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PELICAN HEALTH AT ASHEVILLE	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/15/21 through 11/23/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 4VXF11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted onsite 11/15/21 through 11/19/21 with exit from the facility on 11/19/21. Additional information was obtained offsite through 11/23/21; therefore, the exit date was changed to 11/23/21. A total of 70 allegations were investigated and 41 allegations were substantiated. Event ID #4VXF11.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		12/29/21

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

Electronically Signed | 12/21/2021

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff interviews, and resident interviews, the facility failed to maintain residents' dignity by not providing showers, bathing, and incontinence care resulting in residents feeling "like a homeless person", like staff did not like them, dirty and embarrassed, uncomfortable, and dirty. This affected 3 out of 6 (Resident #27, Resident #13, and Resident #50) sampled residents. 1. Resident #27 was admitted to the facility on 09/17/20 and readmitted on 11/02/21 with diagnoses which included coronary artery disease, congestive heart failure, hypertension, chronic respiratory failure, and diabetes mellitus type II.	F 550	1. Residents # 27, 13, and 50 were cited. Identified residents were given their choice of shower or bath; given preference along with grooming and incontinence care as needed or per request. 2. Resident in the facility have the potential of being affected by this deficient practice. An audit was completed by the Interdisciplinary team to ensure we were honoring all resident preference on: showers vs bed bath including days and shifts desired to the best of our ability. This was concluded on 12.15.21 and implemented by the Director of Nursing on 12.16.21 3. The Administrator and Director of	

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F 550	Continued From page 2 Review of Resident #27's most recent quarterly Minimum Data Set (MDS) dated 11/04/21 revealed she was cognitively intact for daily decision making, had no behaviors for refusal of care, and required total assistance of 2 staff for bathing and toileting. Observation and interview on 11/15/21 at 2:38 PM of Resident #27 revealed her lying in bed in her room watching her TV. Resident #27 expressed concerns about not being provided incontinence care until she had wet through her clothing down to her knees and wet the linens on her bed. Resident #27 stated just yesterday on 11/14/21 she had been told by Nurse Aide (NA) #3 she would have to wait for care until NA #3 completed her charting. She stated she had a shower yesterday and it was the first one she had in 3 weeks. Resident #27 further stated her hair was matted to her head and she could smell her own body odor and it made her feel degraded and "like a homeless person". Resident #27 indicated there was not enough staff at the facility to properly care for the residents and make sure their needs were met. Resident #27 revealed it made her feel like the NAs did not like her or like taking care of her because of her size and she depended on them for her care. Observation on 11/17/21 at 2:42 PM of incontinence care on Resident #27 revealed the resident in bed with brief on with large amount of urine in the brief. NA #3, with gloved hands, cleaned the resident and applied a new brief. Resident #27 requested her draw sheet be changed because she could feel on her legs that it was wet. NA #3 felt of the draw sheet with gloves on and the resident said to her "you can't feel the wetness with gloves on." NA #3	F 550	Nursing began education on 12.1.21 with the 100% of the direct care staff including agency staff and the IDT team on the topic of resident rights to include shower preferences, grooming, and proper incontinence care per plan of care. This education was completed on 12.17.21. Any newly hired staff or agency staff to enter our facility will be educated on this going forward. 4.The Director of Nursing or Unit Manager will audit: shower/bathing/grooming/incontinence care per their plan of care through interviews with cognitively intact residents about care and dignity needs being met and through observations for residents who are not cognitively intact for 5 residents at 5x week for 4 wks; 5 residents 3xweek for 4wks; and 5 residents 1xweek for 4 wks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months or or until the process has shown that it has improved adequately. Completion date: 12/29/21	

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proceeded to change the draw sheet and then took the dirty linens and trash out of the room. Resident #27 then said to the surveyor "NA #3 would not have changed my draw sheet if you had not been in here."

Interview on 11/17/21 at 3:58 PM with NA #3 revealed she frequently worked from 7:00 AM to 3:00 PM or 7:00 AM to 7:00 PM on Resident #27's hall. NA#3 stated she had worked on 11/14/21 and recalled telling Resident #27 she would be right with her as soon as she finished charting on another resident. She stated she did not want to get in trouble for not getting her charting done and sometimes it was hard when you had so many residents to provide care. NA #3 further stated she probably should not have said that to Resident #27. NA #3 indicated she should not have tried to feel wetness on the resident's draw sheet and should have just changed it as the resident requested. NA #3 further indicated she was usually only able to provide 2 incontinence rounds to the residents in an 8-12-hour shift and said it was difficult to do more.

Interview was conducted on 11/18/21 at 11:16 AM with NA #1 who worked 7:00 AM to 3:00 PM most of the time and sometimes stayed over to 7:00 PM to help cover the schedule. NA #1 stated had cared for Resident #27 and said it was difficult with 18 to 20 residents to get incontinence care done every 2 hours. NA #1 further stated they did the best they could and worked together to provide incontinence care to residents that require 2 staff. NA #1 indicated it was hard to do residents that require 2 staff every 2 hours because you had to wait until someone was available to assist with care. NA #1 revealed Resident #27 required 2 staff to transfer her in

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and out of bed but once in the shower room she could be assisted by one staff member. NA #1 stated there were only 2 NAs on the hallway and they usually had 18 or more residents each and it was difficult to do showers because it left only one NA on the hall to answer call lights and provide care. NA #1 further stated residents had not been receiving their showers as scheduled because it was all they could do to keep them clean, dry, and safe.

Interview was conducted on 11/18/21 at 11:16 AM with NA #2 who worked 7:00 AM to 3:00 PM most of the time and sometimes stayed over to 7:00 PM to help cover the schedule. NA #2 stated had cared for Resident #27 and said it was difficult with 18 to 20 residents to get incontinence care done every 2 hours and sometimes were only able to complete care 2 times a shift. NA #2 further stated they did the best they could and worked together to provide incontinence care to residents that require 2 staff. NA #2 indicated it was hard to do residents that require 2 staff every 2 hours because you had to wait until someone was available to assist you with the care. NA #2 further indicated the nurses were not always able to assist you because they were busy with their duties, and you just had to wait on someone. NA #2 revealed Resident #27 has missed showers and bed baths due to the workload of the NAs. NA #2 stated Resident #27 required 2 staff to get her on the shower bed and into the shower room which took both NAs off the floor for a period of time. NA #2 further stated when she was in the shower the NA assigned to her had to remain with her through the entire shower which left only one NA on the floor for the rest of the 30 plus residents. NA #2 indicated it was impossible to get all the showers done due to staffing.

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Interview on 11/19/21 at 3:32 PM with the Director of Nursing revealed she expected residents to receive incontinence care at least every 2 hours and as needed. The DON stated she knew there were staffing concerns and they were working on trying to hire more staff and were offering sign on bonuses to try to recruit staff and using agency staff. She further stated if staff were having difficulties providing care, she would expect them to ask the nurses or administrative nurses for assistance. The Director of Nursing (DON) revealed she would like for all residents to get showers at least 2 times each week. The DON stated if staff were not able to complete the resident's shower on their scheduled day, she expected the NAs to let the resident know and provide them a make-up shower on the next shift or the next day. The DON indicated she felt like the showers were not being provided as scheduled due to staffing. She further indicated they were offering a competitive salary with sign on bonuses but were not getting a lot of candidates for open positions.
2. Resident #13 was admitted to the facility on 5/18/21 with diagnoses which included anxiety and depression.

A review of the quarterly Minimum Data Set (MDS) dated 8/11/21 indicated Resident #13 was cognitively intact and required physical assistance with one staff for bathing and transfers.

An observation conducted on 11/15/21 at 10:35 AM revealed Resident #13's hair appeared to be oily and unbrushed.

An interview conducted with Resident #13 on 11/15/21 at 10:37 AM revealed staff stated to

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Resident #13 showers and baths were being missed due to staff quitting. Resident #13 further revealed her shower schedule was on Tuesday and Fridays but rarely received a bed bath or shower on her scheduled days. Resident #13 indicated she "felt dirty and was embarrassed" that her hair was oily and nasty.

An interview conducted with Nurse Aide (NA) #1 on 11/18/21 at 10:55 AM revealed Resident #13's showers had been missed due to staff shortages for the last four to five months. NA #1 indicated Resident #13 needed limited assistance with showers and transfers. NA #1 indicated Resident #13 had complained about missing showers and Resident #13 had stated she felt dirty and unclean.

An Interview with the Director of Nursing (DON) on 11/19/21 at 3:32 PM revealed she would like for all residents to get showers at least 2 times each week. The DON further she felt like showers had not been provided as scheduled due to staffing. The DON revealed she could not recall if Resident #13 had missed showers or baths, but indicated many residents had.

3. Resident #50 was admitted to the facility on 4/5/21 with diagnoses which included anxiety and depression.

A review of the quarterly Minimum Data Set (MDS) dated 10/9/21 indicated Resident #50 was cognitively intact and was totally dependent with two person staff assistance for bathing and transfers.

An observation was conducted on 11/15/21 at 10:35 AM revealed Resident #50's hair appeared

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F 550	Continued From page 7 to be disheveled with white flakes throughout the hair. An interview conducted with Resident #50 on 11/15/21 at 10:40 AM revealed staff had stated to Residents #50's scheduled showers had been missed due to a shortage of staff the last few months. Resident #50 indicated she "felt uncomfortable and dirty" when her scheduled shower days were missed. An interview conducted with Nurse Aide (NA) #1 on 11/18/21 at 10:55 AM indicated Resident #50 required extensive assistance and there had not been staff to assist with Resident #50's showers. NA #1 further revealed Resident #50 had complained about not receiving a shower or bath on scheduled days and indicated she felt dirty and was mad. An interview conducted with direct care Nurse #1 on 11/18/21 at 2:44 PM revealed scheduled showers and baths had been missed due to not having enough staff. Nurse #1 stated Resident #50 had complained about not receiving a shower or bath on schedule days and Resident #50 stating she felt gross and dirty. An Interview with the Director of Nursing (DON) on 11/19/21 at 3:32 PM revealed she would like for all residents to get showers at least 2 times each week. The DON further she felt like showers had not been provided as scheduled due to staffing. The DON revealed she could not recall if Resident #50 had missed showers or baths, but indicated many residents had.	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		12/29/21

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F 558	Continued From page 8 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide a means to transport a resident to the shower room for 1 of 1 resident (Resident #26) to allow the resident to be showered as ordered by the wound care Nurse Practitioner. This affected 1 of 1 resident reviewed for activities of daily living (ADL). The findings included: Resident #26 was admitted to the facility on 08/10/21 with diagnoses which included hypertension, chronic obstructive pulmonary disease (COPD) and chronic pain. Review of Resident #26's most recent admission Minimum Data Set (MDS) dated 08/12/21 revealed he was cognitively intact for daily decision making and displayed no behaviors for refusal of care. The resident's MDS also revealed bathing coded as not being provided; however, the resident required total assistance of 1 to 2 staff members with all ADL except eating. The MDS indicated the resident was 79 inches tall and weighed 547 pounds. Review of Resident #26's care plan dated 09/28/21 revealed a plan of care for ADL self-care deficit related to activity intolerance, disease	F 558	1. Resident #26 cited. Resident has a shower chair that he is appropriate for and is already utilizing in the shower room 2. Residents in this facility have the potential to be affected by this alleged deficient practice. The Unit Manager along with the therapy department conducted an audit to ensure all residents have an appropriate shower chair/bed to utilize to obtain a shower. No other concerns were found as of the completion of the audit on 12.19.21. 3. The Administrator educated all staff that all residents are to have an appropriate shower chair/bed in order to take a shower if they choose to. This education was completed as of 12.17.21. Any newly hired staff will be educated on this topic upon orientation and new agency staff will be educated via their agency orientation packets. 4. The Director of Nursing or Unit Manager will audit: shower chair/bed accommodations to ensure the need is met. 5 residents at 5x week for 4 wks; 5 residents 3xweek for 4wks; and 5 residents 1xweek for 4 wks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present	

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process, impaired balance, impaired mobility and generalized weakness. The interventions included the resident required total assistance of 2 staff with personal hygiene, oral care, and bathing, praise all efforts at self-care, monitor/document/report any changes, any potential for improvement, reasons for self-care deficit, expected course or declines in function, encourage resident to participate to the fullest extent possible with each interaction.

Review of a wound note dated 11/10/21 written by the wound care Nurse Practitioner (NP) read in part: "Treatment recommendations: #1 Moisture associated skin damage (MASD) buttocks bilaterally - instruction: shower 3 times weekly, no brief while in bed. Apply antifungal and skin prep barrier two times daily (bid). Keep buttocks area clean and dry. Recommend no briefs in bed and optimize nutrition. Plan of care discussed with facility staff."

Observation and interview on 11/15/21 at 2:09 PM with Resident #26 revealed the resident lying in bed with covers over him. The resident stated the facility was not equipped with a shower chair or bed to accommodate his size. The facility had told Resident #26 they were looking into getting a shower bed to accommodate his height but said he was not aware a shower bed had been purchased.

Interview on 11/17/21 at 3:58 PM with Nurse Aide (NA) #3 revealed she was not aware Resident #26 had physician ordered showers three times weekly. NA #3 stated Resident #26 received bed baths because he was too long or too tall for the shower bed and was afraid it would not support him in the shower room to get a shower. NA #3

results and take recommendations on any process improvement for a duration of three months or or until the process has shown that it has improved adequately.

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further stated the facility was supposed to be getting another shower bed that would support him so he could get the showers he preferred but said she had not seen it yet.

Interview on 11/17/21 at 4:41 PM with NA #4 revealed she was not aware Resident #26 had physician ordered showers three times weekly. NA#4 stated Resident #26 was difficult to get into the shower room and was not comfortable with the shower chair or shower bed the facility currently had for residents. NA #4 further stated Resident #26 was receiving bed baths instead of showers but was only scheduled for 2 per week. NA #4 indicated the facility was supposed to be purchasing a shower bed to accommodate Resident #26 but said it had not been brought to their attention that the bed had been delivered to the facility.

Interview on 11/18/21 with Nurse #1 revealed she was not aware Resident #26 had physician ordered showers three times weekly. Nurse #1 stated Resident #26 was afraid to get up in the shower chair or onto the shower bed at the facility because he didn ' t think the chair or bed would support him due to his size. Nurse #1 further stated showers three times weekly were not possible and the NP probably needed to re-evaluate the order. Nurse #1 indicated the staff was having a hard time even getting 2 showers done on residents each week and 3 showers may not be possible especially for Resident #26 because it took 2 staff to provide his bed bath.

Interview on 11/19/21 at 3:32 PM with the Director of Nursing (DON) revealed she was not aware the wound care Nurse Practitioner had ordered Resident #26 have 3 showers per week. The

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F 558	Continued From page 11 DON stated she was aware the resident did not feel comfortable the couple of time they had gotten him into the shower room on the shower chair or shower bed and said the resident was afraid they were not going to hold his weight. She further stated they had talked in IDT about getting a shower bed to accommodate his size but stated she would have to check if it had been ordered or not. The DON indicated if the shower bed had not been ordered she would make sure it was ordered for the resident.	F 558		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		12/29/21

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participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and resident, family, and staff interviews, the facility failed to refer a resident (Resident #82) for hospice services, provide residents with their preference for a shower instead of a partial bed bath (Residents #7, Resident #9, and Resident #25) and accommodate resident requests to be assisted to and from bed when requested (Residents #27 and #8) for 5 of 14 residents reviewed for choices.

Findings included:

1. Resident #82 was admitted to the facility on 03/13/20 with diagnoses that included cardiomyopathy and heart failure.

The hospital discharge summary dated 03/13/20 revealed follow-up information that read in part, "Palliative Care services - a nurse will see you within one week after receiving an order from the facility primary care physician."

A physician's order dated 03/15/20 was for palliative care to evaluate in one week after admission. A notation included on the order was "they have been notified."

A physician's progress note dated 09/08/20 for Resident #82 read in part, "his guardian/Responsible Party (RP) states the Cardiologist (doctor who specializes in the treatment of heart diseases) recommended

1. Residents #82, 7, 9, and 25 were cited. Residents #82 hospice referral was sent on 10.1.21 and services coordinated. Residents #7, 9, and 25 were asked to confirm their shower preferences and given their showers per request. Residents #27 and 8 were asked their preferences on getting in/out of bed as well. Preferences relayed to staff.
2. Residents have the potential to be affected by this alleged deficient practice. The Activities Department gathered preferences concerning getting in/out of bed by dependent residents; a shower preference audit was completed by the interdisciplinary team to ensure we were honoring all resident□s preference on: showers vs bed bath including days and shifts desired to the best of our ability. Lastly, current orders were audited to ensure all hospice orders had been addressed and followed up on appropriately. Staff were informed of all showers and getting in and out of bed preferences on 12.23.21 by the Administrator and DON/Nurse Admin team. Director of Nursing will be responsible for ensuring all Hospice referrals are implemented.
3. Director of Nursing has educated all staff on ensuring all hospice orders/referrals are followed up and documented appropriately. Director of

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F 561	Continued From page 13 hospice in the past. We do not have this in writing from any discharge summary or from the Cardiologist. Since the patient has been asymptomatic from a cardiac standpoint for the past 9 months, follow-up evaluation by the Cardiologist is recommended." A physician's order dated 09/30/21 was for a hospice referral for heart failure. The significant change Minimum Data Set (MDS) dated 10/11/21 revealed Resident #82 had severe impairment in cognition for daily decision making. The MDS indicated he had a life expectancy of less than 6 months and was receiving hospice care. During an interview on 11/15/21 at 10:07 AM, Resident #82's RP revealed prior to his admission to the facility in March 2020, he was referred for hospice services by his Cardiologist due to his heart condition. The RP added she sent the Administrator email correspondence inquiring on the hospice referral, but the referral was not made by the facility until October of this year. Review of email correspondence provided by Resident #82's RP on 11/18/21 at 4:00 PM revealed an email was sent to the Administrator on 03/30/20 at 4:27 PM informing her that Resident #82 was referred to hospice by the Cardiologist and asked what hospice could offer with the Coronavirus restrictions in place. On 03/30/20 at 6:36 PM the RP received an email response from the Administrator that read, "I'm not sure why he was offered hospice but no, they are not allowed in right now." Telephone attempt on 11/18/21 at 4:24 PM for	F 561	Nursing or designee to be informed of any orders. Director of Nursing will ensure all hospice referrals are implemented. IN addition, they were educated on honoring resident shower and getting up/laying down in bed, preferences. This was completed on 12.16.21 by the Director of Nursing. Any newly hired staff will be educated on this topic upon orientation and new agency staff will be educated via their agency orientation packets 4. The Director of Nursing or Unit Manager will audit: shower preference completions; getting in/out of bed preferences; and hospice referrals through review of medical record, observations, and interviews with cognitively intact residents regarding choices for 5 residents at 5x week for 4 wks; 5 residents 3xweek for 4wks; and 5 residents 1xweek for 4 wks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months or until the process has shown that it has improved adequately. 5. Completion date 12/29/21	

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interview with the facility's former SW was unsuccessful.

During an interview on 11/19/21 at 4:23 PM, the Administrator revealed when Resident #82 was admitted to the facility, the physician was aware of the order for hospice and recalled he didn't feel the services were appropriate but she was not sure of the reason. She added if Resident #82 was admitted with an order for hospice and didn't receive the services, the physician or staff should have spoken to the RP and explained why.

Telephone attempt on 11/22/21 at 1:34 PM for interview with the facility physician who evaluated Resident #82 on 09/08/20 was unsuccessful.

During a follow-up interview on 11/23/21 at 3:06 PM, the Administrator clarified the physician or former Director of Nursing should have talked with Resident #82's RP when the referral was not made to hospice and discuss the possibility of palliative care services.

2. Resident #7 was admitted to the facility on 10/19/15 with multiple diagnoses that included left-sided hemiplegia (partial loss of strength or paralysis on one side of the body), heart failure, and anxiety disorder.

Resident #7's care plans, last reviewed/revised on 09/15/21, revealed a plan of care that addressed an activities of daily living self-care performance deficit related to stroke with left-sided hemiplegia and limited mobility. Interventions included provide a sponge bath when a full bath or shower cannot be provided and extensive assistance of 1 to 2 staff members with bathing/showering on preferred shower days

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and as necessary.

The quarterly Minimum Data Set (MDS) dated 10/08/21 revealed Resident #7 had intact cognition and required total assistance of one staff member with bathing.

The master shower schedule revealed Resident #7 was to receive showers on Monday, Wednesday and Saturday on the day shift during the hours of 7:00 AM to 3:00 PM or 7:00 AM to 7:00 PM.

The Nurse Aide (NA) bathing documentation reports for Resident #7 for the months of October 2021 and November 2021 revealed the following:
October: Partial bed baths were documented as provided on 10/03/21, 10/04/21, 10/05/21, 10/07/21, 10/08/21, 10/11/21, 10/13/21, 10/14/21, 10/15/21, 10/16/21, 10/22/21, 10/23/21, 10/24/21, 10/25/21, 10/27/21, and 10/28/21. Showers were documented as provided on 10/02/21, 10/26/21, and 10/30/21.
November: Partial bed baths were documented as provided on 11/01/21, 11/02/21, 11/04/21, 11/05/21, 11/06/21, 11/07/21, 11/09/21, 11/10/21, and 11/11/21. A shower was documented as provided on 11/13/21.

Review of the nurse progress notes for the months of October 2021 and November 2021 revealed no entries related to Resident #7 refusing bathing assistance.

During an interview on 11/15/21 at 12:20 PM, Resident #7 stated he needed staff assistance with bathing and was supposed to receive 3 showers per week but wasn't getting them as scheduled. Resident #7 stated he had not

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received a shower or complete bed bath since October 2021.

During an interview on 11/17/21 at 3:57 PM, NA #3 stated she could not recall if it was the past Saturday or Sunday when she gave Resident #7 a shower.

During an interview on 11/18/21 at 10:53 AM, NA #1 revealed Resident #7 was an early riser and liked his showers right at 6:00 AM. NA #1 revealed if the documentation stated partial bed baths were provided that meant he only cleaned the underarms and the genital and buttock areas. NA #1 confirmed resident showers were not being provided as scheduled and explained there were only 2 NAs assigned to Resident #7's hall with 18 or more residents each and it was difficult to do showers because it left only one NA on the hall to answer call lights and provide care.

During an interview on 11/18/21 at 1:32 PM, NA #2 stated when there were only 2 NAs assigned to Resident #7's hall with 19 to 20 residents each, he wasn't able to provide resident showers as scheduled. NA #2 revealed he had not provided Resident #7 with a shower during the months of October 2021 and November 2021; however, in lieu of a shower, he provided him with a partial bed bath which he described as lathering with soap and water and washing the hair, face, and neck. NA #2 added Resident would get upset when showers were not provided when scheduled.

During an interview on 11/19/21 at 3:32 PM, the Director of Nursing (DON) revealed she would like for all residents to get showers at least 2 times each week. The DON stated if staff were

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not able to complete the resident's shower on their scheduled day, she expected the NAs to let the resident know and provide them a make-up shower on the next shift or the next day. She explained Resident #7 liked his showers early, between 3:00 AM and 4:00 AM; however, there wasn't always someone available to give him a shower at that time and they would try to offer him one later in the day. The DON indicated she felt like the showers were not being provided as scheduled due to staffing. She further indicated they were offering a competitive salary with sign on bonuses but were not getting a lot of candidates for open positions.

3. Resident #9 was admitted to the facility on 11/28/19 with diagnoses that included a progressive neurological disorder, type 2 diabetes mellitus, and dementia.

A review of the annual Minimum Data Set (MDS) dated 10/13/21 assessed Resident #9's cognition as being intact with no rejection of care over the assessment period. The functional status assessment of Resident #9 revealed extensive 2-person assistance was needed with bed mobility, transfers, and toilet use, and total dependence with bathing.

The activity of daily living (ADL) care plan revised on 7/14/21 identified a self-care deficit related to limited mobility secondary to a progressive neurological disorder with the goal Resident #9 would maintain the highest capable level of ADL ability through the next review. Interventions in place for bathing and/or showering included provide total assistance with bathing and/or showering on preferred shower days and as necessary.

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A review of bathing records revealed Resident #9 was to receive a shower on Wednesday and Saturday during the evening shift. There were no documented showers from 10/8/21 through 11/18/21. The documentation revealed Resident #9 received partial bed baths and Nurse Aide (NA) #2 provided a partial bed bath on 11/13/21.

During an interview on 11/16/21 at 9:10 AM Resident #9 revealed he had to ask staff for a shower. Resident #9 revealed his last shower was approximately one week ago and prior to that he couldn't recall the last time he had a shower and stated it had been a long time. Resident #9 revealed he would like to have a shower at least once a week and the only time his hair got washed was when he received a shower.

A second interview was conducted on 11/18/21 at 9:46 AM with Resident #9. Resident #9 revealed he didn't receive his scheduled shower last night, 11/17/21, and didn't receive a bed bath using soap and water. Resident #9 stated he was supposed to get 2 showers a week but doesn't and at this point would be okay with 1 shower a week.

An interview was conducted on 11/18/21 at 11:27 AM with NA #1. NA #1 revealed he knew Resident #9 wanted to receive his scheduled showers. NA #1 revealed if the documentation stated partial bed baths were provided that meant cleaning the underarms and the genital and buttock areas to cover the basics. NA #1 stated because of staffing he was not able to get things done.

An interview was conducted with NA #2 on

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11/18/21 at 1:43 PM. NA #2 revealed baths were missed when 2 NA staff were scheduled to provide care on the unit. NA #2 usually was assigned 19 to 20 residents and stated he couldn't provide resident showers as scheduled. NA #2 confirmed he initialed a partial bed bath was provided for Resident #9 on 11/13/21 and explained a partial bed bath meant to lather with soap and water and wash the resident's hair. NA #2 revealed Resident #9 mostly received partial bed baths and didn't like to get out of bed.

An interview was conducted on 11/19/21 at 3:32 PM with the Director of Nursing (DON). The DON revealed showers were an issue and if missed staff would try to make up the next shift or day if able. The DON indicated the issue with showers being missed was due to being short of staff and the facility was offering sign-on bonuses to attract new staff.

4. Resident #27 was admitted to the facility on 09/17/20 and readmitted on 11/02/21.

Review of Resident #27's most recent quarterly MDS dated 11/04/21 revealed she was cognitively intact for daily decision making, had no behaviors for refusal of care, and required total assistance of 2 staff for transfers from bed to wheelchair.

Observation and interview on 11/15/21 at 2:38 PM of Resident #27 revealed her lying in bed in her room watching her TV. Resident #27 stated for a period she had not wanted to get up out of bed but as recent as last Friday on 11/12/21 she had requested to get up out of bed into her wheelchair and was told the staff, "were too busy to get me up." Resident #27 further stated she had asked on Saturday and Sunday about getting

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up and was told they would get to her but said they never got her up. Resident #27 said she felt like they did not get her up because it took 2 staff and some time to transfer her from the bed to her wheelchair.

Interview 11/17/21 at 3:58 PM with Nurse Aide (NA) #3 revealed she had worked with Resident #27 and stated she had asked to get up out of bed but said she had to have help to get her up and it was difficult to get help with only 2 NAs on the hall. NA#3 stated Resident #27 was not the only resident who requested to get up out of bed they were not able to get up over the weekend. NA #3 further stated it was difficult to tie up the only NAs on the floor in one room to get some of the residents up and they had not had time to get Resident #27 up. NA #3 indicated they do the best they can to get the residents bathed, changed and fed and anything extra may not get done.

Interview on 11/18/21 at 11:16 AM with NA #1 revealed Resident #27 required 2 staff to transfer her in and out of bed. NA #1 stated there were only 2 NAs on the hallway and they usually had 18 or more residents each and it was difficult to do transfers with 2 staff because it left no NA on the hall to answer call lights and provide care. NA #1 further stated it was all they could do to keep the residents clean, dry, and safe. NA #1 indicated there was not enough staff or time to get the resident up out of bed over the weekend of 11/13/21 and 11/14/21.

Interview on 11/18/21 at 1:45 PM with NA #2 revealed Resident #27 had not been gotten up out of bed over the weekend due to the workload of the NAs. NA #2 stated Resident #27 required 2

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staff to get her in and out of bed which took both NAs off the floor for a period.

Interview on 11/19/21 at 3:32 PM with the Director of Nursing (DON) revealed she would like for everyone who wanted to be to be gotten up out of bed. The DON stated she felt like care was not getting done due to the workload on the NAs and the number of residents they had who required 2 staff for care. She indicated they were trying to hire staff with sign on bonuses and using agency to fill in until they can hire their own staff.

5. Resident #25 was admitted to the facility 04/22/16 with diagnoses including diabetes and hypertension (high blood pressure).

The quarterly Minimum Data Set (MDS) dated 09/17/21 revealed Resident #25 was cognitively intact and required transfer assistance for showers.

Review of the activities of daily living (ADL) care plan last updated 09/28/21 revealed Resident #25 had a self-care performance deficit related in part to impaired balance and limited mobility. Interventions included providing 1 staff member to assist with supervision of bathing/showering on preferred shower days as necessary and monitoring for any changes to self-care deficit.

An interview with Resident #25 on 11/15/21 at 12:31 PM revealed she had not had a shower or bed bath in two weeks and she preferred to have at least 2 showers a week.

The master shower schedule revealed Resident #25 was scheduled to receive her shower on

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Saturdays and Wednesdays on the 3:00 PM to 11:00 PM shift.

The Nurse Aide (NA) bathing documentation reports for Resident #25 for October 2021 and November 2021 revealed the following:

October: Partial bed baths were documented as being provided 10/21/21, 10/23/21, 10/24/21, 10/25/21, 10/27/21, 10/28/21, and 10/30/21. A shower was documented as being provided on 10/26/21.
November: Partial bed baths were documented as being provided 11/01/21, 11/02/21, 11/03/21, 11/04/21, 11/05/21, 11/06/21, 11/08/21, 11/11/21. A shower was documented as being provided on 11/18/21.

An interview with Nurse Aide (NA) #7 on 11/17/21 at 3:46 PM revealed when there were only 2 NAs assigned to Resident #25's hall she was unable to get all her showers done. She stated when she wasn't able to complete the scheduled showers she notified the nurse on the hall.

An interview with NA #2 on 11/18/21 at 1:32 PM revealed when there were only 2 NAs scheduled for Resident #25's hall he was not able to get all his showers done. He explained that when a partial bed bath was documented that meant the resident received cleaning assistance with the underarm, genitals, and buttock areas.

An interview with the Director of Nursing (DON) on 11/19/21 at 3:31 PM revealed if residents were scheduled for 2 showers a week she liked for residents to receive 2 showers a week. She stated staffing was the reason showers were not getting done as scheduled. The DON stated

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when possible an effort was made to make up a missed shower the next day but that did not always happen.

An interview with the Administrator on 11/22/21 at 12:13 PM revealed she was aware of the residents not receiving their showers as scheduled. She explained showers were not getting done due to lack of staff. The Administrator stated staff did make every effort to get showers done when possible.

6. Resident #8 was readmitted to the facility on 5/29/2021. Diagnoses included, depression, and heart failure.

Resident #8's quarterly Minimum Data Set (MDS) dated 11/7/21 revealed she was cognitively intact and required extensive to total dependence on staff with transfers.

An interview with Resident #8 on 11/18/21 at 9:36 AM revealed that she was left in her motorized wheelchair too long yesterday evening. Resident #8 verbalized she wanted to be laid down after dinner at approximately 6:30 PM and NA #1 told her they would put her in bed. NA #1 did not come back to assist Resident #8 according to the resident. Resident #8 indicated she was put in bed around 10 PM when second shift staff were available. Resident #8 communicated she could not stay in her chair all day because it caused her discomfort and hurt her bottom. Resident #8 further revealed she often had to wait to get assistance to bed resulting in staying up later than she desired because of staffing.

An interview was completed with NA #1 on 11/18/21 at 10:52 AM who revealed Resident #8

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F 561	Continued From page 24 asked to be put down right before dinner started. He let her know that he would try to get her back to bed when she requested. The NA #1 communicated it was common that residents must wait longer until more staffing was available. He further explained it took two staff members to assist Resident #8 into bed and he had to put off placing her to bed. NA #1 explained he would let second shift know to put her to bed. NA #1 indicated his shift ended at 7:00 PM. A phone interview with NA #9 completed on 11/18/21 at 4:15 PM revealed that Resident #8 was upset she wasn't put in bed earlier in the day when she requested. NA #9 stated she talked to Resident #8 and told her that she had to change some beds for other residents and had some other tasks that needed to be done before she could put Resident #8 to bed. NA #9 recalled it was later in the shift, maybe 8:30 PM or 9:00 PM before she was able to get back to Resident #8. An interview on 11/19/21 at 3:32 PM with the Director of Nursing (DON) stated she felt like care was not getting done due to the workload on the NAs and the number of residents they had who required 2 staff for care. She indicated they were trying to hire staff with sign on bonuses and using agency to fill in until they can hire their own staff.	F 561		
F 568 SS=B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the	F 568		12/30/21

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F 568	Continued From page 25 resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, family and staff interviews, the facility failed to maintain accurate personal trust fund account records for 1 of 3 residents (Resident #82) and failed to provide 3 of 3 residents (Residents #82, #7 and #81) or their representative with quarterly statements of their personal trust fund account managed by the facility. Findings included: 1. Resident #82 was admitted to the facility on 03/13/20. The significant change Minimum Data Set (MDS) dated 10/11/21 coded Resident #82 with severe impairment in cognition for daily decision making. Review of Resident #82's electronic medical record revealed his guardian was listed as his Responsible Party (RP). During interviews on 11/15/21 at 10:07 AM and 11/18/21 at 5:47 PM, Resident #82's RP reported they had not received quarterly statements of his trust fund account managed by the facility and only recently received a copy of the statement when they specifically asked for one. The RP stated when they reviewed his trust fund statement, the balance on the account was listed	F 568	Residents #82, 81, and 7 were cited. Resident #82 guardian was given a statement per her request on 11.2.21 via email. His accounting for money sent in by his guardian was found in an envelop with how it was spent but no official receipts could be accounted for. His current account had only one deposit and no further transactions to show. Resident # 7 did receive his statements every time he asked the Business Office Manager per the BOM. Resident # 81 _received his statement on 12.17.21. 2. Residents have the potential to be affected by this alleged deficient practice. The Business Office Manager will print the quarterly statements from the last quarter of 9/21 and send those out by 12.30.21. 3. The Administrator will educate the Business Office Manager on two items: 1) that they are to start printing the statements at the beginning of every quarter and send out to all residents/guardians/Power of Attorney as indicated by their facesheet. 2) Resident personal funds are to be accurately recorded and maintained within petty cash or non-interest-bearing account if $50.00 0r less and if it is more that $50.00 it will be accurately accounted for and	

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as $30.00 with no other deposits or withdrawals listed. The RP could not recall the exact date but stated prior to depositing the $30.00, they had given $50.00 in cash to the facility Social Worker (SW) for Resident #82's use when needed. The RP added facility staff were unable to provide them with an accounting of the $50.00.

During interviews on 11/17/21 at 10:06 AM and 11/18/21 at 3:31 PM, the Business Office Manager (BOM) revealed she started her employment at the facility in March 2021 and explained quarterly resident trust fund statements were sent directly from Resident Fund Management Service (RFMS) to the responsible person listed on the individual resident account. She confirmed Resident #82's guardian was listed as the RP on his individual trust fund account and any statements should have been mailed to the RP at the address listed on the account. The BOM explained she did not get copies of the statements mailed by RFMS and had no system in place to ensure the residents and/or their RP received their quarterly statements. The BOM explained when cash was given to her for a resident, she gave the individual a receipt, and then mailed the bank a money order for the amount to deposit into the resident's trust fund account. The BOM confirmed Resident #82's trust fund account was opened in April 2021 and the current balance was $30.00 from a deposit made to the account on 4/14/21. The BOM revealed she was unaware Resident #82's RP had previously given $50.00 in cash to the former SW until the RP had informed her via email correspondence. She added the RP had not provided her with a date or time frame when the money was delivered to the former SW and when she went through the all the receipts since

maintained within a trust account. This will be completed by 12.17.21. Any new Business Office Manager will be educated upon hire.
4. The Administrator will audit that 1) quarterly statements have been sent out all four quarters going forward for all residents. 2) Resident Financial Management Services accounts to ensure monies are accounted for and in correct account for 5 residents 5 x week for 4weeks; 5 resident 3xweek for 4 wks; and 5 residents 1xweek for 4wks. The Administrator will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months or or until the process has shown that it has improved adequately.

Completion date: 12/30/21

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January 2021, she was unable to locate a receipt in the amount of $50.00 cash for Resident #82.

Telephone attempt on 11/18/21 at 4:24 PM to speak with the facility's former SW was unsuccessful.

During an interview on 11/18/21 at 4:28 PM, the Activities Director (AD) was unable to recall the exact date but stated sometime in 2020, Resident #82's RP gave the former SW $50.00 in cash for them to purchase items, such as snacks, for Resident #82 when he requested. The AD explained when the money was given to her by the former SW, she was told Resident #82's RP did not want the money kept in his room so she placed it in an envelope with his name and kept it in a locked drawer in her office. She explained whenever she purchased items for Resident #82, she placed the receipt into the envelope and deducted the amount from the balance, which was currently $17.03. She added when the BOM started her employment at the facility, she didn't think to let her know about Resident #82's money she was keeping in her office. The AD confirmed she had not provided Resident #82's RP with an accounting of the money used to purchase items for Resident #82.

During a follow-up interview on 11/19/21 at 1:32 PM, Resident #82's RP verified the address listed on Resident #82's trust fund account was correct and stated they had not received any quarterly statements in the mail.

During interviews on 11/19/21 at 4:23 PM and 11/23/21 at 3:06 PM, the Administrator stated she would expect for residents and/or their RP to receive quarterly statements of their resident trust

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fund account and explained RFMS mailed the statements directly to the responsible person listed on the individual accounts. She added since the facility did not receive copies of the statements, they had no record of when the statements were mailed or received. The Administrator added it was good practice for all money brought into the facility for residents use to be deposited into their individual trust fund account to ensure the money was accounted for properly.

2. Resident #7 was admitted to the facility on 10/19/15.

The quarterly Minimum Data Set (MDS) dated 11/03/21 coded Resident #7 with intact cognition. Review of Resident #7's electronic medical record revealed he was listed as his own Responsible Party (RP).

During an interview on 11/16/21 at 08:29 AM, Resident #7 revealed he had a personal trust fund account that was managed by the facility. He reported he had not received any statements from the facility letting him know how much money he had in his account.

During interviews on 11/17/21 at 10:06 AM and 11/18/21 at 3:31 PM, the Business Office Manager (BOM) revealed quarterly resident trust fund statements were sent directly from Resident Fund Management Service (RFMS) to the responsible person listed on the individual resident account. She confirmed Resident #7 was listed as the responsible person on his individual trust fund account and any statements should have been mailed directly to him at the facility address. The BOM explained she did not

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get copies of the statements mailed by RFMS and had no system in place to ensure the residents and/or their RP received their quarterly statements.

During an interview on 11/19/21 at 4:23 PM, the Administrator stated she would expect for residents and/or their RP to receive quarterly statements of their resident trust fund account and explained RFMS mailed the statements directly to the responsible person listed on the individual accounts. She added since the facility did not receive copies of the statements, they had no record of when the statements were mailed or received.

3. Resident #81 was admitted to the facility on 07/28/16.

During an interview on 11/15/21 at 2:58 PM, Resident #81 revealed he had a personal trust fund account that was managed by the facility. He reported he had not received any statements from the facility regarding his personal trust fund account and would like to know how much money he had in his account.

Review of Resident #81's electronic medical record revealed he was listed as his own RP.

During interviews on 11/17/21 at 10:06 AM and 11/18/21 at 3:31 PM, the Business Office Manager (BOM) revealed quarterly resident trust fund statements were sent directly from Resident Fund Management Service (RFMS) to the responsible person listed on the individual resident account. She confirmed Resident #81 was listed as the responsible person on his individual trust fund account and any statements

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F 568	Continued From page 30 should have been mailed directly to him at the facility address. The BOM explained she did not get copies of the statements mailed by RFMS and had no system in place to ensure the residents and/or their RP received their quarterly statements. During an interview on 11/19/21 at 4:23 PM, the Administrator stated she would expect for residents and/or their RP to receive quarterly statements of their resident trust fund account and explained RFMS mailed the statements directly to the responsible person listed on the individual accounts. She added since the facility did not receive copies of the statements, they had no record of when the statements were mailed or received.	F 568		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		12/29/21

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F 580	Continued From page 31 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and resonsible party interviews the facility failed to notify the legal guardian/responsible party after a physical altercation occurred toward a resident (Resident #55) and a psychiatric medication change (Resident #82) for 2 of 2 residents reviewed for notification.	F 580	1. Residents #55 and #82 were cited. Resident□s #82 guardian was made aware of the medication□s changes. Resident□s #55 POA received a message from the Administrator to return her call on 8.28.21 concerning the notification of incident. Administrator did call the POA again to discuss the incident on 12.16.21.	

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F 580	Continued From page 32 Findings included: 1.Resident #55 was admitted to the facility on 2/17/17 with diagnoses which included hyperlipidemia, hypertension, anxiety, depression, and Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) dated 8/7/21 revealed Resident #55 was cognitively impaired. Review of the incident report dated 8/28/21 was completed by the Administrator and revealed Resident #55 was witnessed getting struck in the stomach by nursing staff during care. Resident #55 did not observe to sustain any injuries after the incident. The incident report further revealed the resident's responsible party was notified with no further details. Review of Resident #55 progress notes revealed no notification was documented in contacting the responsible party about the resident's incident on 8/28/21 or after. An interview conducted with the Administrator on 11/18/21 at 9:45 AM revealed she notified Resident #55's responsible party but could not recall if she left a message or spoke to the family. The Administrator further revealed she would have notified the responsible party because she had investigated the incident on 8/28/21 with Resident #55. Interview with a Nurse #1 on 11/19/21 at 11:40 AM revealed she reported the incident to the DON on 8/28/21. The Nurse #1 further revealed she did not notify the responsible party after the incident. She indicated the DON or Administrator	F 580	2. Residents have the potential to be affected by this alleged deficient practice. The Director of Nursing and the Nurse Administration team audited the last 14 days of all orders; Change of Conditions; Risk Events; and progress notes to ensure notification of any changes did occur and was documented as such. This was completed as of _12.29.21. 3. The Director of Nursing has educated all nursing staff to notify and document that notification of any new orders; changes; state reportable, and risk events. This was completed by 12.17.21. Any new hired nursing staff will be educated on the above process and any new agency nurses will be educated via their orientation packet. 4. The Director of Nursing or Unit Manager will audit all new orders, change of conditions; risk events; and any reportables of 5 residents: 5x week per 4 wks; 3xweek x 4 wks; and 1 x week x4 weeks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months or until the process has shown that it has improved adequately.	

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would notify the responsible party after possible abuse occurred.

An interview conducted with the Director of Nursing on 11/19/21 at 12:53 PM revealed she does not recall if Resident #55's family or legal representatives was notified. The DON stated the Administrator notified families when possible abuse was investigated.

An interview with Resident #55's Responsible Party and emergency contact on 11/19/21 at 1:33 PM revealed the facility had not notify him or family members regarding an incident that occurred on 8/28/21. It was further revealed the responsible party had never been contacted with knowledge of issues between staff and Resident #55. Resident #55's responsible party indicated he was usually notified of medication changes or anything new with Resident #55 and would had expected to be notified if there was an incident or issue regarding Resident #55.

2. Resident #82 was admitted to the facility 03/13/20 with multiple diagnoses that included cardiomyopathy, neurocognitive disorder with behavioral disturbance, temporal lobe epilepsy, and schizoaffective disorder, bipolar type.

The admission Minimum Data Set (MDS) dated 03/20/20 assessed Resident #82 with moderate impairment in cognition for daily decision making. The MDS noted he displayed no verbal, physical or other behavioral symptoms and received antipsychotic medications daily during the 7-day assessment period.

Review of a Physician's progress noted dated 04/28/20 noted in part, Resident #82's Risperdal

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(antipsychotic medication) was reduced to 2 milligrams (mg) twice daily due to excessive sleeping.

Review of a Psychiatric Nurse Practitioner (NP) progress note dated 06/08/20 revealed Resident #82 was seen for an initial visit and noted in part, "I would not recommend any Gradual Dose Reduction (GDR) at this time after review of the hospital medical records. Patient has had a history of failed GDR with severe agitation and aggressive behavior reported. GDR could destabilize the patient and result in harm to himself and possibly others."

The significant change Minimum Data Set (MDS) dated 10/11/21 assessed Resident #82 as being severely impaired for making daily decision but was able to understand others and be understood. The MDS noted he displayed no verbal, physical or other behavioral symptoms and received antipsychotic medications daily during the 7-day assessment period.

During an interview on 11/15/21 at 10:07 AM, Resident #82's guardian/Responsible Party (RP) revealed shortly after his admission in March 2020, the facility's former physician started tapering Resident #82 off his psychiatric medications without discussing the medication changes with her. The RP stated she learned of the changes to the medications from Resident #82 and was not informed by facility staff. In addition, she was not informed by facility staff when Resident #82 started exhibiting behaviors which she felt was due to the decrease in his psychiatric medications.

Review of the email correspondence provided by

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the RP on 11/18/21 at 4:00 PM, noted the RP was informed of the changes to Resident #82's psychiatric medications when the Administrator responded to her email correspondence dated 08/21/20 at 4:32 PM. The Administrator's response noted Resident #82's Risperdal was decreased on 04/28/20 and 06/29/20 due to excessive sleeping and Depakote (anticonvulsant medication) was decreased in July 2020 also due to excessive sleeping. In the email correspondence, the RP also asked whose responsibility it should have been to inform her of Resident #82's escalating behaviors and the Administrator's response read, "the Social Worker or a nurse. I am so sorry that did not happen as it should have."

Review of the nurse progress notes for Resident #82 revealed no entries on or after the dates of 04/28/20 and 06/29/20 indicating the RP was notified of the reduction in his Risperdal medication. An entry dated 7/15/20 noted in part, Resident #82 and the RP were both notified of the decrease to his Depakote medication.

Telephone attempt on 11/18/21 at 4:24 PM for interview with the facility's former SW was unsuccessful.

During an interview on 11/19/21 at 2:31 PM, the Director of Nursing (DON) revealed she had only been in her position since May 2021 and stated the nurse who received the physician's order was the one responsible for notifying the resident and/or their RP of the new or change in medication. She added Resident #82's RP had not voiced any concerns to her regarding not being notified of medication changes.

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F 580	Continued From page 36 During an interview on 11/19/21 at 4:23 PM the Administrator stated the Social Worker or nurse should have spoken to and informed Resident #82's RP when his behaviors were first noticed. Telephone attempt on 11/22/21 at 1:34 PM for interview with the facility physician who evaluated Resident #82 on 04/28/20 was unsuccessful.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		12/30/21

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F 584	Continued From page 37 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean and sanitary home like environment for 18 of 33 rooms (#323, #322, #207, #202, # 203, #207, #228, #204, #317, #205, #206, #319, #315, #310, #318, # 212, #214 # 316, # 218) the rooms were observed to have scraped and cracked walls, dirty bathrooms, dirty resident rooms, cracked and stained toilet caulking, and damaged sink vanities on 4 of 5 resident halls. The findings Included: 1. a. An observation made on 11/15/21 at 4:37 PM revealed the shared bathroom of room 212 and 214 had an odor that resembled the smell of urine. A brown colored substance resembling fecal matter was smeared on the front of the toilet and inside the toilet seat. A second observation made on 11/16/21 at 10:37 AM revealed the shared bathroom of room 212 and 214 had an odor that resembled the smell of urine. A brown colored substance resembling fecal matter was smeared on the front of the toilet	F 584	1. Rooms: 323, 322, 207, 202, 203, 207, 228, 204, 317, 205, 206, 319, 315, 310, 318, 212, 214, 316, and 218 were cited. Environmental Services immediately began deep cleaning all cited rooms. Maintenance Department formulated a plan and supplies to begin repairing all areas of concern. All maintenance repair concerns will be corrected by 12.30.21. 2. Residents have the potential to be affected by this alleged practice. The Administrator will audit all rooms to ascertain if any repairs/cleaning needs to occur by January 8, 2022. All concerns will be addressed at time of discovery. 3. The Administrator will educate the housekeeping department on expectation of cleanliness of rooms and bathrooms. The Administrator will educate the Maintenance department on the expectation of a safe, orderly interior all areas of the facility. The education will be completed by 12.17.21. Any new Maintenance or Housekeeping staff will	

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F 584	Continued From page 38 and inside the toilet seat. During an interview on 11/16/21 at 10:37 AM Resident #76 revealed he resided in room 212 and shared a bathroom with 2 other residents residing in room 214. Resident #76 revealed it was typical for urine to be on the bathroom floor and fecal matter on the toilet seat. Resident #76 revealed Housekeeping (HK) did not do a good job keeping the shared bathroom clean. During an interview on 11/16/21 at 10:45 AM the HK #1 revealed he had been off the last 4 days and was not aware the shared bathroom of room 212 and 214 had stool on the toilet and smelled of urine. HK #1 revealed the shared bathroom needed to be checked several times a day due to the residents being known to get stool on toilet and urine on the floor. HK #1 didn't know who worked the previous shift and stated the HK assigned to the hall should have cleaned and disinfected the bathroom. An interview was conducted on 11/17/21 at 3:46 PM with the HK Manager. The HK Manager revealed on 11/15/21 only 3 HK staff worked, and no HK was assigned to hall where room 212 and 214 was located. The HK Manager considered the shared bathroom of room 212 and 214 as needing high attention due to urine spills and thought a nursing staff member would have cleaned the toilet then reported to HK staff which she expected HK to follow up and clean and disinfect the shared bathroom. The HK Manager expected fecal matter wouldn't be left on the toilet or the bathroom continue to smell of urine till the next day. An interview was conducted with Administrator on	F 584	be educated upon hire. 4. The administrator will audit 5 rooms for cleanliness and repair needs : 5x week per 4 wks; 3xweek x 4 wks; and 1 x week x4 weeks to ensure they meet the appropriate standard. The Administrator will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months or until the process has shown that it has improved Completion date 12/30/21	

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11/19/21 at 2:28 PM. The Administrator revealed HK was contracted through a company and had a difficult time finding staff and had several job openings. The Administrator revealed her expectation was for resident rooms to be checked and cleaned.

b. An observation of room 323 on 11/15/21 at 09:57 AM revealed the following:
Multiple vertical scrapes to wall in room 323 with exposed sheetrock, an area of missing paint to the right-side wall in the room.
In the bathroom, the toilet bowl was cracked.
The outside of the toilet bowl had multiple brown spatters and brown substance to the base of the toilet/caulking area

A follow up observation made on 11/17/21 at 10:40 AM revealed that concerns remained the same with less brown splatter to the toilet base.

c. An observation made on 11/15/21 at 10:11 AM revealed in the shared bathroom of room 322 revealed the following:
Brown material in the front and the sides of the toilet base/caulking area
An uncovered/unlabeled bath pan sitting inside covered bath pan was observed on the floor
An unlabeled tube of toothpaste sitting on the towel dispenser
Two unlabeled toothbrushes sitting on the side of the sink
An unlabeled toothpaste tube sitting on the side of the sink

A follow up observation made on 11/18/21 at 2:35 PM revealed that concerns remained the same.

d. An observation made in room 207 on 11/15/21

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at 10:58 AM revealed the following:
A wash bin was observed not labeled or dated in the shared bathroom
A urine cap (device used to measure urine output) with a resident's name was observed uncovered and stored on the toilet
Shaving cream beside the shared sink in room # was observed to be unlabeled

A follow up observation made on 11/19/21 at 1:03 PM revealed that concerns remained unchanged.

e. An observation of room 202 on 11/15/21 at 11:53 am revealed the following:
One lateral scrape behind the door at the entrance to the room directly above baseboard measuring approximately 4x 6 inch.
Metal and plaster showing in the corner of room 202 above the baseboard
Vertical scrapes to the wall beside B bed
Large area of exposed unpainted sheetrock behind A bed
Broken wall plate for telephone
In the shared bathroom, lateral scratch near the sink approximately 1 foot long. Three gashes/dents on the wall with exposed plaster
Brown/ black substance on caulk around toilet base.
Sink vanity with splintered paneling and rotted wood with black substance covering affected area beside toilet

Follow up observations made on 11/16/21 at 11:00 AM and on 11/17/21 at 10:02 AM revealed no changes to the affected areas.

f. An observation of room #203 made on 11/15/21 at 12:01 PM revealed the following:
A scrape behind the room door approximately 2x2

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inches with exposed plaster

A follow up observation was made on 11/16/21 at 10:55 AM revealed the room was unchanged.

g. An observation made of room 204 on 11/15/21 at 12:09 PM which revealed the following:
Deep scratch to wall behind B bed.
The shared bathroom contained 3 areas of exposed plaster to wall beside toilet
Unlabeled shaving cream sitting on the side of the sink
Labeled but uncovered urine graduate (tool used to measure urine) sitting on the back of the toilet
Brown debris around the base of the toilet
Dried yellow liquid to the left of the toilet.

An observation made on 11/17/21 at 9:35 AM revealed no changes to the room.

h. An observation of room 317 made on 11/15/21 at 12:20 PM revealed the following:
Two holes on wall near the bedroom window with plaster showing. An observation on 11/16/21 at 03:51 PM revealed lateral scrapings, approximately 4 inches on the left side of bathroom door entrance. Multiple vertical gashes behind B-bed headboard with exposed drywall.

A follow up observation was made on 11/17/21 at 10:31 AM revealed the room remained unchanged.

An interview with a housekeeper on 11/16/21 at 3:05 PM revealed Job duties include picking up trash, sweeping, and mopping. Disinfecting side rails, bed controls, headboards, doorknobs, and the toilet handle. In the bathroom we disinfect the

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F 584	Continued From page 42 sinks. To clean the toilet, we would spray the inside and clean it with a brush. We would wipe down the outer surface of the toilet. We would clean rooms daily and look after meals to see if any new problems are there. This housekeeper was observed cleaning rooms 316 and 317 on 11/18/21 at 2:09 PM. An Interview with the housekeeping manager on 11/19/21 at 2:43 PM revealed he expected rooms to be cleaned, completed and staff to then go back to check on the rooms. Housekeeping staff was short in this building. They have several openings for housekeeping staff. An Interview was completed with the Administrator and the Maintenance Director on 11/19/21 at 2:28 PM revealed that the expectation was to try to keep the building in good repair as good as possible. In the past year and half things have fallen to the backburner. The Administrator explained urine graduates were supposed to be bagged and labeled for each resident and that personal items should be separated by body part and stored in the resident rooms. Independent residents would receive education with proper storage of items.	F 584		
F 600 SS=G	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	F 600		12/29/21

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F 600	Continued From page 43 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 and staff interviews the facility failed to protect a resident right to be free from abuse (Resident #55) from Nurse Aide (NA) #8 for 1 of 3 residents reviewed for abuse. The findings included: Resident #55 was admitted to the facility on 2/17/17 with diagnoses which included anxiety, depression, and Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) dated 8/7/21 revealed Resident #55 was severely cognitively impaired and was totally dependent for majority of activities of daily living (ADL). The MDS further revealed Resident #55 was coded for physical and verbal behaviors directed toward others 1 to 3 days a week through the look back period. Review of the incident report dated 8/28/21 revealed Resident #55 was witnessed getting struck in the stomach by nursing staff during care. Resident #55 did not observe to sustain any injuries after the incident. Review of the investigation completed by the Administrator related to Resident #55's incident revealed the following:	F 600	1. Resident #55 was cited. Staff member that was alleged to be abuser was removed from the building immediately. 2. Residents have the potential to be affected by this alleged deficient practice. The Nurse Administration team will conduct an audit of all residents to ensure resident are free from abuse: both skin or verbal interviews will be conducted by 12.28.21. 3. The Administrator and DON will educate all staff on our Abuse policies and procedures by 12.17.21. Any new staff hired will be educated upon hire and any new agency staff will be educated via their orientation packets. 4. The Administrator and/or the Nurse Administration team will conduct on-going audits to ensure residents remain free of abuse through interviews with cognitively intact residents, interviews with staff, and through observation for those residents with cognitive impairment. 5 residents5x week per 4 wks; 3xweek x 4 wks; and 1 x week x4 weeks. The Administrator will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present	

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F 600	Continued From page 44 - Nurse Aide (NA) #5 statement dated 8/28/21 read in part, "NA #8 and I went into Resident #55's room to change him and his bed sheets. While NA #8 and I were changing Resident #55 he began to curse and hit NA #8. NA #8 then slapped Resident #55 on his stomach, and Resident #55 continued to hit NA #8. I then turned around to grab Resident #55 pillow and heard NA #8 get loud with Resident #55 and hit Resident #55 again and when I turned around NA #8 hand was balled in a fist. " - Nurse Aide (NA) #8 statement dated 8/28/21 read in part, "I went into Resident #55's room to change him with NA #5. Resident #55 was soaked so we had to do a complete bed change and change Resident #55's shirt. Resident #55 was fine the first half then as we had to keep rolling Resident #55, he got more and more aggravated cussing and grabbing at stuff. Resident #55 grabbed my left arm and dug his fingernails in my skin. Before he could break skin, I grabbed his hand to remove it and I got my "flat" hand pushed it away. Resident #55 grabbed me on my left arm, and I grabbed his hand with my right hand to pull it off then turned my wrist to finish pushing his hand away towards his stomach. I think in the moment I might have had a little too much force and accidently with flat hand barely popped Resident #55 in the belly. I was blocking then Resident #55 punched me in the right arm and I finished fastening his brief, pulled blanket up, grabbed dirty linen and trash, and walked out. " - Review of investigative actions dated 8/28/21 revealed employment actions taken was NA #8 was asked to not return to the facility. The facility notified the Medical Director, resident's	F 600	results and take recommendations on any process improvement for a duration of three months or until the process has shown that it has improved. completion date 12/29/21	

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responsible party, and suspended identified potential suspected perpetrator until investigation was complete.

A phone interview conducted with Nurse Aide (NA) #5 on 11/22/21 at 3:10 PM revealed she and NA #8 was giving care to Resident #55 and Resident #55 became aggravated and combative. NA #5 observed NA #8 slapped Resident #55 in the stomach with the back side of her hand and it made a popping sound. NA #5 indicated Nurse #8 continued to give care and shouted to Resident #55 in a loud tone to "stop". NA #5 revealed Resident #55 had quit being combative at this time and NA #5 turned her back away from Resident #55 to get a sheet and heard a pop sound and turned to find NA #8 fist balled up like she had punched the resident. NA #5 and NA #8 completed care and left Resident #55's room. NA #5 stated she was training with NA #5 and was educated by other staff members if Resident #55 was combative to step away. NA #5 indicated she was in shock when NA #8 struck at Resident #55 during care and did not know what to do. NA #5 stated she reported the incident to Nurse #8 immediately after leaving the Resident #55 room.

A phone interview conducted with NA #8 on 11/19/21 at 10:20 AM revealed she had worked with Resident #55 multiple times and was aware he could be combative during care. It was further revealed NA #8 and NA #5 was giving care to Resident #55 and he became aggravated slapping at NA #8. NA #8 put up her arm blocking Resident #55 and pushed it away. NA #8 indicated Resident #55's arm could have swung back and hit him but could not recall. NA #8 revealed she continued to give care and Resident #55 grabbed NA #8 arm and NA #8 jerked away.

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NA #8 revealed she jerked away but denied hitting or speaking to Resident #55 in a loud tone. Na #8 indicated she was educated by upper management if Resident #55 had become combative or agitated to rush through care. NA #8 stated he had a bad day and was aggravated but denies hitting or speaking to Resident #55 in a loud tone.

An interview conducted with Nurse #8 on 11/19/21 at 11:40 AM revealed NA #5 reported that NA #8 was frustrated when giving care to Resident #55 because the resident had become combative. Nurse #8 further revealed NA #5 witnessed NA #8 hit Resident #55 in the stomach and when NA #5 had turned away and turned back NA #8 had her fist in a ball. Nurse #8 indicated Resident #55 was sometimes combative, but nursing staff was educated to step away and let Resident #55 calm down. Nurse #8 completed a body check and checked for markings all over Resident #55 and did not observe any marks or bruises. Nurse #8 stated she contacted the DON right after the incident occurred.

An interview was conducted with the Director of Nursing (DON) on 11/19/21 at 2:53 PM revealed Nurse #8 contacted her right after the incident occurred, and the DON contacted the Administrator immediately. The DON indicated Resident #55 was combative at time with care, but nursing staff was educated to step away to deescalate the situation. The DON further revealed she had no prior issues with NA #8 and feels that she did not hit Resident #55.

An interview conducted with the Administrator on 11/19/21 at 1:08 PM revealed Resident #55 could

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F 600	Continued From page 47 be combative during care, but staff was educated to stay calm and back away if they need too. It was further revealed when the incident was reported by the DON she immediately went to the facility to investigate. The Administrator indicated she spoke to all staff involved and did not substantiate because it was "he said she said", and Resident #55 sustained no injuries. The Administrator revealed NA #8 was asked to not come back and work until the investigation was over.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interviews, the facility failed to implement their abuse policy and procedures in the area of reporting to adult protective services for 1 of 3 sampled residents reviewed for staff to resident abuse (Resident #55). Findings included: A review of the facility policy and procedure titles	F 607	1. Resident #55 cited. 2. Residents have the potential to be affected by this alleged deficient practice. If appropriate, the Administrator will report any alleged abuse allegation to DSS going forward. 3. Regional Director of Operations and Regional Director of Clinical Services educated administrator that any abuse allegations that were appropriate were to	12/29/21

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F 607	Continued From page 48 "Abuse, Neglect, and Exploitation" dated November 1, 2020 read in part: Reporting and response: A1.) The facility will have written procedures that include reporting all alleged violation to the Administrative, state agency, adult protective services, and to all other required agencies (e.g. law enforcement when applicable) with in specified time frame. 1a.) Immediately, but no 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 2b.) Not later than 24 hours if events that cause the allegation do not involve abuse and do not result in serious bodily injury. Resident #55 was admitted to the facility on 2/17/17 with diagnoses which included anxiety, depression, and Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) dated 8/7/21 revealed Resident #55 was severely cognitively impaired. The MDS further revealed Resident #55 was coded for physical and verbal behaviors directed toward others 1 to 3 days a week through the look back period. Review of the incident report dated 8/28/21 revealed Resident #55 was witnessed getting struck in the stomach by nursing staff during care. Resident #55 was not observed to sustain any injuries after the incident. The incident report further revealed the incident was not reported to adult protective services. Review of the investigation completed by the Administrator related to Resident #55's incident revealed the following: - Nurse Aide (NA) #5 statement dated 8/28/21	F 607	be reported to DSS. This will be done by 12.17.21. 4. The Regional Director of Operations will audit future abuse reportables to ensure appropriate outside contacts were notified per policy for 3 months. The Administrator will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months or until the process has shown that it has improved. Completion date: 12/29/21	

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F 607	Continued From page 49	F 607		

read in part, "NA #8 and I went into Resident #55's room to change him and his bed sheets. While NA #8 and I were changing Resident #55 he began to curse and hit NA #8. NA #8 then slapped Resident #55 on his stomach, and Resident #55 continued to hit NA #8. I then turned around to grab Resident #55 pillow and heard NA #8 get loud with Resident #55 and hit Resident #55 again and when I turned around NA #8 hand was balled in a fist. "

- Nurse Aide (NA) #8 statement dated 8/28/21 read in part, "I went into Resident #55's room to change him with NA #5. Resident #55 was soaked so we had to do a complete bed change and change Resident #55's shirt. Resident #55 was fine the first half then as we had to keep rolling Resident #55, he got more and more aggravated cussing and grabbing at stuff. Resident #55 grabbed my left arm and dug his fingernails in my skin. Before he could break skin, I grabbed his hand to remove it and I got my "flat" hand pushed it away. Resident #55 grabbed me on my left arm, and I grabbed his hand with my right hand to pull it off then turned my wrist to finish pushing his hand away towards his stomach. I think in the moment I might have had a little too much force and accidently with flat hand barely popped Resident #55 in the belly. I was blocking then Resident #55 punched me in the right arm and I finished fastening his brief, pulled blanket up, grabbed dirty linen and trash, and walked out. "

- Review of investigative actions dated 8/28/21 revealed employment actions taken was NA #8 was asked to not return to the facility. The facility notified the Medical Director, resident's responsible party, and suspended identified

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F 607	Continued From page 50 potential suspected perpetrator until investigation was complete. An Interview conducted with the Administrator on 11/19/21 at 1:08 PM revealed adult protective services and law enforcement were not contacted after Resident #55's incident on 11/28/21. The Administrator further revealed it was reported to the state agency and she felt that was where it should had been reported. The Administrator indicated Resident #55's incident did not need to be reported to adult protective services because it was reported to the state agency.	F 607		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the state mental health authority when a resident with a Level II Preadmission Screening and Resident Review (PASRR) had a significant change in condition for 1 of 2 residents (Residents #82) reviewed for PASRR. Findings included: Resident #82 was admitted to the facility on 03/13/20 with multiple diagnoses that included schizoaffective disorder, bipolar type.	F 646	1. Resident #82 was cited and no longer in the facility. 2. Residents in the facility have the potential to be affected by this alleged deficient practice. A PASRR audit will be completed on all residents with current level I and level II PASARR for significant changes in condition and referred as applicable to mental health authority. Audit to be completed by 12.29.21. 3. Education will be provided to Business office staff and interdisciplinary team that will be assisting with this process that any resident who experiences a significant	12/29/21

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F 646	Continued From page 51 Review of a PASRR Level II determination letter indicated Resident #82 had a Level II PASRR effective as of 06/11/21 with no expiration date. The significant change Minimum Data Set (MDS) dated 10/11/21 revealed Resident #82 had severe impairment in cognition, displayed delusions, rejected care 4 to 6 days, and wandered 1 to 3 days during the MDS assessment period. It was noted on the MDS that Resident #82 was evaluated by Level II PASRR and determined to have a serious mental illness. During an interview on 11/19/21 at 10:10 AM, the Administrator stated the Social Worker (SW) was the one responsible for requesting a re-evaluation of PASRR for residents when needed. She explained the facility SW recently ended her employment with the facility and since then, any referrals to PASRR would not have been submitted. The Administrator added they had not known the state mental health authority needed to be notified when a resident with a Level II PASRR had a significant change in physical and/or mental condition. She confirmed the state mental health authority was not notified when the significant change MDS assessment dated 10/11/21 for Resident #82 was completed.	F 646	change of condition will be referred to a the mental health authority per regulations. Any new staff will be educated upon hire of this process. 4. Administrator will audit to ensure that residents with level II PASSARs that have significant changes in condition are being referred to the Mental Health Authority for 5 residents per week x4 weeks; 5 residents per 3xwk per 4wks; and 5 residents a week per 4xweeks to ensure compliance with PASRR II COC regulations. completion date: 12/29/21	
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, and staff	F 677	1. Resident #27, Resident #26, Resident	12/29/21

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F 677	Continued From page 52 interviews the facility failed to provide showers or complete bed baths for 6 of 18 residents (Resident #27, Resident #26, Resident #81, Resident #82, Resident #13, and Resident #50) and failed to provide nail care and grooming for 3 of 18 residents (Resident #54, Resident #23, and Resident #45) reviewed for activities of daily living (ADL). Resident #27 stated because of not getting her showers, her hair was matted to her head, and she could smell her own body odor and it made her feel degraded and like a homeless person. The findings included: 1. Resident #27 was admitted to the facility on 09/17/20 and readmitted on 11/02/21 with diagnoses which included coronary artery disease and congestive heart failure. Review of Resident #27's most recent quarterly MDS dated 11/04/21 revealed she was cognitively intact for daily decision making, had no behaviors for refusal of care, and required total assistance of 2 staff for bathing. Review of Resident #27's care plan dated 11/11/21 revealed a plan of care for ADL self-care performance deficit related to debility, disease process, fatigue, chronic respiratory failure and pain. The interventions included the resident requires extensive assistance of 2 staff with bathing/showering on preferred shower days and as necessary, the resident requires extensive assistance of 1 staff with personal hygiene and oral care, the resident requires total assistance of 2 staff to move between surfaces as necessary and monitor/document/report as needed any changes, any potential for improvement, reasons	F 677	#81, Resident #82, Resident #13, were cited and audited to ensure correct shower/grooming preferences were in place. All residents provided with incontinence care/bathing/grooming care per their preference and POC. Resident #82 no longer in facility. 2. Residents with potential to be affected by the alleged deficit practice, the following has been achieved: Activity Department to conduct audit through interviews with cognitively intact residents and interviews with responsible parties for cognitively impaired residents to ensure bathing/grooming preferences are being honored. Bathing/grooming preferences implemented on 12.17.21 3. Director of nursing or designee to educate direct care staff on importance of ADL care as well as honoring resident preferences. direct care staff educated if in the event that bathing/grooming/incontinence care is unable to be performed per preference the Director of Nursing needs to be notified immediately to ensure assistance is provided to ensure care needs are met. This will be completed by 12.17.21. All newly hired staff will be educated upon hire and new agency staff will be educated via orientation packet. 4. DON or Unit Manager to audit 5 residents to ensure ADL	

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F 677	Continued From page 53 for self-care deficit, expected course or declines in function. Observation and interview on 11/15/21 at 2:38 PM of Resident #27 revealed her lying in bed in her room watching her TV. Resident #27 stated she had a shower yesterday and it was the first one she had in 3 weeks. Resident #27 further stated her hair was matted to her head and she could smell her own body odor and it made her feel degraded and like a homeless person. Resident #27 indicated there was not enough staff at the facility to properly care for the residents and make sure their needs were met. Review of the master shower schedule revealed Resident #27 was scheduled for showers on Sunday and Wednesday on 2nd shift (3:00 PM to 11:00 PM or 7:00 PM to 7:00 AM). Review of the documented bathing for Resident #27 August through November 2021 revealed the following: ·August: 08/04/21 (SH), 08/09/21 (SH), 08/19/21 (SH), 08/20/21 (SH) 08/21/21 (BB), 08/24/21 (SH), 08/27/21 (BB) and 08/30/21 (BB) and there were 2 missed showers/bed baths that were not documented as completed. ·September: 09/08/21 (BB), 09/10/21 (SH), 09/28/21 (SH) and 09/30/21 (BB) and there were 6 showers/bed baths that were not documented as completed. ·October: 10/25/21 (SH) and 10/26/21 (BB) and there were 7 missed showers/bed baths that were not documented as completed. ·November: 11/14/21 (SH) and there were 3 missed showers/bed baths that were not documented as completed.	F 677	care/bathing/grooming is being provided through observations and interviews with both cognitively intact residents and impaired cognitive residents for 5 residents 5x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months or or until the process has shown that it has improved adequately. completion date 12/29/21	

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Interview on 11/18/21 at 11:16 AM with Nurse Aide (NA) #1 revealed Resident #27 required 2 staff to transfer her in and out of bed but once in the shower room she could be assisted by one staff member. NA #1 stated there were only 2 NAs on the hallway and they usually had 18 or more residents each and it was difficult to do showers because it left only one NA on the hall to answer call lights and provide care. NA #1 further stated residents had not been receiving their showers as scheduled because it was all they could do to keep them clean, dry, and safe.

Interview on 11/18/21 at 1:45 PM with NA #2 revealed Resident #27 has missed showers and bed baths due to the workload of the NAs. NA #2 stated Resident #27 required 2 staff to get her on the shower bed and into the shower room which took both NAs off the floor for a period of time. NA #2 further stated when she was in the shower the NA assigned to her had to remain with her through the entire shower which left only one NA on the floor for the rest of the 30 plus residents. NA #2 indicated it was impossible to get all the showers done due to staffing.

Interview on 11/18/21 at 3:38 PM with Nurse #1 revealed Resident #27 had missed showers/bed baths due to the number of residents the NAs had to provide care. Nurse #1 stated it was impossible for 2 NAs to do showers, vitals, turning and repositioning and incontinence care for 18-20 residents each and be able to complete their work and documentation. Nurse #1 further stated the nurses were so busy with medications, orders and required charting that it was difficult for them to provide any assistance to the NAs with resident care.

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Interview on 11/19/21 at 3:32 PM with the Director of Nursing (DON) revealed she would like for all residents to get showers at least 2 times each week. The DON stated if staff were not able to complete the resident's shower on their scheduled day, she expected the NAs to let the resident know and provide them a make-up shower on the next shift or the next day. The DON indicated she felt like the showers were not being provided as scheduled due to staffing. She further indicated they were offering a competitive salary with sign on bonuses but were not getting a lot of candidates for open positions.

2. Resident #26 was admitted to the facility on 08/10/21 with diagnoses which included hypertension, chronic obstructive pulmonary disease (COPD) and chronic pain.

Review of Resident #26's most recent admission Minimum Data Set (MDS) dated 08/12/21 revealed he was cognitively intact for daily decision making and displayed no behaviors for refusal of care. The resident's MDS also revealed bathing coded as not being provided; however, the resident required total assistance of 1 to 2 staff members with all ADL except eating.

Review of Resident #26's care plan dated 09/28/21 revealed a plan of care for ADL self-care deficit related to activity intolerance, disease process, impaired balance, impaired mobility and generalized weakness. The interventions included the resident required total assistance of 2 staff with personal hygiene, oral care, and bathing, praise all efforts at self-care, monitor/document/report any changes, any potential for improvement, reasons for self-care

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deficit, expected course or declines in function, encourage resident to participate to the fullest extent possible with each interaction.

Review of a wound note dated 11/11/21 written by the wound care Nurse Practitioner (NP) read in part: "Treatment recommendations: #1 Moisture associated skin damage (MASD) buttocks bilaterally - instruction: shower 3 times weekly, no brief while in bed. Apply antifungal and skin prep barrier two times daily (bid). Keep buttocks area clean and dry. Recommend no briefs in bed and optimize nutrition. Plan of care discussed with facility staff."

Observation and interview on 11/15/21 at 2:09 PM with Resident #26 revealed he was not getting bathed as often as he should and had missed some baths since being admitted to the facility. The resident stated the facility was not equipped with a shower chair or bed to accommodate his size. The facility had told Resident #26 they were looking into getting a shower bed to accommodate his height but said he was not aware a shower bed had been purchased.

Observation on 11/17/21 at 10:30 AM with the wound care Nurse Practitioner and wound treatment nurse of Resident #26's area on his buttocks revealed areas on both buttocks that were red and not open. As the resident was turned over there was stool on the resident's skin and on his draw sheet. The NP asked the wound treatment nurse if the resident was due for a shower on 11/17/21 and the wound care nurse responded she did not know but would check the schedule. The NP after removing her gloves and sanitizing her hands put on the resident's call light

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F 677	Continued From page 57	F 677		

so he could be cleaned. The NP commented the wounds looked better and seemed to be healing but it was important for staff to keep the area clean and dry.

Review of the master shower schedule revealed Resident #26 was scheduled for showers on Tuesdays and Fridays on day shift (7:00 AM to 3:00 PM or 7:00 AM to 7:00 PM).
Review of the documented bathing for Resident #26 for September through November 2021 revealed the following:

·September: 09/01/21 shower (SH), 09/07/21 bed bath (BB), 09/08/21 (BB), 09/10/21 (SH), 09/20/21 (BB) and 09/28/21 (SH) and there were 4 missed showers/bed baths that were not documented as completed.
·October: 10/15/21 (BB) and 10/26/21 (BB) and there were 7 missed showers/bed baths that were not documented as completed.
·November: 11/09/21 (BB) and 11/12/21 (BB) and there were 2 missed showers/bed baths that were not documented as completed.

Interview on 11/17/21 at 3:58 PM with Nurse Aide (NA) #3 revealed she was not aware Resident #26 had physician ordered showers three times weekly. NA #3 stated Resident #26 received bed baths because he was too long or too tall for the shower bed and was afraid it would not support him in the shower room to get a shower. NA #3 further stated the facility was supposed to be getting another shower bed that would support him so he could get the showers he preferred but said she had not seen it yet. NA #3 indicated it was impossible to get all the showers done with only 2 NAs on the hall.

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Interview on 11/17/21 at 4:41 PM with NA #4 revealed she was not aware Resident #26 had physician ordered showers three times weekly. NA#4 stated Resident #26 was difficult to get into the shower room and was not comfortable with the shower chair or shower bed the facility currently had for residents. NA #4 further stated Resident #26 was receiving bed baths instead of showers but was only scheduled for 2 per week. NA #4 indicated the facility was supposed to be purchasing a shower bed to accommodate Resident #26 but said it had not been brought to their attention that the bed had been delivered to the facility. She further indicated she was not sure how they would be able to provide Resident #26 3 bed baths or shower per week because it was impossible to get all the showers done with only 2 NAs on the hallway.

Interview on 11/18/21 with Nurse #1 revealed she was not aware Resident #26 had physician ordered showers three times weekly. Nurse #1 stated Resident #26 was afraid to get up in the shower chair or onto the shower bed at the facility because he didn't think the chair or bed would support him due to his size. Nurse #1 further stated showers three times weekly were not possible and the NP probably needed to re-evaluate the order. Nurse #1 indicated the staff was having a hard time even getting 2 showers done on residents each week and 3 showers may not be possible especially for Resident #26 because it took 2 staff to provide his bed bath.

Interview on 11/19/21 at 3:32 PM with the Director of Nursing (DON) revealed she would like for all residents to get showers at least 2 times each week. The DON stated if staff were not able to complete the resident ' s shower on their

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scheduled day, she expected the NAs to let the resident know and provide them a make up shower on the next shift or the next day. The DON indicated she felt like the showers were not being provided as scheduled due to staffing. She further indicated they were offering a competitive salary with sign on bonuses but were not getting a lot of candidates for open positions.

3. Resident #54 was admitted to the facility on 09/17/21 and readmitted on 11/11/21 with diagnoses which included cancer, hypertension, and diabetes mellitus.

Review of Resident #54's most recent admission MDS dated 09/21/21 revealed he was cognitively intact for daily decision making, communicated via a dry erase board, and required extensive to total assistance with all activities of daily living (ADL).

Review of Resident #54's care plan dated 10/05/21 revealed a plan of care for ADL self-care performance deficit related to activity intolerance, external devices, fatigue, impaired balance, limited mobility and pain. The interventions included the resident required extensive assistance by 1 to 2 staff with bathing/showering on preferred shower days and as necessary, the resident requires extensive assistance by 1 to 2 staff with personal hygiene and oral care, encourage resident to use bell to call for assistance, resident requires a white board to communicate and ensure availability and functioning of adaptive communication equipment and monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course and declines in function.

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Observation and interview on 11/15/21 at 10:47 AM revealed Resident #54 lying in bed with head of bed elevated 45 degrees. The resident was able to shake his head to yes/no questions and mouthed he was not feeling well today. There was a white board with dry erase markers available on his overbed table to enable him to communicate with staff. It was noted he had written on his board "I would please like for my fingernails to be trimmed." Observation of his fingernails revealed they were ¼ to ½ inch beyond the end of his fingers. There was a message written across the room on another white board for staff to please provide oral care.

Observation and interview on 11/16/21 at 10:34 AM revealed Resident #54 with the message about his fingernails still on his white board and his fingernails remained ¼ to ½ inch beyond the end of his fingers. Resident once again mouthed he was not feeling well today.

Interview on 11/17/21 at 3:58 PM with NA #3 revealed had not noticed the message on Resident #54's white board about wanting his fingernails trimmed. NA #1 stated since he had diabetes, the NAs were not allowed to trim his nails but said she had not reported the message to the nurse assigned to the resident.

Observation and interview on 11/18/21 at 10:29 AM revealed Resident #54 resting in bed. He mouthed he finally got his nails trimmed and mouthed in a whisper they felt much better since being trimmed.

Interview on 11/18/21 at 11:16 AM with NA #1 revealed had not noticed the message on

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Resident #54's white board about wanting his fingernails trimmed. NA #1 stated since he had diabetes, the NAs were not allowed to trim his nails, but the nurse would be able to trim them.

Interview on 11/18/21 at 1:45 PM with NA #2 revealed had not noticed the message on Resident #54's white board about wanting his fingernails trimmed. NA #2 stated would not be able to trim his nails because the resident had diabetes but stated the nurse would be able to trim them. NA #2 further stated had not reported the message on the board to the nurse or noticed the resident's fingernails.

Interview on 11/18/21 at 3:38 PM with Nurse #1 revealed she had not noticed the message on his white board about wanting his fingernails trimmed but stated the wound care nurse had brought it to her attention after she saw it and had trimmed his nails.

Interview on 11/19/21 at 3:32 PM with the Director of Nursing (DON) revealed nail care was to be provided to residents on shower days and as needed. The DON stated she would have expected someone to have looked at the message on the white board and provided Resident #54 nail care as soon as the note was written. The DON further stated it was her expectation that resident's nails be checked on every shower day and be trimmed and filed as needed or requested.

4. Resident #82 was admitted to the facility on 03/13/20 and readmitted on 09/21/21 with diagnoses that included upper end of left humerus fracture, cardiomyopathy, chronic pain, and weakness.

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The significant change Minimum Data Set (MDS) dated 10/11/21 revealed Resident #82 had severe impairment in cognition for daily decision making and required total assistance of 1 staff member with bathing.

Review of Resident #82's care plans, last reviewed/revised on 11/17/21, revealed a plan of care that addressed an ADL self-care performance deficit related to activity intolerance, fatigue and was at risk for changes and decline in functional status related to the disease process. Interventions included extensive assistance by 1 to 2 staff members with bathing/showering on preferred shower days and as necessary, personal hygiene and oral care, and moving between surfaces as necessary.

Review of the master shower schedule revealed Resident #82 was to receive showers on Wednesday and Saturday on the evening shift during the hours of 3:00 PM to 11:00 PM or 7:00 PM to 7:00 AM.

Review of the Nurse Aide (NA) bathing documentation reports for Resident #82 for the months of October 2021 and November 2021 revealed the following:
October: Partial bed baths were documented as provided on 10/02/21, 10/03/21, 10/04/21, 10/05/21, 10/07/21, 10/08/21, 10/13/21, 10/14/21, 10/16/21, 10/22/21, 10/23/21, 10/24/21, 10/27/21, and 10/28/21. Showers were documented as provided on 10/11/21, 10/15/21, 10/25/21, 10/26/21, and 10/30/21.
November: Partial bed baths were documented as provided on 11/01/21, 11/02/21, 11/04/21, 11/05/21, 11/06/21, 11/07/21, 11/09/21, 11/10/21, and 11/11/21. Showers were documented as

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provided on 11/13/21 and 11/17/21.

Review of the nurse progress notes for the months of October 2021 and November 2021 revealed no entries related to Resident #82 refusing bathing assistance.

During an interview on 11/18/21 at 11:16 AM, NA #1 revealed Resident #82 required staff assistance with bathing needs and on occasion, would refuse to take a shower. NA #1 revealed if the documentation stated partial bed baths were provided that meant he only cleaned the underarms and the genital and buttock areas. NA #1 confirmed resident showers were not being provided as scheduled and explained there were only 2 NAs assigned to Resident #82's hall with 18 or more residents each and it was difficult to do showers because it left only one NA on the hall to answer call lights and provide care.

During an interview on 11/18/21 at 1:45 PM, NA #2 stated when there were only 2 NAs assigned to Resident #82's hall with 19 to 20 residents each, he wasn't able to provide resident showers as scheduled. NA #2 revealed he had not provided Resident #82 with a shower during the months of October 2021 and November 2021; however, in lieu of a shower, he provided him with a partial bed bath which he described as lathering with soap and water and washing the hair, face, and neck. NA #2 stated Resident #82 wanted to take a shower and would be cooperative with taking one if the NAs had time to provide.

During an interview on 11/19/21 at 3:32 PM, the Director of Nursing (DON) revealed she would like for all residents to get showers at least 2 times each week. The DON stated if staff were

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not able to complete the resident's shower on their scheduled day, she expected the NAs to let the resident know and provide them a make-up shower on the next shift or the next day. The DON indicated she felt like the showers were not being provided as scheduled due to staffing. She further indicated they were offering a competitive salary with sign on bonuses but were not getting a lot of candidates for open positions.

5. Resident #81 was admitted to the facility on 07/28/16 with multiple diagnoses that included Parkinson's disease, osteomyelitis of the left ankle and foot, chronic pain, contracture of muscle-multiple sites, and diabetes.

Review of Resident #81's care plans, last reviewed/revised on 09/01/21, revealed a plan of care that addressed an ADL self-care performance deficit related to activity intolerance, Parkinson's disease, impaired balance and limited mobility. Interventions included extensive assistance by 1 to 2 staff members with bathing/showering on preferred shower days and as necessary.

The quarterly Minimum Data Set (MDS) dated 10/27/21 revealed Resident #81 had intact cognition and required extensive assistance of one staff member with bathing.

Review of the master shower schedule revealed Resident #81 was to receive showers on Monday and Thursday on the day shift during the hours of 7:00 AM to 3:00 PM or 7:00 AM to 7:00 PM.

Review of the Nurse Aide (NA) bathing documentation for Resident #81 for the months of October 2021 and November 2021 revealed the

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following:
October: Partial bed baths were documented as provided on 10/02/21, 10/05/21, 10/07/21, 10/08/21, 10/11/21, 10/12/21, 10/14/21, 10/15/21, 10/16/21, 10/22/21, 10/23/21, 10/24/21, 10/26/21, 10/27/21, and 10/28/21. Showers were documented as provided on 10/01/21, 10/13/21, 10/25/21, and 10/30/21.
November: Partial bed baths were documented as provided on 11/01/21, 11/02/21, 11/04/21, 11/05/21, 11/06/21, 11/07/21, 11/09/21, 11/10/21, and 11/11/21. A shower was documented as provided on 11/16/21.

Review of the nurse progress notes for October 2021 and November 2021 revealed no entries related to Resident #81 refusing bathing assistance.

During an interview on 11/15/21 at 2:44 PM Resident #82 stated he needed staff assistance with bathing but it was hard to get help from staff. Resident #81 added he would like to have a shower but hadn't had one in 8 days.

During an interview on 11/18/21 at 11:16 AM, NA #1 revealed Resident #81 never refused bathing assistance and would take a shower "every day if he could." NA #1 revealed if the documentation stated partial bed baths were provided that meant he only cleaned the underarms and the genital and buttock areas. NA #1 confirmed resident showers were not being provided as scheduled and explained there were only 2 NAs assigned to Resident #81's hall with 18 or more residents each and it was difficult to do showers because it left only one NA on the hall to answer call lights and provide care.

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During an interview on 11/18/21 at 1:45 PM, NA #2 stated when there were only 2 NAs assigned to Resident #81's hall with 19 to 20 residents each, he wasn't able to provide resident showers as scheduled. NA #2 revealed he had not provided Resident #81 with a shower during the months of October 2021 and November 2021; however, in lieu of a shower, he provided him with a partial bed bath which he described as lathering with soap and water and washing the hair, face, and neck. NA #2 stated Resident #81 wanted to take a shower and would be cooperative with taking one if the NAs had time to provide.

During an interview on 11/19/21 at 3:32 PM, the Director of Nursing (DON) revealed she would like for all residents to get showers at least 2 times each week. The DON stated if staff were not able to complete the resident's shower on their scheduled day, she expected the NAs to let the resident know and provide them a make-up shower on the next shift or the next day. The DON indicated she felt like the showers were not being provided as scheduled due to staffing. She further indicated they were offering a competitive salary with sign on bonuses but were not getting a lot of candidates for open positions.

6. Resident #13 was admitted to the facility on 5/18/21 with diagnoses which included hypertension and hyperlipidemia.

A review of the quarterly Minimum Data Set (MDS) dated 8/11/21 indicated Resident #13 was cognitively intact and required physical assistance of one person for bathing and transfers.

Review of the shower schedule revealed Resident #13 was scheduled for showers on Tuesday and Fridays during evening shift.

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Resident #13's shower schedule for October and November 2021 revealed a shower or bath was not documented as given on 10/1/21, 10/5/21, 10/12/21, 10/19/21, 10/22/21, 11/5/21, and 11/12/21.

An observation was conducted on 11/15/21 at 10:35 AM revealed Resident #13 hair appeared to be oily and unbrushed.

An interview conducted with Resident #13 on 11/15/21 at 10:37 AM revealed multiple showers had been missed the last two months due to staff quitting. Resident #13 further revealed her shower schedule was on Tuesday and Fridays but stated she rarely received a bed bath or shower on her scheduled days.

An interview conducted with Nurse Aide (NA) #2 on 11/18/21 at 1:32 PM revealed there has not been enough staff to complete showers as scheduled in the past few months. NA #2 further revealed they had worked evening shifts multiple times and Resident #13 had not received a shower or bath because there was a staff shortage. NA #2 indicated that showers and baths had been missed often.

An interview conducted with Nurse #1 on 11/18/21 at 2:44 PM revealed Resident #13 had never refused showers or care. Nurse #1 further revealed Resident #13's scheduled showers and baths had been missed due to not having enough staff during evening shifts. Nurse #1 stated she had worked evening shifts multiple times and it was hard to give 100% care to the residents in a timely manner.

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An interview with the Director of Nursing (DON) on 11/19/21 at 3:32 PM revealed she would like for all residents to get showers at least 2 times each week. The DON further revealed if staff were not able to complete the resident's shower on their scheduled day, she expected the NAs to let the resident know and provide them a make-up shower on the next shift or the next day. The DON indicated she felt like showers had not been provided as scheduled due to staffing.

7. Resident #50 was admitted to the facility on 4/5/21 with diagnosis which included hypertension.

A review of the quarterly Minimum Data Set (MDS) dated 10/9/21 indicated Resident #50 was cognitively intact and was total dependent of two staff for bathing and transfers.

Review of the shower schedule revealed Resident #50 was scheduled for showers on Tuesday and Fridays during day shift.

Resident #50's shower schedule for October and November 2021 revealed a shower or bath was not documented as given on 10/1/21, 10/5/21, 10/8/21, 10/15/21, 10/19/21, 10/22/21, 10/26/21, and 11/5/21.

An observation was conducted on 11/15/21 at 10:35 AM revealed Resident #50's hair appeared to be disheveled and flakey with dandruff.

An interview conducted with Resident #50 on 11/15/21 at 10:40 AM revealed most scheduled shower days Resident #50 had not received a bath or shower consistently in several weeks. Resident #50 further revealed she preferred and

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loved her showers and would never refuse them. Resident #50 indicated scheduled showers had been missed weekly due to shortage of staff.

An interview conducted with Nurse Aide (NA) #1 on 11/18/21 at 10:55 AM revealed Resident #50 had never refused care or showers. NA #1 further stated Resident #50's showers had been missed due to staff shortages. NA #1 indicated Resident #50 required extensive assistance and there had not been staff to assist with showers.

An interview conducted with Nurse #1 on 11/18/21 at 2:44 PM revealed Resident #50 preferred showers and recalled Resident #50 missing scheduled bath days. Nurse #1 further revealed scheduled showers and baths had been missed due to not having enough staff and would be pushed to the next shift but rarely got done. Nurse #1 stated it was hard to give 100% care to the residents in a timely manner.

An interview with the Director of Nursing (DON) on 11/19/21 at 3:32 PM revealed she would like for all residents to get showers at least 2 times each week. The DON further revealed if staff were not able to complete the resident's shower on their scheduled day, she expected the NAs to let the resident know and provide them a make-up shower on the next shift or the next day. The DON indicated she felt like showers had not been provided as scheduled due to staffing.

8. Resident #23 was admitted to the facility 10/21/19 with diagnoses including anemia and non-Alzheimer's dementia.

The quarterly Minimum Data Set (MDS) dated 08/31/21 revealed Resident #23 was severely

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cognitively impaired and was totally dependent on staff assistance for bathing.

The care plan for activities of daily living (ADL) last updated 09/06/21 revealed Resident #23 had an ADL self-care performance deficit related to activity intolerance and dementia. Interventions included extensive assistance of 1 to 2 staff members with bathing/showering on shower days and as necessary and encouraging Resident #23 to participate to the fullest extent possible with each interaction.

An observation of Resident #23 on 11/16/21 at 8:44 AM revealed she was lying in bed with uncombed hair and jagged edges to her fingernails.

An observation of Resident #23 on 11/18/21 at 8:42 AM revealed she was lying in bed with uncombed hair. Brown material was noted under Resident #23's fingernails and her fingernail edges remained jagged.

An observation of Resident #23 on 11/19/21 at 8:29 AM revealed she was in bed feeding herself. Resident #23's hair was uncombed, brown material was noted under her fingernails, and her fingernails had jagged edges.

Review of the master shower schedule revealed Resident #23 was scheduled to receive her shower on Tuesdays and Fridays on the 3:00 PM to 11:00 PM shift.

Review of bathing documentation for Resident #23 for October 2021 and November 2021 is as follows:

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October: Partial bed baths were documented as performed 10/22/21, 10/23/21, 10/27/21, 10/28/21. Showers were documented as being provided 10/25/21, 10/26/21, and 10/30/21.
November: Partial bed baths were documented as being provided 11/01/21, 11/02/21, 11/04/21, 11/05/21, 11/06/21, 11/07/21, 11/10/21, and 11/11/21. No showers were documented as being provided in November.

An interview with Nurse Aide (NA) #7 on 11/17/21 at 3:46 PM revealed when there were only 2 NAs assigned to Resident #23's hall she was unable to get all her showers or nail care done. She stated when she wasn't able to complete the scheduled showers or nail care she notified the nurse on the hall.

An interview with NA #2 on 11/18/21 at 1:32 PM revealed when there were only 2 NAs scheduled for Resident #23's hall he was not able to get all his showers or nail care done. He explained that when a partial bed bath was documented that meant the resident received cleaning assistance with the underarm, genitals, and buttock areas.

An interview with the Director of Nursing (DON) on 11/19/21 at 3:31 PM revealed if residents were scheduled for 2 showers a week she liked for residents to receive 2 showers a week. She stated staffing was the reason showers were not getting done as scheduled. The DON stated when possible an effort was made to make up a missed shower the next day but that did not always happen. She stated nail care should be done if needed when showers were given.

An interview with the Administrator on 11/22/21 at 12:13 PM revealed she was aware of the

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residents not receiving their showers as scheduled. She explained showers were not getting done due to lack of staff. The Administrator stated staff did make every effort to get showers done when possible. She stated nail care should be performed when showers were done or when needed.
9. Resident #45 was admitted to the facility 10/8/19 with diagnosis including major depressive disorder.

A review of the activity of daily living (ADL) care plan revised on 9/29/21 identified Resident #45 as having an ADL self-care performance deficit with the goal to maintain the current level of ADL function through the review date. Interventions included provide limited to extensive assistance by 1 or 2 staff with bathing and/or showering on preferred shower days and as necessary and provide limited assistance with personal hygiene.

A review of the quarterly Minimum Data Set (MDS) dated 10/8/21 assessed Resident #45's cognition as being moderately impaired. The MDS assessment of functional status revealed Resident #45 required supervision with 1-person assist with personal hygiene and was totally dependent on staff for bathing. The MDS assessment of behaviors revealed no rejection of care.

A review of the shower schedule revealed Resident #45 was scheduled to receive a shower on Sunday and Thursday. The last shower documented was provided by Nurse Aide #2 on 11/14/21.

An observation on 11/16/21 at 10:26 AM revealed Resident #45's fingernails on both hands

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extended approximately 2.5 to 3 centimeters pass the tip of the finger. Resident #45 had several patches of white chin hairs approximately 0.5 to 1 centimeter in length on both sides and underneath the chin.

During an interview on 11/16/21 at 10:26 AM Resident #45 revealed her nails needed to be clipped and the patches of hairs on her chin were unwanted. Resident #45 revealed she was able to dress and toilet herself and did not use the call light to ask for help.

A second observation on 11/17/21 at 11:06 AM revealed Resident #45's fingernails on both hands extended approximately 2.5 to 3 centimeters pass the tip of the finger. Resident #45 had several patches of white chin hairs approximately 0.5 to 1 centimeter in length on both sides and underneath the chin.

A third observation on 11/18/21 at 9:55 AM revealed Resident #45's fingernails on both hands extended approximately 2.5 to 3 centimeters pass the tip of the finger. Resident #45 had several patches of white chin hairs approximately 0.5 to 1 centimeter in length on both sides and underneath the chin.

During an interview and observation on 11/18/21 at 9:59 AM Nurse #4 revealed she was responsible for the care of but hadn't noticed Resident #45 patches of chin hairs or long fingernails. Nurse #4 stated the Nurse Aide (NA) should shave chin hairs and clip fingernails during the shower and she tried to get with NA staff to ensure resident care was done. Nurse #4 revealed at times there had been 1 NA on the hall and care was missed.

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F 677	Continued From page 74 During an interview on 11/18/21 at 2:09 PM NA #2 stated during a shower chin hair would be shaved and nail care done. NA #2 revealed Resident #45 didn't make her needs known to staff and needed to be checked and if chin hairs weren't shaved and fingernails weren't cut, it was missed. NA #2 revealed there were times he and 1 other NA were assigned the unit making it difficult to complete assigned task and check on residents. During an interview on 11/19/21 at 3:32 PM the Director of Nursing (DON) revealed nail care and shaving were supposed to be part of the bathing routine and expected it would be done. The DON revealed she was aware of issues with bathing when short of staff.	F 677		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		12/29/21

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F 725	Continued From page 75 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 observations, record reviews, and interviews with residents and staff, the facility failed to maintain sufficient nursing staff to assure preferred choices were honored for showers and transfer in and out of bed; failed to assure dependent residents received weekly bathing and timely assistance with incontinence care, nail care, and grooming for 12 of 22 residents reviewed for dignity and respect, choices, and activities of daily living (Resident #7, Resident #8, Resident #9, Resident #13, Resident #23, Resident #26, Resident #27, Resident #45, Resident #50, Resident #54, Resident #81, and Resident #82). The findings included: This tag was cross-referred to: F-550: Based on record reviews, observations, staff interviews, and resident interviews, the facility failed to maintain residents' dignity by not providing showers, bathing, and incontinence care resulting in residents feeling "like a	F 725	1. Resident #7, #8, #9,#13, #23, #26, #27, #45,#50, #54, #81 cited and provided with care per their preference and POC. Resident #82 no longer in facility. 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved Admin to conduct PPD audit to solidify staffing needs. This will be completed by 12.17.21 3. Administrator will ensure all open positions are reviewed daily. Administrator will post all open positions in Hosted Time applicate tracker as needed. Administrator/Director of Nursing will check Hosted Time daily Monday through Friday for applicants and schedule interviews as applicable. Administrator will adjust advertising needs as needed for up to date ads. Administrator/Director of Nursing to educate staffing coordinator on ratios/PPD level of staff required by 12.17.21. Administrator/Director of Nursing will review staffing sheet daily to	

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F 725	Continued From page 76 homeless person", like staff did not like them, dirty and embarrassed, uncomfortable, and dirty. This affected 3 out of 6 (Resident #27, Resident #13, and Resident #50) sampled residents. F-561: Based on observations, record review and resident, family, and staff interviews, the facility failed to provide residents with their preference for a shower instead of a partial bed bath (Residents #7 and #9) and accommodate resident requests to be assisted to and from bed when requested (Residents #27 and #8) for 5 of 14 residents reviewed for choices. F-677 Based on record reviews, resident, and staff interviews the facility failed to provide showers or complete bed baths for 6 of 18 residents (Resident #27, Resident #26, Resident #81, Resident #82, Resident #13, and Resident #50) and failed to provide nail care and grooming for 3 of 18 residents (Resident #54, Resident #23, and Resident #45) reviewed for activities of daily living (ADL). Resident #27 stated because of not getting her showers, her hair was matted to her head, and she could smell her own body odor and it made her feel degraded and like a homeless person. During an interview on 11/15/21 at 3:20 PM Nurse #9 explained she had approximately 26 residents and was working with NA #9 who had the same assignment. Nurse #9 stated weekend staffing was harder due to no support help from the management team who help pass meal trays, answer call lights and the phone. Nurse #9	F 725	ensure appropriate staffing. Any new staff scheduler hired will be educated upon hire date. 4. Administrator to audit to ensure sufficient staffing as evidenced by care needs are maintained 5x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Administrator will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months or or until the process has shown that it has improved adequately. 5. Completion date 12/29/21	

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revealed agency staff picked up what they want and usually don't want the weekend shift.

During an interview on 11/15/21 at 3:38 PM NA #9 revealed her assignment included 5 residents needing total assistance using a mechanical lift, 1 resident needing total assistance with feeding and 10 residents that were incontinent. NA #9 revealed her assignment was to provide care for approximately 26 residents and she hadn't been able to provide residents with their scheduled showers at this time.

An interview was conducted on 11/17/21 at 9:40 AM with the Staffing Scheduler (SS). The SS revealed he judged the number of nursing staff needed based on the number of residents, their acuity and/or complexity of care needs discussed with him during meetings with the Interdisciplinary Team. The SS stated there were days the facility was short of nursing staff and one Nurse Aide (NA) would be assigned to provide care for 20 or more residents. The SS revealed residents have told him they didn't get a shower and he tried to ensure it would be done that day or the next. The SS used multiple agency staffing companies and his goal was to have 5 nurses working the day shift and 4 for the evening shift and 3 for the night shift. The SS revealed the goal for NA staff was to have 6 working during the day and evening shifts and 5 working on the night shift. The SS revealed the facility census hovered around 90 residents and if he couldn't find staff coverage leadership personnel came in to cover the shift and were on call 24 hours 7 days a week. The SS revealed the facility offered $50 or $100 bonuses for staff who

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F 725	Continued From page 78 pick up shifts and a list of shifts needing coverage was provided to nursing staff. During an interview on 11/22/21 at 3:45 PM the Director of Nursing (DON) revealed there had been times the facility was short of staff. Bonuses were provided when staff come in to cover shifts and the SS, Unit Manager, and herself have covered when unable to find coverage. The DON explained the hiring process was ongoing, and the facility was actively trying to recruit new staff and offered sign-on bonuses but was hit or miss with applicants and the facility was doing their best to get positions filled. During an interview on 11/22/21 at 4:12 PM the Administrator revealed she received reports from staff they couldn't get their work completed or showers done due to working short staffed. The Administrator revealed the facility currently worked with 5 different staffing agencies to supplement the schedule but there were times when call outs occurred and nursing worked short of staff. Bonuses were offered when staff pick up shifts but if unable to get anyone to cover, the Administrator revealed she would come in and help out on the floor as a Personal Care Aide along with other administrative staff and understood staffing was a concern and stated they were doing the best they could with staffing.	F 725		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		12/29/21

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F 760	Continued From page 79 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, staff, former Nurse Practitioner (NP) and Medical Director interviews, the facility failed to prevent a medication error by not administering Lithium (a mood stabilizer medication that works in the brain) to a resident (Resident #12) for four consecutive days resulting in increased anxiety for the resident and feeling of "being all to pieces" without the medication. The findings included: Resident #12 was admitted to the facility on 03/14/20 and readmitted on 04/04/20 with diagnoses which included, anxiety disorder, and bipolar disorder. Resident #12's most recent quarterly Minimum Data Set (MDS) dated 08/11/21 revealed she was cognitively intact for daily decision making and was on antianxiety and antidepressant medications daily. Review of a psychotherapy progress noted dated 08/04/21 revealed the following under patient objective quote: "They ran out of my Lithium again. I'm all to pieces." The note further revealed under patient reports and progress observed: "Patient was assured this provider would consult with Nurse Practitioner (NP) to assist the patient to access her medication in a timely manner. NP was consulted and she stated she would attempt to source the medication from a local pharmacy to assist the patient."	F 760	1. Resident #12 cited. Director of Nursing completed an audit on 12.21.21 of current medication orders and MAR for Resident #12 to ensure all medications are accurate And being administered as ordered. No issues found. 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved: Director of Nursing or Unit Manager to audit all residents to ensure medications are available and being administered as ordered by 12.25.21. No additional concerns identified. 3. Director of Nursing to educate licensed nursing staff on processes for medication reordering, availability and administration of medications as ordered to include licensed nurse will follow pharmacy reordering process and standard and STAT cut-off times to ensure new medications orders are promptly entered into PCC, submitted to pharmacy via electronic order entry system, delivered from pharmacy and available for administration as ordered for next scheduled dose. In the event that medications are not available timely by pharmacy, the licensed nurse will notify the physician and utilize the Cubex back-up system to ensure timely administration as ordered by 12.17.21.	

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F 760	Continued From page 80 Review of a Lithium lab drawn on 11/08/21 and reported on 11/09/21 revealed a Lithium level of 0.50 millimoles per liter (mmol/L) with a therapeutic range of 0.50 to 1.20. Review of Resident #12's care plan dated 11/13/21 revealed a plan of care for impaired cognitive function/impaired thought processes related to unspecified bipolar disorder. The interventions included administer medications as ordered and monitor/document for side effects and effectiveness. Observation and interview on 11/18/21 at 2:45 PM revealed Resident #12 in her wheelchair attending the Resident Council meeting. Resident #12 stated she had missed 4 days of her Lithium about 3 to 4 months ago. Resident #12 further stated being without her Lithium made her feel "crazy" and said she knew she "acted different." Review of Resident #12's physician orders for July through November 2021 revealed an order for Lithium Carbonate Capsule 150 mg - give 3 capsules by mouth one time a day related to bipolar disorder at 12:00 noon. Review of Resident #12's Medication Administration Record (MAR) for July and August 2021 revealed Resident #12 missed doses on 07/30/21, 07/31/21, 08/01/21, and 08/02/21. Review of Resident #12's nursing progress notes revealed notes written on 07/30/21, 07/31/21, and 08/01/21 indicating "awaiting arrival" of medication. Interview on 11/19/21 at 10:14 AM with Nurse #2 assigned to care for the resident on 07/31/21 and	F 760	Any newly hired licensed nursing staff will be educated upon hire. New agency licensed nursing staff will be educated via their agency orientation packet. 4. Director of Nursing or Unit Manager to audit to ensure ordered medications are available, administered and documented on MAR as ordered by the physician for 5 residents 5x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months to maintain compliance with residents being free from significant medication errors. completion date: 12/29/21	

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08/01/21 revealed Resident #12 was out of her Lithium those days and it was not given. Nurse #2 stated usually if medication is ordered before 5:00 PM it was delivered the evening on the same day. She further stated sometimes they had to call several days to get medications and it just depended on the medication as to how long it would take to be delivered. Nurse #2 indicated she was not aware if there was a contract with a local pharmacy for emergency dispensing of medications. She stated the resident was on Lithium and took 3 capsules daily. According to Nurse #2 she remembered calling about the Lithium both days she worked but couldn't recall if the pharmacy had received the original refill request so she stated she sent the refill request again for the Lithium. Nurse #2 indicated she remembered Resident #12 being upset at the time and anxious but said she was not sure if it was because she had not taken her meds or because her room was being changed.

Phone interview on 11/19/21 at 10:54 AM with the former NP for the facility revealed she recalled the psychotherapist had called her because she was concerned about Resident #12 not receiving her Lithium. The NP further revealed the psychotherapist was concerned if the resident did not get her Lithium, she could easily decompensate so the NP stated she called the pharmacy directly and the medication was delivered. The NP agreed that it could be concerning for the resident to decompensate if she did not receive her Lithium and it was not ideal for her to go days without the Lithium.

Phone interview was attempted with the Psychotherapist, but she was out of the country and could not be reached.

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F 760	Continued From page 82 Phone interview on 11/19/21 at 1:00 PM with the Medical Director (MD) revealed Resident #12 missing doses of her Lithium was familiar and remembered the resident mentioning to him her medication had run out but could not recall if the facility had notified him of the resident missing 4 consecutive doses. The MD stated in an unstable resident missing 4 consecutive doses of Lithium could potentially present a problem but said Resident #12 was stable and had been on the medication for a long time. He further stated he was not terribly concerned about her missing the doses of Lithium but said he would prefer residents received their medications as ordered.	F 760		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791		12/29/21

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F 791	Continued From page 83 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to refer a resident with identified dental needs to the dentist as requested by the resident's Responsible Party (RP) and the Nurse Practitioner's order for 1 of 2 residents reviewed for dental (Resident #82). Findings included: Resident #82 was admitted to the facility on 03/13/20 with multiple diagnoses that included chronic pain. The admission Minimum Data Set (MDS) dated 03/20/20 revealed Resident #82 had no dental issues.	F 791	1. Resident #82 cited no longer in facility. 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved: DON or designee to audit all residents to identify any dental service needs and ensure dental care and/or dental referral orders provided and/or ordered by 12.23.21. 3. Director of Nursing to educate interdisciplinary team and current facility and agency licensed nursing staff to ensure dental needs are identified and	

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F 791	Continued From page 84 Review of a Nurse Practitioner (NP) progress note dated 05/11/20 read in part, Resident #82 was seen for evaluation of facial swelling. The NP noted Resident #82 complained of right upper tooth pain that was worse when chewing. She further noted upon physical exam, he continued eating which interfered with the oral/dental exam but indicated he had right-sided facial swelling with no obvious abscess or ulcerations. The plan was to treat the facial swelling and tooth pain empirically with antibiotics for a dental abscess and "dentistry referral would be requested however, will likely be deferred in the setting of the COVID-19 pandemic." Review of Resident #82's physician orders revealed the following: 05/11/20: Amoxicillin 500 milligrams (mg) three times a day for tooth infection for 7 days. 05/11/20: dental consult for tooth pain. 07/23/20: dentist consult as soon as possible. During an interview on 11/15/21 at 10:07 AM, Resident #82's guardian/Responsible Party (RP) revealed when he was admitted to the facility March 2020, she sent email correspondence to the Administrator informing her that Resident #82 was referred by the dentist for oral surgery for teeth extraction and provided her with the contact number for the oral surgeon to arrange an appointment. She added the Administrator informed her that due to the COVID-19 pandemic, only emergency appointments were being scheduled at that time. The RP reported she followed up with email correspondence to the facility Social Worker (SW), former Director of Nursing (DON) and Administrator in May 2020 requesting the appointment be made due to him	F 791	communicated to her in a timely manner. IN addition, the education will contain that all dental referral orders are to be communicated immediately to the Director of Nursing or a Unit Manager in order to arrange timely services. This will be completed by 12.17.21. Any new hired licensed nursing staff will be educated upon hire date. Any new agency licensed nursing staff will be educated via their orientation packet. The licensed nurse will assess resident oral/dental care needs upon admission, quarterly and as needed and notify Director of Nursing and physician to obtain dental referrals as appropriate. 4. Director of Nursing to audit any identified need for dental services to ensure referral and services are implemented timely for 5 residents 5x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months to maintain compliance with resident dental care and services. Completion date: 12/29/21	

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F 791	Continued From page 85	F 791		

experiencing tooth pain and even offered to transport him to the dentist but was again told residents were only being sent to outside appointments on an emergency basis.

Review of the email correspondence provided by Resident #82's RP on 11/18/21 at 4:00 PM revealed the following:
On 03/26/20 at 3:03 PM, an email was sent to the Administrator informing her of a referral made by the dentist to the oral surgeon for teeth extraction.
On 05/12/20 at 10:24 AM, an email was sent to the facility SW inquiring about the dental appointment and the RP would be willing to transport Resident #82 to the appointment with the understanding he would be placed in isolation upon his return. An email response was received at 2:04 PM from the former DON that read, "we are not sending residents out unless there is a true emergency at this time. This is under the direction of the federal government guidelines. Once we are cleared to do this, we will gladly send him to these visits."
On 05/14/20 at 1:20 PM, an email was sent to both the facility SW and Administrator informing them the oral surgeon's office was scheduling appointments and were willing to extract Resident #82's teeth as recommended by the dentist.

Telephone attempt on 11/18/21 at 4:24 PM for interview with the facility's former SW was unsuccessful.

During an interview on 11/23/21 at 3:06 PM, the Administrator explained Resident #82 was admitted right when the COVID-19 pandemic started and she did not recall the email correspondence dated 03/26/20 she had with Resident #82's RP or the RP mentioning a

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F 791	Continued From page 86 referral to the oral surgeon. The Administrator added she was not made aware of the email correspondences in May 2020 to the former SW and DON requesting a dental appointment with the oral surgeon for Resident #82. The Administrator stated she felt they tried to address his dental needs and he was seen by the facility dentist in August 2020 when onsite visits resumed. She acknowledged Resident #82 was seen by the NP on 05/11/20 and prescribed antibiotics for dental abscess but could not explain why Resident #82 was not sent out to the dentist when the order for a dental consult was written by the NP on 05/11/20 and confirmed they were allowing emergent visits outside the facility at that time.	F 791		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide adaptive equipment for 1 of 1 resident who was determined to need a divided plate (Resident #59) reviewed for adaptive equipment. Findings included: Resident #59 was admitted to the facility 08/10/18 with diagnoses including non-Alzheimer's dementia and heart failure.	F 810	1. Resident #59 cited. She will continue to be provided with red divided plate. Order and tray card reviewed to ensure documentation to indicate need for divided plate is accurate during the survey. 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved Dietary	12/29/21

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F 810	Continued From page 87 A quarterly Minimum Data Set (MDS) dated 10/01/21 revealed Resident #59 was severely cognitively impaired for daily decision making and required limited assistance with eating. The MDS further indicated Resident #59 had weight loss, was not on a Physician prescribed weight loss regimen, and received a mechanically altered diet. The care plan for nutrition last updated 10/27/21 revealed Resident #59 was to receive a mechanically altered diet for all meals, was to be served supplements as ordered, and was to be seen by the Registered Dietician (RD) as needed. An interview with Speech Therapist (ST) on 11/15/21 at 2:34 PM revealed she had recommended Resident #59 receive her food on a red divided plate due to her diagnosis of dementia. She explained she had read a study that stated residents with dementia seemed to be better able to see their food if it was served on a red plate due to the contrast of colors between the food and the plate. The ST stated residents with dementia who received their food on a red divided plate seemed to have more independence with feeding themselves and increased oral intake. An observation of Resident #59's lunch plate on 11/15/21 at 1:08 PM revealed her meal of pureed chicken, mashed potatoes, and a pureed green vegetable was served on a regular plate. An observation of Resident #59's meal ticket at the same date and time revealed she was to receive her food on a red divided plate. An interview with Personal Care Aide (PCA) #1	F 810	Manager/Registered Dietician audited all tray cards and dietary orders to ensure residents with orders for adaptive eating devices are in place, correlate in dietary tray card and PCC orders systems. This will be completed by 12.22.21 3. Administrator to educate all dietary staff, interdiciplinary staff, and current facility and agency direct care nursing staff to ensure tray cards are reviewed and tray contents match tray card before tray leaves kitchen and prior to delivery to the resident. This will be completed by 12.17.21. Any new direct care staff hired will be educated upon date of hire. New agency direct care staff will be educated via orientation packet. 4. Dietary Manager and Unit Managers to audit 5 tray cards and trays to ensure accuracy prior to tray leaving kitchen and prior to food being delivered to 5 residents: 5x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Dietary manager and Director Of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months to maintain compliance with resident adaptive eating devices. completion date 12/29/21	

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F 810	Continued From page 88	F 810		

on 11/15/21 at 1:10 PM revealed she served Resident #59 her lunch meal tray and did not notice her meal ticket stated she was to receive her food on a red divided plate.

An interview with Nurse #6 on 11/15/21 at 1:14 PM revealed Resident #59 usually received her food on a red divided plate and she wasn't sure why Resident #59's food was served on a regular plate.

An interview with the Dietary Manager on 11/15/21 at 2:16 PM revealed when food was plated, a Dietary Aide called out the type of diet to the Cook and notified the Cook if any adaptive plate was needed. She explained a Dietary Aide also checked the meal tray for accuracy before it left the kitchen. The Dietary Manager confirmed if a meal ticket stated a red divided plate was to be used the food should be served on a red divided plate.

An interview with Dietary Aide #1 on 11/15/21 at 2:27 PM revealed he was responsible for checking meal trays for accuracy before they left the kitchen at the lunch meal on 11/15/21. He explained he was really busy and just did not see the notation that Resident #59's food should have been served on a divided plate.

An interview with the Director of Nursing (DON) on 11/19/21 at 3:31 PM revealed she expected residents to receive adaptive equipment on their meal trays as recommended.

An interview with the Administrator on 11/22/21 12:13 PM revealed she expected dietary staff to check meal trays for accuracy before they left the kitchen and also expected nursing staff to make

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F 810	Continued From page 89 sure adaptive equipment was present on meal trays when served.	F 810		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label, date, or remove expired food stored ready for use in 2 of 3 reach-in refrigerators (refrigerator #1 and refrigerator # 2) and 1 of 2 nourishment room freezers (freezer # 1). The facility failed to maintain clean fans from an accumulation of dust on 1 of 1 dishware air dryers. Findings included: 1. Observation with the Dietary Manager (DM) in	F 812	1. No residents cited. Immediate labeling and/or disposal of all food containers in refrigerators/freezers. Immediate cleaning of dishwasher air dryer. 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved: Dietary Manager to audit all food storage areas for accurate label, dating and/or disposal	12/29/21

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F 812	Continued From page 90 refrigerator # 1 on 11/15/2021 at 9:39 AM revealed 4 containers of uncovered, unlabeled, undated fruit, a 6-liter container of fruit dated 11/7/2021, 8 small unlabeled, undated plastic containers with a green food item in them, and an unlabeled, undated plastic grocery bag with 2 unlabeled, undated plastic containers in it. 2. Observation with the DM in refrigerator # 2 on 11/15/2021 at 9:43 AM revealed 2 unlabeled, undated plastic containers of whipped topping and an unlabeled, undated container of lunch meat. 3. Observation with the DM in the dish room on 11/15/2021 at 9:43 AM revealed an approximate ¾ inch accumulation of dust on the intake fan of the dishware air dryer. 4. Observation with the DM in nourishment room freezer #1 on 11/18/2021 at 9:31 AM revealed an opened, unlabeled container of ice cream and an unlabeled frozen entrée. The DM stated in an interview on 11/15/2021 at 9:43 AM that the fruit, whipped topping, and lunch meat in the refrigerator should have been covered, labeled, dated, and/or disposed of. The DM stated the food item in the small plastic containers was relish, and each container should have been labeled and dated. The DM stated the plastic grocery bag of food items should not have been kept in the refrigerator, and the ice cream and frozen entrée in the nourishment room freezer should have been labeled. The DM further stated the fan of the dishware air dryer needed to be cleaned. In a follow up interview on 11/18/2021 at 9:31 AM	F 812	of all food items. Dietary Manager or Registered Dietician to audit all dietary equipment for cleanliness and clean equipment as appropriate by 12.17.21. 3. Dietary Manager/Registered Dietician or designee to educate all dietary staff on accurate dating, labeling, disposal and storage of food items and cleaning of all equipment. This will be completed by 12.17.21. Any newly hired dietary staff will be educated upon date of hire. Dietary staff will be assigned to monitor kitchen and nourishment rooms for proper food storage and labeling, as well as equipment for cleanliness during routine daily rounds. Concerns will be addressed as identified. 4. Dietary Manager or Registered Dietician to audit all food storage areas for proper dating and labeling and dietary equipment for cleanliness 5x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Dietary Manager will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months to maintain compliance with food procurement; storage, preparation and serve sanitary. Completion date 12/29/21	

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F 812	Continued From page 91 the DM stated she was in the process of educating kitchen staff to label, date, and/or discard of food items in the kitchen and nourishment rooms. The DM also stated she was in the process of reviewing whether she or the maintenance department were responsible for cleaning the fan of the dishware air dryer. Interview with the Maintenance Director on 11/19/2021 at 9:00 AM revealed the maintenance department was not responsible for cleaning the fan of the dishware air dryer. The Administrator stated in an interview on 11/22/21 at 4:00 PM that her expectation was for food in the refrigerators and freezers be labeled, dated, and thrown away if expired. The Administrator stated she was unsure who was responsible for cleaning the fan of the dishware air dryer and her expectation was that it be kept clean.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		12/29/21

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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.

§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-

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F 842	Continued From page 93 (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 maintain complete and accurate medical records related to a resident's fall with no injury and resident's allegation of abuse for 2 of 2 residents reviewed for accidents (Resident #82 and #55). Findings included: 1. Resident #82 was admitted to the facility on 03/13/20 with multiple diagnoses that included chronic pain and cardiomyopathy. Review of Resident #82's electronic medical record revealed a post-fall review form dated 09/24/21 completed by the Administrator. Further review revealed Resident #82 was found on the floor between the bathroom door and Bed A at approximately 1:40 AM and was assessed with no injuries. Review of the nurse progress notes revealed there was no documentation of Resident #82's fall on 09/24/21 at 1:40 AM. Review of the fall/incident report provided by the	F 842	1. Resident #82 cited and no longer in facility. Resident # 55 late entry documented in medical record for resident incident 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved: Director of Nursing to audit 12/1-12/14/21 resident incidents to ensure complete documentation of all fall incidents and abuse allegations/altercations. This will be completed by 12.28.21. 3. Director of Nursing to educate all current facility and agency licensed nursing staff and Interdiciplinary team staff related to accurate and timely documentation standards within the resident record. This will be completed by 12.17.21. Any new hired licensed nurse staff will be educated upon hire and any new agency licensed nursing staff will be educated via their orientation packets.	

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F 842	Continued From page 94 facility on 11/16/21 at 3:09 PM revealed there was no fall or incident recorded for Resident #82 on 09/24/21. During an interview on 11/19/21 at 2:31 PM, the Director of Nursing (DON) explained when a resident had a fall, the nurses were instructed to follow the Code Orange protocol which included assessing the resident for any injuries, documenting the fall in a nurse progress note and completing an incident report. The DON was unaware Resident #82 had a fall on 09/24/21 as indicated on the post fall review documented in his medical record. The DON stated nursing staff should have documented Resident #82's fall in a detailed nurse progress note and completed an incident report. During an interview on 11/19/21 at 4:23 PM, the Administrator revealed she was unaware of Resident #82 having a fall on 09/24/21. The Administrator reviewed Resident #82's medical record and confirmed there was a post fall review completed on 09/24/21 indicating he had fallen. The Administrator explained Nurse #5 created the post fall review documentation; however, she was not informed of the fall and was not sure why the assessment was created. During an interview on 11/22/21 at 9:13 AM, Nurse #5 recalled during the evening shift in the early morning hours, she was out in the hall and heard a noise that sounded like a "bump", she immediately went into Resident #82's room and found him lying on the floor. Upon her assessment, she stated Resident #82 voiced no complaints of pain or had any apparent injuries so staff assisted him up off the floor and back to bed. She was unable to recall the actual date,	F 842	4. Director of Nursing or Unit manager to audit 5 resident medical records to ensure documentation is accurate, timely, and complete for fall incidents and abuse allegations/altercations 5x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months to maintain compliance with resident records. Completion date 12/29/21	

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time or further specifics related to his fall and stated it would have been the date and time she documented the post fall review. Nurse #5 explained when she started at the facility in August 2021, she was not instructed on the facility's fall protocol and wasn't sure how to document the fall which was why she completed the post fall review. Nurse #5 could not recall if she informed the oncoming nurse of Resident #82's fall but stated she did report the incident to the DON that morning.

During a follow-up interview on 11/22/21 at 5:45 PM, the Administrator stated she was only aware of Resident #82 having 2 previous falls and when she opened the post fall review completed by Nurse #5 on 09/24/21, she must not have looked at the date of the assessment thinking it was referring to one of his previous falls. The Administrator added neither she nor the DON were informed of any incident on 09/24/21 concerning Resident #82 and there was no risk assessment completed to alert them of a fall. She added Nurse #5 should have documented Resident #82's fall in a nurse progress note and completed an incident report.

2.Resident #55 was admitted to the facility on 2/17/17 with diagnoses which included anxiety, depression, and Alzheimer's disease.
Review of the quarterly Minimum Data Set (MDS) dated 8/7/21 revealed Resident #55 was severely cognitively impaired and was totally dependent for majority of activities of daily living (ADL).

Review of the incident report dated 8/28/21 revealed Resident #55 was witnessed getting

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struck in the stomach by nursing staff during care. Resident #55 was not observed to sustain any injuries after the incident.

Review of the nurse progress notes revealed there was no documentation of Resident #55's incident on 8/28/21.

An interview conducted with Nurse #8 on 11/19/21 at 11:40 AM revealed she was the Nurse on shift for on 8/28/21 when Nurse Aide (NA) #5 reported that Resident #55 was struck in the stomach. Nurse #8 further revealed she contacted the Director of Nursing (DON) and completed a body assessment for injury on Resident #55. Nurse #8 indicated she could not recall why there was no progress notes for Resident #55 incident on 8/28/21. Nurse #8 stated documented notes would be in the electronic nursing chart and if notes were not there then she had not completed them.

An interview conducted with the DON on 11/19/21 at 12:53 PM revealed Nurse #8 contacted the DON on 8/28/21 and reported Resident #55 had been struck in the stomach by nursing staff. The DON indicated nursing staff would normally document and incident that occurred during their shift. The DON further revealed she would expect nursing staff to document any incidents in resident's chart.

An interview conducted with the Administrator on 11/19/21 at 1:08 PM revealed an investigation was completed on 8/28/21 due to allegations of Resident #55 being struck in the stomach by nursing staff. The Administrator further revealed she could not recall why there was no nursing progress notes documented for Resident #55 on

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F 842	Continued From page 97 8/28/21 by nursing staff.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention 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	F 880		12/29/21

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F 880	Continued From page 98 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to implement their infection control policies and procedures when 4 of 4 staff (Nurse Aide (NA) #3, NA #4, NA #5, and NA #6) were observed providing incontinence care to 3 residents (Resident #26, Resident #27, and Resident # 1) failed to discard their dirty gloves, sanitize their hands, and apply clean	F 880	1. Resident #26 was cited and remains in facility and will continue to receive incontinence care and appropriate infection prevention and control practices.. NA #3, NA #4, NA #5, and NA #6 Educated related to proper hand hygiene during incontinence care and infection control policies and procedures. Return	

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F 880	Continued From page 99 gloves when moving from a dirty to a clean procedure. The findings included: Review of the facility's entitled Handwashing/Hand Hygiene policy last revised in August 2015 revealed the following policy statement: "This facility considers hand hygiene the primary means to prevent the spread of infection." Policy interpretation and implementation: under #7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: under h. Before moving from a contaminated body site to a clean body site during resident care. 1. Observation of incontinence care for Resident #26 on 11/17/21 at 10:35 AM with NA #3 and NA #4 providing care revealed the resident was in bed without a brief as ordered by the wound physician. When the resident was turned on his side there was stool on the resident's buttocks and on the draw sheet underneath him. NA #3 with gloves on, proceeded to clean the resident with resident care wipes while NA #4 held the resident over on his side. NA #3 finished cleaning the resident and changed his draw sheet underneath him that was also soiled. Without sanitizing her hands, NA #4 changed her gloves after discarding the soiled linens in a soiled linen bag and held Resident #26 over while NA #3, without sanitizing her hands and changing her gloves, reached over onto the bedside table and took the barrier cream from the table and proceeded to apply the cream to Resident #26's buttocks with the same gloves used to clean the	F 880	demonstration validated by licensed nurse by 12/28/21. 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved: Director of Nursing to audit incontinence care and hand hygiene by visual observation of staff to ensure facility policies and infection control standards are met related to incontinence care and hand hygiene. This was completed on 12/17/21. 3. Director of Nursing to educate all current facility and agency direct care staff related to proper hand hygiene during incontinence care and infection control policies and procedures. This will be completed by 12.17.21. Any new hired direct care staff will be educated upon hire. Any new agency direct care staff will be educated via orientation packet. 4. Director of Nursing or Unit Manager to monitor infection control standards as it relates to incontinence care and hand hygiene through observation with 5 direct care staff weekly x 4 weeks then, 3 direct care staff weekly x 4 weeks then, 1 direct care staff weekly for 4 weeks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months to maintain compliance with infection prevention and control practices	

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F 880	Continued From page 100 resident. NA #3 then proceeded to change Resident #26's pillowcases and placed clean pillowcases between the resident's skin folds with the same gloves she had used during incontinence care. After completing all tasks for Resident #26, she discarded her gloves, sanitized her hands, and removed the dirty linen and trash from the resident's room. Interview on 11/17/21 at 2:33 PM with NA #4 revealed she frequently worked from 7:00 AM to 3:00 PM on Resident #26's hall. NA #4 stated she had received education on infection control practices during her orientation regarding hand washing and had received education since that time on infection control. NA #4 stated she realized she had changed gloves without sanitizing her hands and knew better but had gotten in a hurry and just forgot to follow the proper procedure for handwashing. Interview on 11/17/21 at 3:58 PM with NA #3 revealed she frequently worked from 7:00 AM to 3:00 PM or 7:00 AM to 7:00 PM on Resident #26's hall. NA #3 stated she had received education on infection control practices during her orientation regarding hand washing and had received education since that time on infection control. NA #3 described the procedure she had followed while providing incontinence care to Resident #26 and realized she had not taken off her dirty gloves, sanitized her hands and applied clean gloves prior to applying cream to his buttocks. NA #3 stated she should have removed her dirty gloves, sanitized her hands, and applied clean gloves prior to putting cream on the resident's buttocks. NA #3 further stated she just got in a hurry and forgot to follow the proper procedure.	F 880	during incontinence care. Completion date 12/29/21	

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Interview on 11/19/21 at 09:33 AM with the Infection Preventionist (IP) revealed she had educated staff continuously on handwashing. The IP stated they had a skills blitz on an annual basis which was coming up soon and all staff were educated on infection control principles and asked to do return demonstrations of proper handwashing and quizzed on techniques. The IP further stated their education extended to Agency staff working in the building as well. The IP indicated NA #3 had been educated on proper handwashing and should have followed the proper procedure for handwashing while providing incontinence care to Resident #26.

2. Observation of incontinence care on Resident #27 on 11/17/21 at 2:42 PM revealed the resident in bed with brief on with large amount of urine in the brief. NA #3 with gloved hands cleaned the resident and applied a new brief. Resident #27 requested her draw sheet be changed because she could feel on her legs that it was wet. NA #3 with the same gloves on changed the residents wet draw sheet. Without discarding her dirty gloves, sanitizing her hands, and putting on clean gloves, NA #3 reached onto the resident's shelving to get her barrier cream and with the same gloves, applied barrier cream to Resident #27's buttocks and then with the same gloves placed the barrier cream back on the resident's shelving. After completing all tasks for Resident #27, she discarded her gloves, sanitized her hands, and removed the dirty linen and trash from the resident's room.

Interview on 11/17/21 at 3:58 PM with NA #3 revealed she frequently worked from 7:00 AM to

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3:00 PM or 7:00 AM to 7:00 PM on Resident #27's hall. NA #3 stated she had received education on infection control practices during her orientation regarding hand washing and had received education since that time on infection control. NA #3 described the procedure she had followed while providing incontinence care to Resident #27 and realized she had not taken off her dirty gloves, sanitized her hands and applied clean gloves prior to applying cream to her buttocks. NA #3 stated she should have removed her dirty gloves, sanitized her hands, and applied clean gloves prior to putting cream on the resident's buttocks. NA #3 further stated she just got in a hurry and forgot to follow the proper procedure.

Interview on 11/19/21 at 09:33 AM with the Infection Preventionist (IP) revealed she had educated staff continuously on handwashing. The IP stated they had a skills blitz on an annual basis which was coming up soon and all staff were educated on infection control principles and asked to do return demonstrations of proper handwashing and quizzed on techniques. The IP further stated their education extended to Agency staff working in the building as well. The IP indicated NA #3 had been educated on proper handwashing and should have followed the proper procedure for handwashing while providing incontinence care to Resident #27.

3. Resident #1 was observed to have been incontinent of urine on 11/15/21 at 12:54 PM. A continuous observation of Nurse Aide (NA) #5 and NA #6 on 11/15/21 from 12:54 PM to 1:00 PM revealed NA #5 unfastened Resident #1's brief and cleaned him with resident care wipes. NA #5 assisted Resident #1 to roll toward her while wearing the same gloves used to provide

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incontinence care. NA #6 completed incontinence care for Resident #1 with resident care wipes, applied a brief, and removed her soiled gloves. NA #6 did not perform hand hygiene after removing her soiled gloves. Resident #1 was assisted onto his back by NA #6. NA #5 and NA #6 fastened Resident #1's clean brief, pulled up his and pants, assisted him to the side of the bed and then into his wheelchair. NA #6 rolled Resident #1 out of the room in his wheelchair. NA #5 then removed her gloves and performed hand hygiene.

An interview with NA #5 on 11/15/21 at 1:00 PM revealed she had been trained to remove her gloves after incontinence care and perform hand hygiene but she got in a hurry and did not remove her gloves and perform hand hygiene appropriately.

An interview with NA #6 on 11/15/21 at 1:05 PM revealed she had been trained to wash her hands or use hand sanitizer after removal of soiled gloves but she got in a hurry and forgot to perform hand hygiene appropriately.

An interview with the Director of Nursing (DON) on 11/19/21 at 3:31 PM revealed she expected nursing staff to remove soiled gloves after incontinence care and perform hand hygiene after gloves were removed.

An interview with the Administrator on 11/22/21 at 12:13 PM revealed she expected nursing staff to remove gloves after incontinence care and perform hand hygiene after gloves were removed.