility on 03/23/21. His diagnoses included; Diabetes and Dementia with behavioral disturbances.

A care plan dated 04/12/21 revealed Resident #28 had a diagnoses of insulin dependent diabetes mellitus. The goal of care included to exhibit no symptoms of hyperglycemia or hypoglycemia through the next review. Interventions included to observe for signs and symptoms of hyperglycemia and hypoglycemia and administer insulin and obtain blood sugars as ordered.

The Minimum Data Set (MDS) quarterly assessment dated 09/03/21 revealed Resident #28 had severely impaired cognition. He required limited assistance with ambulation and activities of daily living. He received insulin on 6 of 7 days during the assessment period.

A review of the physician's order dated 09/28/21 revealed an order for Novolog insulin 100 units/ml to inject 10 units 15 minutes before meals and hold for blood sugar less than 300 mg/dl.

A review of the Medication Administration Record (MAR) dated September 2021 revealed on 09/28/21 at 8:00 AM, 1:00 PM and 5:00 PM Resident #28's blood glucose was 225 mg/dl on all three occasions which were documented by Nurse #8. Novolog insulin 10 units/ml was administered subcutaneously at 8:00 AM, 1:00

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PM and 5:00 PM by Nurse #8.

A review of the Medication Administration Record (MAR) dated September 2021 revealed on 09/29/21 at 8:00 AM Resident# 28's blood glucose was 225 mg/dl and Novolog insulin 10 units/ml was administered by Nurse #8 at 8:00 AM.

An interview was conducted on 10/20/21 at 2:38 PM with Nurse #8. She stated she was familiar with Resident #28 and stated she did administer Novolog insulin 10 units to Resident #28 on 09/28/21 and 09/29/21. She stated she did not realize the resident had hold parameters in place for the insulin until after she administered the 8:00 AM dose of Novolog on 09/29/21. She stated it was an oversight and she didn't read the order correctly. She stated she did not recall Resident #28 having any reaction to receiving the 10 units of insulin on 09/28/21 or 09/29/21.

A review of Resident #28's blood glucose readings from 09/28/21 through 09/29/21 revealed his blood glucose ranged from 123 - 270 mg/dl.

An interview was conducted on 10/21/21 at 2:40 PM with the Clinical Corporate Nurse Consultant along with the DON and Unit Manager #2. The Clinical Corporate Nurse Consultant stated the nurse should have read the order prior to administering the Novolog insulin and held the dose per the order if the blood glucose was less than 300 mg/dl.

A phone interview was conducted on 10/26/21 at 5:05 PM with the Consultant Pharmacist's Clinical Director. She indicated there would be no

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significant risk or concern for a resident to receive 10 units of a short acting insulin such as Novolog for a blood sugar of 225 mg/dl before meals.

Example #3

Resident #42 was admitted to the facility on 04/29/21 with a diagnosis of diabetes (DM) and COVID 19.

Resident #42's quarterly Minimum Data Set (MDS) dated 09/15/21 revealed resident had no cognitive impairments.

Resident #42's Physician order listed the following orders: administer 5-units of Levemir (a long-acting insulin) subcutaneously in the PM for diabetes (started on 07/14/21 and discontinued on 09/14/21 by Nurse #3), administer 4-units of Novolog (a fast-acting insulin) as needed for blood sugar over 350 (started on 07/21/21), and administer 22-units of Levemir in the AM for elevated blood sugar (started 09/03/21 and discontinued on 09/14/21), administer Dexamethasone (steroid) 6 mg tablet by mouth daily cough related to for COVID-19 (started 09/08/21 and discontinued on 09/18/21), and administer 30-units of Levemir in the AM for elevated blood sugar (started 09/14/21).
A record review revealed there was no order to discontinue Levemir 5-units in the PM and was discontinued by Nurse #3 without an order on 09/14/21.

Review of Resident #42's Medication Administration Record (MAR) dated 09/14/21 revealed to check Resident #42's blood sugar before meals. Resident #42's

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September-October/2021 MAR revealed her blood sugar levels were checked before meals by nursing staff per order and the results ranged from a low of 58 to a high of 551. Review of the resident's MAR indicated when her blood sugar went above 350, she was covered with sliding scale insulin and was given 4-units of Novolog per as needed physician order.

On 10/21/21 at 9:50 AM an interview was conducted with Nurse #2 (via phone) who wrote down took the verbal order to increase Resident #42's Levemir to 30-units on 09/14/21. Nurse #2 stated she did not remember writing the verbal order given by the NP on 09/14/21 to increase Resident #42's Levemir to 30 units. Nurse #2 said she could not remember the resident or the Levemir order.

On 10/20/21 at 10:30 AM an interview was conducted with the Clinical Corporate Consultant (CCC), and Corporate Regional Director. She said it was also her expectation that Resident #42's evening Levemir 5-unit order should not have been discontinued by Nurse #3 without a physician order.

On 10/21/21 at 2:15 PM an interview was conducted with the facility's Nurse Practitioner (NP). The NP stated the verbal order that she gave to Nurse #2 and was written by Nurse #2 to increase Resident #42's Levemir to 30 units on 09/14/21 was not complete and poorly written and also was missing the intended continuation of the PM Levemir 5-unit dose. The NP referred to her 09/15/21 progress note which read in part, "She continues on Dexamethasone which was started last week on 09/08/21. Yesterday, due to elevated blood sugars, Levemir was increased from 22-

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units to 30 units every morning, she continues Levemir 5-units at bedtime and sliding scale for blood sugars greater than 350." The NP said the PM dose of Levemir 5-units should not have been discontinued by Nurse #3 on 09/14/21. NP added if the resident had received the additional 5 -units of Levemir at night, her blood sugar levels might have been much lower in the AM, and possibly too low. The NP said Resident #42 already had a sliding scale insulin order in place to give 4-units of Novolog for blood sugars greater than 350 which the NP said was adequate PM insulin coverage from 09/14/21 to present.

On 10/21/21 at 5:10 PM an interview was conducted with Nurse #3 via phone. Nurse #3 stated either the NP or the Medical Director (MD) gave an order to discontinue Resident #42's PM dose of Levemir 5-units on 09/14/21 due to Resident #42's low AM blood sugar levels. Nurse #3 said the order was written on a Nurse's Physician Order Sheet with the reason for the PM Levemir discontinuation being that the residents' "6:00 AM blood sugar levels were consistently low." There was no record in Resident #42's electronic chart or physical chart to support the order for the evening 5-unit Levemir dose to be discontinued on 09/14/21.

Review of Resident #42's E-MAR dated 09/07/21 through 10/20/21, including a (10-day timeframe resident was on Dexamethasone) revealed the following morning blood sugar levels: 09/07/21 - 244, 09/08/21 - 147, 09/09/21 - 132, 09/10/21 - 215, 09/11/21 - 297, 09/12/21 - 296, 09/13/21 - 94, 09/15/21 - 315, 09/16/21 - 206, 09/17/21 - 194, and 09/19/21 - 421.

A further review of the E-MAR during 09/14/21

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F 760	Continued From page 49 through 10/20/21 revealed the Levemir 30-units was administered to Resident #42 daily according to the physician's order. On 10/22/21 at 12:35 PM an interview was conducted with the facility's Medical Director. The MD stated she was at the facility all day on 09/14/21, wrote orders and gave many verbal orders. The MD said she was not able to remember all the orders she gave that day and added it was her expectation that her progress notes be followed by nursing and that Resident #42's PM dose of Levemir 5-units should have been continued per her progress notes. The MD stated the resident was on sliding scale insulin and would have received 4 units of Novolog for blood sugars above 350 and the morning dose of Levemir was increased from 22 units to 30 units due to being diagnosed with COVID-19 and receiving a course of dexamethasone. MD indicated the resident had a long history of high and low sugars and was more concerned with the resident's low blood sugars going too low.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		11/26/21

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F 761	Continued From page 50 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review the facility failed to ensure medications were under direct observation by the administering Medication Aide who left medication unattended at the bedside for 1 of 1 resident's (Resident #14). Findings included: Resident #14 was admitted to the facility on 10/14/15 with multiple diagnoses that included mild cognitive impairment, atrial fibrillation, and chronic pain. An annual Minimum Data Set (MDS) assessment completed on 07/28/21 documented Resident #14 had intact cognition. She required extensive assistance with bed mobility, transfers, dressing, toileting and hygiene. She was occasionally incontinent of bladder and bowel. She had received antidepressant, anticoagulant and opioid medications on seven of the days during the look back assessment period.	F 761	F761 – Label/Store Drugs and Biologicals Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Res #14 medication was removed, on 10/19/21 from the resident room and education was provided by the Director of Nursing to Resident #14. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing and Unit managers completed a facility observation round on 10/19/21, to ensure that no other resident had any medications at bedside. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 761	Continued From page 51 On 10/20/21 at 2:45 PM a medication cup that contained one orange pill broken in half was observed on the bedside table in Resident #14's room. Unit Manager #2 came to the room and observed the medication left at the resident's bedside. She removed the medication from the resident's room. In an interview with Unit Manager #2 on 10/20/21 at 2:50 PM she stated Resident #14 did not have a physician's order to administer her own medication. She confirmed the medication should not have been left unattended in Resident #14's room. The Director of Nursing stated she did not expect the nursing staff to leave medications in a resident's room. In an interview with Medication Aide #3 on 10/20/21 at 3:00 PM she stated she had left the medication at the bedside in Resident #14's room. She reported the pill was Diltazem (a cardiac medication) that the resident received three times a day. She explained Resident #14 would not always take the medication while she was standing in the room and she often left it at the bedside. She concluded she understood it was not acceptable to leave medication at the bedside and in the future she would document the medication had been refused, discard it and notify the nurse.	F 761	recur. All nursing staff, including agency nursing staff, were educated regarding the medication at bedside, by the facility unit managers, on 10/27/21. This included that if any resident requested to administrator their own medication that they should report that request to the director of nursing and an assessment would be completed for that resident. The facility administrative staff will complete ambassador rounds 5 x/week for 6 weeks, then monthly, to ensure there is not medications at resident bedside The facility administrator will complete a summary of audit results and present at the facility monthly QAPI committee, to ensure continued compliance. Include dates when corrective action will be completed; 11/26/21	
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	F 842		11/26/21

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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

§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.

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F 842	Continued From page 53 §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 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 record review and staff interviews the facility failed to accurately document the administration of a medication, Clonazepam 0.25 Milligrams (MG), on the Medication Administration Record (MAR) for 1 of 20 resident's whose MAR's were reviewed in the survey sample, Resident #43. Findings included: The October 2021 physician orders for Resident #43 included the following active orders for the administration of Clonazepam: 1) Clonazepam 1 MG tablet-take one tablet by mouth every morning for anxiety (started on 10/4/20); 2) Clonazepam 0.25 MG-take one tablet by mouth at 5 PM daily for anxiety (started 12/06/19); and	F 842	F842 Resident Records □ Identifiable Information: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #43□s attending physician was contacted for a clarification of current orders for Clonazepam,by unit manager. The correct dose of the medication was received on 10/17/21 Resident #43 is currently receiving their medications accurately based on physician orders. Nurse #6 no longer works at this facility.	

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F 842	Continued From page 54 3) Clonazepam 1 MG tablet-give 2 tablets (2 MG) by mouth at bedtime for anxiety (started 03/21/21). Review of the Controlled Drug Receipt Record/Disposition Form for Resident #43, Clonazepam 1 MG tablet, revealed a one Milligram tablet was removed from the locked narcotic drawer on 10/07/21 by Nurse #6 at 5:30 PM and again on 10/11/21 at 4:15 PM by Medication Aide #4. Review the October 2021 Medication Administration Record for Resident #43 revealed Nurse #6 documented she had administered 0.25 MG of Clonazepam to Resident #43 at 4:00 PM on 10/07/21 and Medication Aide #4 documented she administered 0.25 MG of Clonazepam to Resident #43 on 10/11/21 at 4:00 PM. In an interview on 10/20/21 at 4:00 PM with Unit Manager #2 and the Director of Nursing (DON), Unit Manager #2 stated the incorrect dosage of Clonazepam had been administered in error to Resident #43 at 4:00 PM on 10/07/21 and 10/11/21 and had not been documented accurately on the MAR either day. The DON stated she expected residents to receive medications as ordered by the physician and for staff to document the administration of medications on the MAR accurately. In an interview with Medication Aide #4 on 10/20/21 at 4:15 PM she stated she had told the nurse the bubble pack for Clonazepam 0.25 MG had not arrived from the pharmacy. She reported she was instructed to give the 1 MG dose tablet in lieu of the 0.25 MG dose to Resident #43. She could not remember the name of the nurse who	F 842	MA #3 received re-training by the director of nursing regarding the 10 rights of medication administration, this was completed on 11/23/21. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current facility residents have the potential to be effected by this practice: Current Licensed Nurses and Medication Aides will be educated on the 10 rights of medication administration, by the Director of Nursing and/or Unit Manager, 11/26/21. The Nurse Consultant, Director of Nursing and Unit managers conducted a comparison of the Medication Administration Record to medications available in the medication cart 10/20/21, to ensure medications are available. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. During, the morning meeting the new orders for current residents and new admissions will be reviewed by the Director of Nursing, Administrative Nurses and Unit Managers. The new and/or admission orders will be compared to the MAR and then to the medication received from pharmacy. If medications are not accurate and/or not received, the pharmacy will be notified by the Director	

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F 842	Continued From page 55 instructed her to give the wrong dosage of medication. After administering Clonazepam 0.1 MG to Resident #43 she documented on the MAR that she had administered 0.25 MG. In an additional interview with Medication Aide #4 on 10/21/21 at 3:45 PM she stated on the day she gave Resident #43 the wrong dose of Clonazepam the resident had not become lethargic or act any different. She stated she had informed the resident she was giving her a higher dose and reported the resident responded, "it didn't work anyway." Medication Aide #4 stated she knew it was not okay to give the increased dose without a physician's order. In a telephone conversation on 10/21/21 at 10:44 AM Nurse #6 stated she did not remember Resident #43 and did not remember administering her medications on 10/07/21. She recalled she had passed the 4:00 PM medications on the resident's hall on 10/07/21 because the Medication Aide who had been passing the medications had left at 2:00 PM that day. She reported she did not remember giving this particular medication because she had only passed medications on the resident's hall one time during the month she had been employed at the facility.	F 842	of Nursing and/or designated nurse to ensure the accurate medication is received, this review will begin by 11/26/21 The Director of Nursing, Administrative Nurses and/or Unit Managers will conduct 3 medication pass audits, on different facility nurses, weekly (M-F) for 4 weeks and 4 monthly for 2 months to ensure the nurses are following the 10 rights of medication administration. Negative findings will be addressed if noted. The results of the medication pass audits will be reviewed weekly during the morning meeting by the Director of Nursing, Administrative Nurses and Unit Managers to ensure Licensed Nurses and Medication Aides are competing medication passes accurately. Monitoring: The Director of Nursing will bring the results of the audits to The Quality Assurance Performance Improvement monthly for 3 months. The QAPI committee will then determine if the plan is effective. Different interventions will developed as deemed necessary by the committee to continue to sustain compliance. Include dates when corrective action will be completed; 11/26/21	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		11/26/21

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(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

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F 880	Continued From page 57 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, a review of the facility policy titled, "Transmission Based Precautions" and review of the CDC (Centers for Disease Control) guidelines regarding linen and laundry management best practices, the facility failed to 1.a) implement Contact Precautions immediately upon identifying a resident (Resident #54) under suspicion of C-Difficile (Clostridium Difficile- a contagious bacteria that causes severe diarrhea and colitis) after the resident experienced new onset of 3 loose stools in a 24-hour period. b) the facility staff failed to don personnel protective equipment (PPE) prior to entering a resident's room who was	F 880	F880 – Infection Control Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Nurse #8 received 1:1 education regarding: Communicating changes in resident's infectious status to the staff when isolation precautions are implemented by Corporate Nurse Consultant on 10/17/21. Corporate Nurse Consultant conducted 1:1 education to	

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F 880	Continued From page 58 under suspicion of C-Difficile for 1 of 1 resident observed for Transmission Based Precautions (Resident #54). 2) staff failed to discard soiled towels that were observed lying on a sofa in a resident's room for 1 of 1 resident observed for infection control (Resident #66). Findings included: The facility infection control policy effective January 2018 titled, "Transmission Based Precautions" read in part; transmission-based precautions were to be implemented for residents who were known to be or suspected of being infected or colonized with infectious agents. Healthcare personnel caring for residents on Contact Precautions were to wear a gown and gloves for all interactions that may involve contact with the residents, or potentially contaminated areas in the resident's environment. Donning personal protective equipment (PPE) upon room entry and discarding before exit is done to contain pathogens especially those that have been implicated in transmission through environmental contamination such as C. Difficile. 1.a) Resident #54 was admitted to the facility on 11/08/19. Her diagnoses included; Non-Alzheimer's Dementia, and Cognitive Communication Deficit. An interview was conducted on 10/17/21 at 12:00 PM with Unit Manager #2. She stated the facility had one resident on Transmission Based Precautions (Resident #54) who was in room 208 at that time. She stated the resident was suspected of C- Difficile earlier that morning due to having three loose stools.	F 880	Nurse #8 regarding infection control protocol to include appropriate signage and implementation of PPE upon suspecting an infectious disease process on October 17th, 2021. CNA #9 received 1:1 education regarding the appropriate way to handle linen according to infection control protocol by Director of Nursing on 11/17/21. Current facility residents were reviewed on 10/18/21 for infectious disease status by the Director of Nursing/designee. Determination was made as to whether isolation protocols needed to be implemented and communicated to staff. No other current residents identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 10/17/2021, current licensed staff were also re-educated by the Corporate Nurse Consultant and Unit Manager regarding communicating changes in resident’s infectious status to the staff when isolation precautions are implemented. This education was completed 11/17/21. 11/17/21 Licensed staff were also education also consisted of infection control protocol regarding communication to the staff regarding the implementation of PPE upon suspicion of an infectious disease process by the Corporate Nurse Consultant, Director of Nursing or Administrative Nurses. Infection control protocols for handling of	

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F 880	Continued From page 59 An observation was conducted on 10/17/21 at 12:05 PM of the 200 hallway. Resident #54's room (#208) was observed with no Contact Precautions in place. There was no sign on the resident's door to notify staff that Resident #54 was on Contact Precautions, and no supply cart outside of the resident's room that contained PPE supplies. An interview was conducted on 10/20/21 at 12:10 PM with Nurse #8. She stated Resident #54 was under suspicion for C-Difficile as of earlier that morning. She stated Nurse Aid #9 reported to her that Resident (#54) had three loose stools with odor and mucous around 8:00 AM that morning. She stated she notified the on-call Nurse Practitioner who instructed her to collect a stool sample and follow isolation protocols. Nurse #8 stated she recently started working at the facility in September 2021 and wasn't completely familiar with the facility isolation protocols although she received infection control training upon hire. She stated she should have placed the resident (#54) on Contact Precautions and notified staff immediately after identifying three loose stools and suspected C-Difficile. An observation was conducted on 10/17/21 at 12:15 PM of Resident #54's room (#208). An Enhanced Droplet Precaution sign was posted on the door and a supply cart that contained gloves, gown, mask and eye wear was observed outside of the resident's room. A follow up interview was conducted on 10/17/21 at 12:15 PM with Nurse #8. She stated she intended to place a sign indicating Contact Precautions for Resident #54 and instead placed Enhanced Precautions signs and she would	F 880	linen was started 10/20/21 and will be completed by 11/26/21. Current nursing staff will be educated on Infection Control and Personal Protective Equipment utilizing the “Relias Training System Modules”. On 11/18/21 the NHA/designee educated the facility Managers on the “Ambassador Program”. The Ambassador rounding tool includes observations to ensure infection control protocol is being adhered to consistently. The rounding tool was implemented on 11/18/21 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Interviews and observation rounds will be conducted by the Director of Nursing/designee to ensure staff awareness of residents requiring isolation and to ensure the proper infection control protocol is being adhered to. Ambassador rounds will be conducted daily, Monday thru Friday, utilizing the Ambassador round tool to monitor for dirty linen handling along with other standards of practice. Negative findings will be addressed if noted. The Administrator, Director of Nursing and Management Team will review the results of the interviews, observational audits and Ambassador Tools in the morning meeting, Monday thru Friday for 4 weeks and monthly for 2 months to ensure proper infection control interventions have	

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F 880	Continued From page 60 correct the error immediately. A follow up interview was conducted on 10/17/21 at approximately 4:00 PM with Unit Manager #2. She stated Resident #54 had the appropriate isolation precaution sign in place for Contact Precautions and stated a supply cart with PPE was located outside of the resident's room and indicated staff were made aware Resident #54 was on Contact Precautions. An interview was conducted on 10/18/21 at 5:06 PM with the Infection Control Preventionist. She stated the facility protocol for a resident suspected of C-Difficile included; that staff should immediately place the resident on contact precautions and notify the physician and get an order for a stool culture, then notify the resident's responsible party. She stated the resident would be placed on acute charting which included vital signs, monitoring stools, and monitoring the overall condition of the resident. She reported the resident would remain on Contact Precautions until the stool culture results were obtained. An interview was conducted on 10/21/21 at 4:00 PM with the Clinical Corporate Nurse Consultant along with the Director of Nursing (DON) and Unit Manager #2. The Clinical Corporate Nurse Consultant stated Resident #54 should have immediately been placed on Contact Precautions after the resident was suspected of C. Difficile. She stated the nurse should have placed the appropriate sign on the resident's door and placed the supply cart with the appropriate supplies outside of the residents room. b) An observation was conducted on 10/17/21 at 12:15 PM of Resident #54's room (#208). An	F 880	been implemented and communicated to staff and proper infection control protocol is being followed. Negative findings will be addressed if noted. Results of all audits will be taken to Quality Assurance Performance (QAPI) Committee meeting by the Director of Nursing for 3 months for review. The QAPI Committee will determine if the plan is effective. Additional interventions will be developed and implemented based on findings to ensure sustained compliance. Include dates when corrective action will be completed; 11/26/21	

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F 880	Continued From page 61	F 880		

Enhanced Droplet Precaution sign was posted on the door and a supply cart that contained gloves, gown, mask and eye wear was observed outside of the resident's room.

During the observation conducted on 10/17/21 at 12:15 PM Nurse Aid #9 was observed pushing Resident #54 back into her room in her wheelchair and assisting Resident #54 while in the room without wearing gloves or a gown.

An interview was conducted on 10/17/21 at 12:20 PM with Nurse Aid #9. She stated she was not aware Resident #54 was placed on Contact Precautions and indicated the nurse did not notify her. She stated the supply cart with PPE and the isolation sign must have just been placed there and she did not notice it before entering the resident's room. She indicated the nurse's medication cart was partially blocking the residents room door and she didn't see the sign on the door prior to entering the room. She stated Resident #54 was cognitively impaired and was wheelchair bound and required extensive assistance with transfers and activities of daily living. She stated the resident had been in the hallway in her wheelchair and had not had any contact with other residents or staff.

An observation was conducted on 10/17/21 at 12:30 PM of Resident #54's room. Nurse #8 was observed entering the resident's room without donning gloves or a gown, she was wearing a mask, and picked up Resident #54's lunch tray and walked out of the room with the tray. Nurse #8 stated she went into the room without thinking and forgot to put on gloves and gown prior to entering the room. She stated she should have applied gloves and a gown before she entered

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F 880	Continued From page 62 the room. An interview was conducted on 10/18/21 at 5:06 PM with the Infection Control Preventionist. She indicated staff should have donned PPE prior to entering the room after Resident #54 was placed on Contact Precautions. An interview was conducted on 10/21/21 at 4:00 PM with the Clinical Corporate Nurse Consultant along with the Director of Nursing (DON) and Unit Manager #2. The Clinical Corporate Nurse Consultant stated the staff should have donned the appropriate PPE prior to entering a resident's room who was on Contact Precautions. Example #2 A review of a document updated March 20, 2020 titled: Centers for Disease Control (CDC) and Prevention Appendix D - Linen laundry Management Best Practices for Linen (and Laundry) handling stated "Never carry soiled linen against the body. Always place it in the designated container. Carefully roll up soiled linen to prevent contamination of the air, surfaces, and cleaning staff. Do not shake linen. If there is any solid excrement on the linen, such as feces or vomit, scrape it off carefully with a flat, firm object and put it in the commode or designated toilet/latrine before putting linen in the designated container. Place soiled linen into a clearly labeled, leak-proof container (e.g., bag, bucket) in the patient care area."	F 880		

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F 880	Continued From page 63	F 880		

A right heel pressure wound dressing change observation on 10/20/21 at 10:30 AM with the Wound Care Nurse (WTN) and Personal Care Assistant (PCA #1). After resident #66's right heel dressing changed was completed, a pile of unbagged soiled towels with brownish and reddish substance on them were observed laying on resident's couch near the hallway door.

An interview was conducted on 10/20/21 at 10:45 AM with the WTN, PCA, and Resident #66. Resident #66 stated he had "messed himself" earlier that morning, due to being on a stool softener, and that a Nursing Aide (NA) cleaned him up and must have left the soiled linen on the couch after cleaning him up. Resident #66 said he did not remember who the staff member was. WTN and PCA stated they never saw the soiled linen laying on the couch previously. They both stated if they had cleaned up Resident # 66, they would have followed good clinical practices by bagging the soiled linen and placing the bag in the soiled linen container. Both the WTN and PCA were aware that placing the unbagged soiled linen on the couch was an infection control issue but stated that the staff member must have been trying to get the resident's care completed quickly.

During an interview on 10/20/21 at 5:05 PM with Director of Nursing (DON), Infection Control Nurse (ICN), and Reginal Clinical Director RCD). DON and ICN stated it was their expectation that all soiled linen be bagged by nursing staff, and not just place unbagged soiled linen on a resident's couch.

During an interview on 10/21/21 at 10:30 AM with the facility's Administrator and RCD. The

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F 880	Continued From page 64 Administrator stated it was his expectation that all staff fully follow facility's infection control policies, and for all soiled linen to be first bagged by facility staff prior to placing them on the resident's couch.	F 880		