STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification Survey was conducted 11/15/21 to 11/19/21. The facility was not found in compliance with the requirement CFR 483.73, Emergency Preparedness, and was cited at E0001 and E0015. Event ID # 8MUE11.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness	E 001		12/24/21

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

Electronically Signed | 12/17/2021

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E 001	Continued From page 1 program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a facility and comprehensive Emergency Preparedness (EP) plan which had been developed, reviewed, and maintained specifically for the facility. The facility failed to maintain, review, and update the EP plan, conduct a facility and community based risk assessment, the EP plan failed to address patient/client population, update for current contacts, collaborate with local stakeholders, develop, update, and review EP policies and procedures based on the developed EP plan, address subsistence needs for residents and staff, address evacuation, transportation, needs of evacuees, and staff responsibilities, update or review for arrangements with other facilities, review and update the communication plan, update names and contact information, put into place EP training, testing, and establish a program, and document information in the EP regarding the emergency generator. Findings included:	E 001	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. EOO1 Establishment of the Emergency Program Corrective Action for Affected Residents On 12/15/21, the Administrator assembled the Emergency Preparedness Plan (EP) to include: an update EP plan, conducted a facility and community based risk assessment, addressing patient/client population, update for current contacts, collaboration with local stakeholders,	

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E 001	Continued From page 2 A review of the facility's supplied Emergency Preparedness plan material on 11/18/21 revealed: A. The supplied EP plan provided by the facility was a corporate EP plan and did not provide facility specific information, such as information about the facility staff, local surroundings, evacuation site, potential emergency specific situations related to the facility ' s location, information regarding local resources such as the fire department, emergency coordinator, information regarding the facility ' s emergency power, etc ... in the event of an emergency. B. The facility provided EP plan had not been reviewed or updated annually. The current Administrator, the current Director of Nursing, nor any other facility staff were listed in the EP plan. C. The provided EP plan did not provide information about community-based risk assessment. D. The supplied EP plan did not address the facility resident population such as persons at risk or the type of services the facility had the ability to provide in an emergency. E. The reviewed EP plan did not address the procedures for EP collaboration with local, tribal, regional, state and federal EP officials. F. The provided EP plan policies and procedures, emergency plan for risk assessment, and the communication plan were not reviewed and updated annually by the facility. G. The facility provided EP plan did not provide	E 001	developed, updated, and reviewed EP policies and procedures based on the developed EP plan, addressed subsistence needs for residents and staff, addressed evacuation, transportation, needs of evacuees, and staff responsibilities, updated and reviewed for arrangements with other facilities, reviewed and updated the communication plan, updated names and contact information, put into place EP training, testing, and established a program, and documented information in the EP regarding the emergency generator. Corrective Action for Potentially Affected Residents On 12/15/21, the Administrator assembled the Emergency Preparedness Plan (EP) to include: an update EP plan, conducted a facility and community based risk assessment, addressing patient/client population, update for current contacts, collaboration with local stakeholders, developed, updated, and reviewed EP policies and procedures based on the developed EP plan, addressed subsistence needs for residents and staff, addressed evacuation, transportation, needs of evacuees, and staff responsibilities, updated and reviewed for arrangements with other facilities, reviewed and updated the communication plan, updated names and contact information, put into place EP training, testing, and established a program, and documented information in the EP regarding the emergency generator Systemic Changes	

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E 001	Continued From page 3 information regarding a system to track the location of on-duty staff and sheltered residents in the facility ' s care during an emergency including the specific name and location of a receiving facility or other location. H. The supplied EP plan did not provide information for arrangements with other facilities, who would provide transportation, primary and alternate means of communication with external sources of assistance. I. The supplied EP plan did not address the development of arrangement with other facilities and other providers to receive residents in the events of limitations or cessation of operations. J. The provided EP plan for communication was not facility specific, nor was it reviewed by the facility administration. K. There were no names nor contact information for facility specific staff, residents ' physician, other facilities, and/or volunteers in the supplied EP plan. L. The names and contact information contained in the EP plan for emergency officials contact information was not facility specific, nor was it reviewed and signed off by the facility administration. K. The facility failed to provide information regarding training and testing for the facility specific EP plan. L. The facility failed to provide information regarding EP training program which would include training of the facility specific EP policies	E 001	The Administrator was in-serviced on 12/17/21 by the President/Regional Director of Operations regarding the importance of developing and maintaining the EP plan within the facility including but not limited to: an update EP plan, conducted a facility and community based risk assessment, addressing patient/client population, update for current contacts, collaboration with local stakeholders, developed, updated, and reviewed EP policies and procedures based on the developed EP plan, addressed subsistence needs for residents and staff, addressed evacuation, transportation, needs of evacuees, and staff responsibilities, updated and reviewed for arrangements with other facilities, reviewed and updated the communication plan, updated names and contact information, put into place EP training, testing, and established a program, and documented information in the EP regarding the emergency generator. Quality Assurance On 12/27/2021 The President/Regional Director of Operations, Clinical Nurse consultant and/or Regional Quality Assessment Nurse will review the EP Plan, via in person or electronically, weekly for 4 weeks and monthly for 2 months to ensure the plan is updated and intact. The Emergency Preparedness Plan review will be brought to the Facility QA team meetings for review by the QA team. QA team to include the Administrator , director of nursing, assistant director , health information manager, unit manger, dietary manager,	

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E 001	Continued From page 4 and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. M. The EP plan lacked facility specific information regarding the emergency generator location, inspection, testing, and fuel. An interview was conducted with the Regional Director of Operation (RDO) on 11/18/21. The RDO stated the Administrator was out of town and unavailable. He explained in her absence, he was unable to locate the facility EP plan and the facility staff he had spoken to were unaware of where the EP plan was. He further stated the EP plan he provided was a copy of the corporate EP plan which provided a framework which could be utilized in the event of an emergency. He stated it did not provide facility specific information, however it was what the facility EP plan was based on. He also stated due to being unable to locate the facility EP plan he was unable to provide information on what was in the EP plan including when it was reviewed, local emergency information, community information, facility contact information, and other information specific to the facility. He said it was important to have a facility EP plan and in the event of an emergency, and in the absence of the administrator, the facility EP plan should be in a location which is easily accessible and where staff can utilize it as a resource in the event of an emergency. He said he was going to talk to the Administrator and would ask where the EP plan was and would provide it for my review when he was able to locate it. A phone interview was conducted with the	E 001	environmental services director, MDS nurse, and wound nurse. Any incidents of non-compliance will result in continued reviews.	

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E 001	Continued From page 5 Administrator on 11/19/21 at 3:29 PM and she stated she would look for the EP plan when she returned to the facility and would notify me when she had found it.	E 001		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):]	E 015		12/24/21

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E 015	Continued From page 6 Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to have subsistence food available to meet the needs for residents and staff as identified in the emergency preparedness plan. This had the potential to affect all residents in the facility. The findings included: The facility's emergency preparedness plan revealed a document titled, "Disaster Preparedness- Food Service in a Disaster" last approved 01/2021 read in part: Supplies of staple foods and of perishable foods for a minimum of a three day period will be maintained on the premises at all times.	E 015	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. E015 Subsistence Needs for Staff and Patients 1. Corrective Action for Affected Residents. No resident affected alleged deficient	

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E 015	Continued From page 7 When calculating the emergency inventory, include residents, staff, additional emergency responders, family members and any of the general public. An initial tour of the kitchen was completed on 11/15/2021 at 9:55 AM. Observation of the emergency preparedness food storage area in the dry storage room revealed the following items on hand: 1 case of thickened water 4 large cans of green beans 4 large cans of cranberry sauce 6 large cans of chili beans 6 large cans of chili sauce No emergency tube feeding supplies were observed An interview was completed with the Dietary Manager (DM) on 11/15/2021 at 9:55 AM. She explained she was reassigned to this facility September 2021. The DM expressed the facility did not have enough emergency food on hand for the residents since her arrival to the facility September 2021. She was aware the facility should have a 3 day supply of emergency food on hand at all times. An interview was conducted with the Director of Nursing on 11/18/21 at 5:59 PM. She explained that the facility should always have an emergency food supply on hand. The facility's administrator was unavailable for interview.	E 015	practice. Emergency food supply was purchased on 11/29/2021 and stocked by Dietary Service Director on 12/1/2021 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 11/29/2021, the Dietary Director completed a food order to purchase emergency food supply. Emergency food supply was stocked on 12/1/2021. 3. Systemic changes On 12/14/2021 the Dietary Service Director completed In-serviced to all full time, part time, and as needed dietary staff. Topics included: " Emergency policies and regulations. " Inspections to observe all food are within their dates and only used for emergency purposes (or with approval from Dietary Service Director). " Process of completing emergency plans. This information has been integrated into the standard orientation training for all dietary staff and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring	

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E 015	Continued From page 8	E 015	procedure. On 12/27/2021 The Dietary Manager or assigned personnel will monitor emergency food supply by completing kitchen inspections and food orders weekly x 1 month, and then monthly x 2 months using the Dietary Quality Assurance Audit. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 11/15/21 through 11/19/21. Event ID# 8MUE11. Six of the twelve complaint allegations were substantiated resulting in deficiencies F550, F 561, F584, F677, and F692.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		12/24/21

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F 550	Continued From page 9 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide care in a manner to protect a resident's dignity who required assistance with incontinent care for 1 of 4 residents (Resident #477)	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state	

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F 550	Continued From page 10 reviewed for dignity and respect. Resident #477 reported waiting for incontinent care made her feel horrible. Findings included: Resident #477 was admitted on 10/07/2021. A review of the admission Minimum Data Set (MDS) dated 10/14/2021 revealed Resident # 477 was cognitively intact. A review of the care plan dated 10/29/2021 revealed Resident # 477 required assistance with activities of daily living (ADL) and was incontinent of bowel and bladder. Interventions included instructions to check on her frequently and provide incontinence care as needed. While touring the 400 hall and walking past Resident #477's room on 11/16/21 at 9:30 AM she was observed calling out for assistance and her call light was activated. NA #11 was observed passing breakfast trays to the residents on the 400- hall. A continuous observation and interview were completed from 9:31 AM until 9:43 AM of Resident #477. Resident #477 stated she needed to be cleaned up. She was observed sitting in bed with her breakfast meal on her bedside table. Resident #477 indicated she had been waiting for approximately 1 to 2 hours for staff to provide incontinence care. The room had noticeable and lingering odor of feces. At 9:43 AM NA #11 entered Resident #477's room and closed the room door. In a follow up interview on 11/18/2021 at 11:35	F 550	regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 Resident Rights/Exercise of Rights Corrective Action for Affected Residents For resident # 447, a corrective action was obtained on 11/16/2021 NA#11provided incontinent care to resident #447. CNA was re-educated immediately by the Director of Nursing, on the resident's right to dignity, respect and the right to make choices. On 11/16/2021, Nurse Manager monitored hall during lunch and dinner to ensure call light being answered during meals and incontinent care being provided as indicated. Corrective Action for Potentially Affected Residents All residents who need assistance with toileting have the potential to be affected by this alleged deficient practice. On 12/1/2021, 12/3/2021, and 12/6/2021 the Director of Nursing and Nurse Managers performed audits for incontinent episodes during meals. Any resident identified with toileting or incontinent needs were promptly toileted or care provided by the assigned CNA. Systemic Changes On 12/7/2021, the Director of Nursing began in-servicing all current full time, part time and PRN Nurses and CNA□s. This in-service included the following topics:	

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F 550	Continued From page 11 AM, Resident # 477 stated she had to sit in diarrhea until after breakfast on 11/16/2021. She stated "that made me feel horrible. Sitting in diarrhea is terrible." Resident #477 further revealed staff response for help was frequently slow and she started trying to hold her bowl and bladder at mealtimes because there was no one available to assist her. In an interview on 11/16/21 at 2:24 PM NA #11 revealed she was the only nursing assistant on the hall on that shift. She stated that she had provided incontinence care for Resident #477 at 7:00 AM that morning. NA #11 revealed she and Nurse #10 were aware Resident #477 needed incontinence care prior to the breakfast meal service but she delivered the meal trays to all the residents on 400- hall before she assisted her with incontinence care. NA# 11 verbalized that if a resident requested incontinence care during a mealtime, she passed all the trays and then provided incontinence care. In an interview on 11/18/2021 at 7:56 AM the Regional Director of Operations explained resident care should take priority. He stated it was a delicate situation when a resident had an incontinent episode during meal service, but the incontinent resident should have been taken care of. In an interview on 11/18/2021 at 3:15 PM the Director of Nursing verbalized residents should be provided incontinence care during meal service, so they have a dignified meal experience.	F 550	" Residents Rights " Toileting before, during, and after meal times The Director of Nursing will ensure that any Registered Nurse, Licensed nurse or nurse aide to include agency staff who has not received this training 12/18/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance On 12/27/2021 The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Residents Rights. The monitoring will include reviewing a sample of residents prior to and during meal time for toileting and incontinent care needs. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by to ensure their needs are met. Quality Of Life/Quality Assurance Committee. Reports will be given by the Director of Nursing to the monthly Quality of Life- QA committee and corrective	

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F 550	Continued From page 12	F 550	action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
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 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		12/24/21

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F 561	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide showers for 2 of 6 residents, Resident #122 and Resident #42 reviewed for being allowed choices regarding bathing. Findings included: 1. Resident # 122 was admitted to the facility on 8/25/2015 and her diagnoses included kidney disease, diabetes, and heart disease. A quarterly Minimum Data Set assessment dated 10/27/2021 indicated Resident #122 was cognitively intact and required extensive assistance with bathing. Resident #122's Care Plan dated 5/22/2021 stated she required extensive assistance with personal care. Resident #122's electronic documentation of showers given for 11/2021 indicated she should receive a shower on Tuesdays and Fridays on the 3:00 pm to 11:00 pm shift. The documentation further indicated Resident #122 did not have showers documented on 11/12/2021 or 11/16/2021. An interview was conducted with Resident #122 on 11/15/2021 at 11:31 am and she stated she did not get her showers every Tuesday and Friday as they were scheduled. Resident #122 stated they did not usually have enough staff to give her a shower or provide incontinence care. Resident #122 stated she would like to have a shower on her shower days.	F 561	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F561 Self Determination Corrective Action for Affected Residents For resident #42 shower given on 11/18/2021 by CNA and for resident #122 a bed bath was given on 11/17/2021. On 11/19/2021, residents #42 and #122 were interviewed by Social Worker to determine resident□s preference for shower. Resident□s preferences were updated in the resident□s plan of care by minimum Data Set (MDS)nurse. Corrective Action for Potentially Affected Residents All residents who need assistance with bathing have the potential to be affected by this alleged deficient practice. On 12/7/2021, Nursing and Social Workers will conducted resident interviews and will update shower preferences and establish updated resident care plan and resident profile to reflect preferences. Systemic Changes On 12/13/2021, the Director of Nursing began in-servicing all current full time, part time and PRN Nurses and CNA□s.	

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F 561	Continued From page 14 On 11/18/2021 at 5:57 pm Nurse Aide #3 was interviewed and stated she had worked the 3:00 pm to 11:00 pm shift on the 200 hall on 11/16/2021. She stated she did not give Resident #122 a shower. She stated she did not arrive until 5:00 pm and she did not have time to give her a shower because she immediately started passing dinner trays. Nurse Aide #3 stated she was not sure how she was supposed to know which residents she should give a shower to and did not know if there was a shower list. An interview was conducted with the Director of Nursing on 11/18/2021 at 3:51 pm and she stated the Nursing Department was staffing challenged. The Director of Nursing stated she felt the staff were taking short cuts to get things done and Resident #122 should receive a shower on her scheduled shower days and whenever she requested a shower. 2. Resident #42 was admitted to the facility on 2/20/2019. Her diagnoses included kidney disease and heart disease. A quarterly Minimum Data Set Assessment dated 8/13/2021 indicated Resident #42 was cognitively intact and required total assistance with bathing. Resident #42's Care Plan dated 9/15/2021 indicated she required total assistance with bathing. Resident #42's electronic documentation of showers given for 11/2021 indicated she should receive a shower on Mondays and Thursdays on the 7:00 am to 3:00 pm shift. The documentation further indicated Resident #42 did not have showers documented as given on 11/4/2021,	F 561	This in-service included the following topics: ADL care to include how to locate shower schedule and resident rights related shower preferences and Care Need Requirements. The Director of Nursing will ensure that any Nurse or CNA who has not received this training by 12/18/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by date of compliance. Quality Assurance 12/27/2021 The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Residents Shower Preferences. The monitoring will include reviewing a sample of residents to ensure shower preferences are being followed. This will be completed weekly for 4 weeks then monthly x 2 months or until resolved to ensure their needs are met. Quality Of Life/Quality Assurance Committee Reports will be given to the Monthly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 561	Continued From page 15 11/8/2021 and 11/15/2021. On 11/15/2021 at 10:30 am an interview was conducted with Resident #42, and she stated she did not get her shower because the staff were so short staffed. Resident #42 stated she would like to get her showers on her scheduled shower days. During an interview with Nurse Aide #5 on 11/19/2021 at 1:16 pm she stated she had Resident #42 on her assignment frequently. Nurse Aide #5 stated she could remember one time she had not been able to give Resident #42 her shower because they did not have enough staff. Nurse Aide #5 stated Resident #42 had agreed to not having a shower on that occasion. Nurse Aide #5 stated she had every other Monday and Thursday off, and Resident #42 told her she did not get her shower when she was not working. An interview was conducted with the Director of Nursing on 11/18/2021 at 3:51 pm and she stated the Nursing Department was staffing challenged. The Director of Nursing stated she felt the staff were taking short cuts to get things done and that she did need more staff. The Director of Nursing stated Resident #42 should have received a shower on her scheduled shower days and whenever she requested a shower. Several attempts were made to reach the Nurse Aides that cared for Resident #42 on the dates she did not receive a shower without success.	F 561	The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		12/24/21

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§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 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

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F 584	Continued From page 17 sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to maintain clean walls on 4 of 4 hallways (Hallways 100, 200, 300, and 400), clean privacy curtains in 2 of 18 rooms (Rooms 209 and 214), clean resident bathroom in 1 of 3 resident rooms (Room 507), functioning paper towel dispensers in 2 of 3 resident bathrooms (Rooms 507 and 514), and dusting of the over the bed lights in 3 of 3 resident rooms (504, 507, and 514) reviewed for environment. The facility failed to maintain a clean environment for 5 of 6 hallways (100, 200, 300, 400 and 500 hallways). Findings included: 1. An observation of 200-hallway on 11/18/2021 at 10:25 am revealed there was a 4-inch dark brown stain to the door frame of room 212; there were ten 1 to 3-inch splatters of a dark brown substance on the wall between rooms 211 and 213; and thirteen 3-inch splatters of a dark brown substance on the wall between rooms 215 and 217. During an observation of 100-hallway on 11/18/2021 at 10:55 am six 3-inch areas of dark brown substance were noted splattered o the wall at room 101; one 2-inch area of dark brown substance was found on the lower wall at room 103 door; and four 2-inch areas of brown substance was observed on the wall between rooms 105 and 107. The wall and baseboards on 400 hall, outside room 404, were observed on 11/18/2021 at 11:07	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F584 Safe/Clean/Comfortable/Homelike Environment Corrective action for affected residents. For resident # 100 hall, 200 hall, 300 hall, 400 hall, and 500 hall. Corrective action for resident(s) affected by the alleged deficient practice: On 11/18/21, the rooms on 100 hall, 200 hall, 300 hall, 400 hall, and 500 hall was cleaned by the housekeeping and maintenance staff to include sweeping and mopping of floor, replacing privacy curtains, dusting overbed lighting and windowsills. The maintenance staff replaced batteries in paper towel dispensers. On 11/19/2021, housekeeping staff (Floor Tech) began cleaning hallway walls and floors. Corrective Action for Potentially Affected Residents. On 12/3/2021, the Environmental Service Director completed 100% audit of all rooms/hallways in the facility was completed to ensure that all rooms and halls were cleaned according to policy.	

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F 584	Continued From page 18 am to have 12 areas of dark brown substance splattered on the wall. During an observation of the 300-hallway on 11/18/2021 at 11:10 am a 7-inch area of dark brown substance was noted on the wall at the entrance to the hallway and two 4-inch areas of a dark brown substance was noted between rooms 307 and 309. On 11/18/2021 at 11:04 am the Floor Technician was interviewed and stated he cleaned the hallways 3 weeks ago. He stated it was the Floor Technician's responsibility to clean the walls in the hallways. The Floor Technician stated he had not been able to clean the walls in the hallways due to a shortage of staff in the housekeeping department, he had been pulled from his job to work as a Housekeeper cleaning resident rooms. On 11/18/2021 at 11:11 am the Regional Director of Clinical Operations was toured the facility's 100, 200, 300 and 400 hallways. The areas of dark brown substance on the walls of each hall were observed during the tour. The Regional Director of Clinical Operations stated he was not sure how the housekeeping staff traced when the hallways were cleaned. He stated the Housekeeping Manager left the facility's employment 2 weeks ago and the facility was actively looking for someone to replace them. The Regional Director of Clinical Operations stated he had not been aware the hallways were not being cleaned. 2. During an observation of room 209 on 11/18/2021 at 10:19 am the privacy curtain for bed 209A had three 12-inch dark brown stains and the privacy curtain for bed 209B had two	F 584	Any rooms/halls identified as needing cleaning were cleaned on 12/3/2021 added to deep cleaning schedule. On 11/18/2021, the Maintenance Director completed 100% audits of all rooms in the facility was to ensure that all privacy curtain were clean and without tears, frays stains, or odor. Results: 7 privacy curtains needed replaced and remaining needed laundered. Any privacy curtain needing replaced or laundered was immediately replaced or laundered on 11/18/2021. On 11/18/2021, the Maintenance Director completed 100% audit of all rooms in the facility to ensure that all paper towel dispensers were in good repair. Results: 4 rooms needed replacement/repair this was completed on 11/18/2021. Any rooms that identified paper towel dispensers in need of repair received the necessary repairs and /or replacements on 11/18/2021. Systemic Changes All housekeepers and maintenance staff will be re-educated by the Environmental Services Director beginning on 12/15/2021on cleaning rooms according to policy on regular intervals to include dust mop and damp mop resident room floors, empty trash receptacles, replenish toilet tissue, paper towels, soap, hand sanitizer, and odor control. Clean furnishings used by residents and visitors. Clean spot on walls. Complete cleaning of bathrooms. Complete cleaning of overbed lights, high areas, window blinds and window sills on regular intervals. Removing and cleaning privacy curtains on regular intervals or as needed. Sanitize	

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F 584	Continued From page 19 5-inch dark brown stains and seven 3-inch dark brown stains. On 11/18/2021 at 10:22 am and observation of room 214 revealed there were five 2-inch dark brown stains to the privacy curtain. During an interview on 11/18/2021 at 11:11 am with the Regional Director of Clinical Services he indicated the facility's Housekeeping Manger had left the facility's employment 2 weeks ago. He stated the facility was actively looking for a replacement. The Regional Director of Clinical Services stated the facility had started replacing the privacy curtains in the facility today. He stated he had not been aware of the condition of the privacy curtains. 3. During an observation of Room 507 on 11/18/2021 at 10:37 am three 2-inch areas of brown substance was found on the floor in front of the commode; one 1-inch area of brown substance was found on the wall beside the commode; and the commode had multiple areas of brown substance around the edge of the bowl. An interview was conducted with Nurse #4 on 11/18/2021 at 10:40 am and she stated the areas on the wall, floor, and the edge of the commode bowl looked like stool. The Nurse stated she would ask a housekeeper to clean the bathroom. On 11/18/2021 at 10:45 am an interview was conducted with Housekeeper #1. She stated she worked parttime and had not worked in the facility for over a week. She stated she cleans the rooms and bathrooms on her assignment two times during her shift and cleans up any spills between cleanings. Housekeeper #1 she had not	F 584	beds on deep cleaning schedules. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all laundry and housekeeping staff and was completed on 12/17/2021. Any staff who does not receive scheduled in-service training as of 12/18/2021 will not be allowed to work until training has been completed. Quality Assurance On 12/27/2021 The Administrator or designee will monitor compliance utilizing the Quality Assurance Tool Clean/ Safe Homelike Environment weekly x 4 weeks then monthly x 3 months. The tool will monitor a sample of rooms and bathrooms for cleanliness and high dusting, malfunctioning paper towel dispensers, and dirty, torn, or frayed privacy curtains and walls and baseboards in hallways. Reports will be presented to the weekly Quality Assurance (QA) committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the housekeeping and personal laundry issues. The weekly QA Meeting is attended by the Administrator, Director of	

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gotten to room 507 during her shift that began at 7:00 am. She stated the brown substance on the wall, floor, and commode bowl in the bathroom of room 507 looked like stool to her.

During an interview with the Regional Director of Clinical Services on 11/18/2021 at 11:11 am he stated the facility was actively looking for a replacement for the Housekeeping Manager that left the facility's employment 2 weeks ago. He stated staffing for housekeeping had been challenging but the facility would continue to actively seek new staff and had offered sign on bonuses.

4a. Observations of the bathroom in room 507 conducted on 11/15/21 at 3:46 PM, 11/16/21 at 1:47 PM, and 11/17/21 at 3:33 PM revealed the automatic paper towel dispenser did not dispense paper towels after multiple attempts were made to activate the motion sensor. Further observation revealed paper towels to be visible through the transparent cover of the paper towel dispenser.

An interview and observation were conducted on 11/18/21 at 11:10 AM with Housekeeper #1. She stated she wasn ' t aware the paper towel dispenser wasn't working. The paper towel dispenser was observed to not dispense paper towels despite repeated attempts. She said she did not know how long the paper towel dispenser had not been working. She explained she believed the paper towel dispenser needed to have the batteries replaced but she did not have batteries to put into the paper towel dispenser. She said the maintenance department had the batteries for the paper towel dispensers. She further stated she had not contacted maintenance but would need to contact maintenance and

Nursing, Minimum Data Set Coordinator, Rehab Manager, Health Information Manager, Environmental Services Manager, and the Dietary Manager

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inform the maintenance person batteries needed to be replaced in the towel dispenser in room 507. She additionally explained she thought the floor technician checked all of the paper towels.

4b. Observations of the bathroom in room 514 conducted on 11/15/21 at 12:22 PM and 11/17/21 at 3:38 PM revealed the automatic paper towel dispenser did not dispense paper towels after multiple attempts were made to activate the motion sensor. Further observation revealed paper towels to be visible through the transparent cover of the paper towel dispenser.

During an observation of Nurse #4 conducted on 11/17/21 at 11:54 AM she went into the bathroom of room 514 and could be heard washing her hands. She was then observed to exit room 514, with wet hands, and went into the adjacent room and came out of the bathroom in the adjacent room with dry hands.

During an interview conducted on 11/18/21 at 11:22 AM with the Admissions Director, she stated she was helping to supervise the Housekeeping department due to a vacancy of the Housekeeping Director position. She explained housekeeping should let the maintenance department know if batteries were needed to be replaced in the towel dispensers, and then the maintenance person would replace the batteries in the paper towel dispenser.

During an interview conducted on 11/18/21 with the Regional Director of Operation (RDO) he stated he expected for the paper towel dispensers to work so that staff could wash and dry their hands properly.

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Attempts to interview the Maintenance Director were unsuccessful.

5a. Observations of the over the bed lights in room 504 conducted on 11/15/21 at 3:04 PM and 11/16/21 at 2:19 PM revealed the top of the over the bed lights to have a gray dust build up which was visible on one's fingers when they were brushed along the top of the light. The dust which came off onto one's fingers was heavy enough that the dust would fall to the floor off the fingers.

5b. Observations of the over the bed lights in room 507 conducted on 11/15/21 at 3:46 PM, 11/16/21 at 1:47 PM, and 11/17/21 at 3:33 PM revealed the top of the over the bed lights to have a gray dust build up which was visible on one's fingers when they were brushed along the top of the light. The dust which came off onto one's fingers was heavy enough that the dust would fall to the floor off the fingers.

An interview and observation were conducted on 11/18/21 at 11:10 AM with Housekeeper #1. She was observed cleaning room 507 and was sweeping the floor. She said she still had to wipe the room down. She said she did dust the top side of the lights when she did her high dusting, but she did not dust the top side of the lights while a resident was in the bed. An observation of the over the bed lights revealed the top of the lights to have a gray dust build up which was visible on one's fingers when they were brushed along the top of the over the bed light. The dust which came off onto one's fingers was heavy enough that the dust would fall to the floor off the fingers. Upon seeing the dust, the housekeeper said she did believe the over the bed lights needed to be

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F 584	Continued From page 23 dusted. 5c. Observations of the over the bed lights in room 514 conducted on 11/15/21 at 12:22 PM and 11/17/21 at 3:38 PM revealed the top of the over the bed lights to have a gray dust build up which was visible on one's fingers when they were brushed along the top of the light. The dust which came off onto one's fingers was heavy enough that the dust would fall to the floor off the fingers. During an interview conducted on 11/18/21 at 11:22 AM with the Admissions Director, she stated she was helping to supervise the Housekeeping department due to a vacancy of the Housekeeping Director position. She explained as part of routine housekeeping, she would expect for "high dusting" to be completed including dusting the top of the over the bed lights. She further stated each room received a routine monthly deep cleaning and during that deep cleaning extra attention is provided for detailed cleaning of the room for a more thorough clean. During an interview conducted on 11/18/21 with the RDO he stated he expected for "high dusting," including dusting the over the bed lights, to be completed as part of routine housekeeping when the resident rooms were cleaned.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 636		12/24/21

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functional capacity.

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

§483.20(b)(2) When required. Subject to the

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F 636	Continued From page 25 timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an admission Minimum Data Set (MDS) for 3 of 5 residents (Resident #475, #477, #383) reviewed for resident assessments. Findings included: 1. Resident #475 was admitted on 10/25/2021 with diagnoses that included history of left knee replacement and hypertension. Review of Resident #475's admission MDS with an assessment reference date (ARD) of 11/1/2021 revealed the MDS was not completed. An interview with the MDS Nurse #1 on 11/16/2021 at 2:50 PM revealed the admission MDS assessments were not completed and were past the completion due date. She stated she was responsible for the long term care residents and MDS Nurse #2 completed the MDS	F 636	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 636 COMPREHENSIVE ASSESSMENT & TIMING Corrective Action: Resident #475. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 11/01/2021. Completed, Submitted and Accepted on 11/19/2021 to the State Quality Improvement Evaluation System QIES system.	

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F 636	Continued From page 26 assessments for the residents admitted for short term rehabilitation. MDS Nurse #1 explained the MDS department did not have staff in place to get the MDS assessments completed timely. An interview was completed with the MDS Nurse #2 on 11/17/2021 at 12:30 PM. MDS Nurse #2 explained she was part time. MDS Nurse #2 voiced the MDS assessments were behind due to not having staff in place to get the MDS assessments completed timely. She stated resident #475's admission MDS should have been completed on 11/7/2021 and it remained incomplete. An interview was conducted with the Regional Director of Operations on 11/18/21 at 7:56 AM. He stated the MDS assessments were behind. He communicated the MDS assessments should be completed timely. 2. Resident #477 was admitted 10/7/2021 with diagnoses that included femur fracture, diabetes, and anxiety. Review of Resident #477's admission MDS with an assessment reference date (ARD) of 10/14/2021 revealed the MDS was not completed. An interview with the MDS Nurse #1 on 11/16/2021 at 2:50 PM revealed the admission MDS assessments were not completed and were past the completion due date. She stated she was responsible for the long term care residents and MDS Nurse #2 completed the MDS assessments for the residents admitted for short term rehabilitation. MDS Nurse #1 explained the MDS department did not have staff in place to get	F 636	Resident #477. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 10/14/2021. Completed, Submitted and Accepted on 11/17/2021 to the State Quality Improvement Evaluation System QIES system. Resident #383. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 11/08/2021. Completed, Submitted and Accepted on 12/07/2021 to the State Quality Improvement Evaluation System QIES system. Identification of other residents who may be involved with this practice: All current residents with Comprehensive Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 12/08/2021 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity. Out of the 131 current residents, 6 number of residents did not have their comprehensive assessments completed within 14 calendar days after admission, excluding readmission in which there is no significant change in the resident□s physical or mental condition. This assessments were completed, submitted, and accepted by 12/13/2021. Systemic Changes: On 12/10/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse	

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F 636	Continued From page 27 the MDS assessments completed timely. An interview was completed with the MDS Nurse #2 on 11/17/2021 at 12:30 PM. MDS Nurse #2 explained she was part time. MDS Nurse #2 voiced the MDS assessments were behind due to not having staff in place to get the MDS assessments completed timely. She stated the admission MDS for Resident #477 should have been completed on 10/21/2021 and it was completed on the evening of 11/16/2021. An interview was conducted with the Regional Director of Operations on 11/18/21 at 7:56 AM. He stated the MDS assessments were behind. He communicated the MDS assessments should be completed timely. 3. Resident #383 was admitted 11/1//2021 with diagnoses that included a recent history of COVID-19, diabetes, pressure ulcers, hypertension and atrial fibrillation. Review of Resident #383's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/14/2021 revealed the MDS was not completed. MDS Nurse #1 was interviewed on 11/18/21 at 11:52 AM regarding the Admission MDS assessment for Resident #383. She noted they were behind on completing the assessments due to staffing. MDS Nurse #2 was interviewed on 11/18/21 at 12:03 PM regarding Resident #383's Admission MDS not being completed by the required date. She stated they were behind on the MDS assessments and had been since September	F 636	(LPN) Minimum Data Set (MDS) Support nurses. Dietary Manager, Therapist, Social Workers that participates in the MDS assessment process was in serviced /educated by the MDS nurse consultant. The education focused on: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity. OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident□s status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, and Significant Change in Status Assessment (SCSA)and Significant Correction to Prior Comprehensive Assessment (SCPA). The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: this is the resident□s first time in this facility, OR the resident has been admitted to this facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. The Annual assessment is a	

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F 636	Continued From page 28 2021. She noted the facility had a high volume of admissions and discharges and they could not keep up. An interview was conducted with the Regional Director of Operations on 11/18/21 at 7:56 AM. He stated the MDS assessments were behind. He communicated the MDS assessments should be completed timely.	F 636	comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments□ ARDs and completion dates. Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:(i) Identification and demographic information(ii) Customary routine.(iii) Cognitive patterns.(iv) Communication.(v) Vision.(vi) Mood and behavior patterns. (vii) Psychological well-being.(viii) Physical functioning and structural problems.(ix) Continence.(x) Disease diagnosis and health conditions.(xi) Dental and nutritional status.(xii) Skin Conditions. (xiii) Activity pursuit.(xiv) Medications. Special treatments and procedures.(xvi) Discharge planning.(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on	

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F 636	Continued From page 29	F 636	all shifts. This in service was completed by 12/10/2021. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: On 12/27/2021 -To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will review weekly, 5 residents electronic records Minimum Data Set(MDS) assessment this could be either one of the following Comprehensive assessments (Admission Assessment, Annual Assessment, and Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment) to ensure that the comprehensive assessments are completed timely.This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by	

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F 636	Continued From page 30	F 636	Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment.	F 640		12/24/21

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F 640	Continued From page 31 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, the facility failed to complete quarterly Minimum Data Assessments (MDS) within 14 days of the Assessment Reference Dates (ARD) for 3 of 5 residents reviewed for quarterly MDS completion (Resident #2, Resident #13 and Resident #17). Findings included: 1. Resident #2 was readmitted to the facility on 07/05/2021. A review of the MDS assessments for Resident #2 revealed that a quarterly MDS with an ARD of 10/12/2021 was not marked as completed until 11/18/2021. An interview conducted with the MDS Nurse Coordinator on 11/18/2021 at 3:39 PM revealed that the MDS was completed late because she was the only full time MDS nurse and she was not able to complete the MDS assessments timely	F 640	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 640 ENCODING/TRANSMITTING RESIDENT ASSESSMENTS Corrective Action: Resident #2. Quarterly Minimum Data Set Assessment, Assessment Reference Date (ARD) 10/12/2021. Completed, Submitted and Accepted on 11/19/2021 to the State Quality Improvement Evaluation System QIES system.	

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F 640	Continued From page 32 due to the rapid rate of resident admissions and discharges. On 11/18/2021 at 4:09 PM an interview conducted with the Director of Nurses (DON) revealed that the expectation was that all MDS assessments be completed timely and as require by the RAI (Resident Assessment Manual). 2. Resident #13 was admitted to the facility on 04/08/2020. A review of the MDS assessments for Resident #13 with an ARD of 10/14/2021 was not marked as completed and sections B,C,D,E and Q remained marked as in progress. An interview conducted with the MDS Nurse Coordinator on 11/18/2021 at 3:39 PM revealed that the MDS was completed late because she was the only full time MDS nurse and she was not able to complete the MDS assessments timely due to the rapid rate of resident admissions and discharges. On 11/18/2021 at 4:09 PM an interview conducted with the Director of Nurses (DON) revealed that the expectation was that all MDS assessments be completed timely and as require by the RAI (Resident Assessment Manual). 3. Resident # 17 was admitted to the facility on 11/19/2020. A review of the MDS assessments for Resident #17 revealed that a quarterly MDS with an ARD of 10/14/2021 was not marked as completed until 11/17/2021. An interview conducted with the MDS Nurse Coordinator on 11/18/2021 at 3:39 PM revealed that the MDS was completed late because she was the only full time MDS nurse and she was not	F 640	Resident #13. Quarterly Minimum Data Set Assessment, Assessment Reference Date (ARD) 10/14/2021. Completed, Submitted and Accepted on 11/22/2021 to the State Quality Improvement Evaluation System QIES system. Resident #17. Quarterly Minimum Data Set Assessment, Assessment Reference Date (ARD) 10/14/2021. Completed, Submitted and Accepted on 11/17/2021 to the State Quality Improvement Evaluation System QIES system. Identification of other residents who may be involved with this practice: All current residents with Quarterly Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 12/08/2021 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity. Out of the 131 current residents, 2 number of residents did not have their quarterly assessments completed within 14 calendar days of the assessment reference date. This assessments were completed by 12/13/2021. Systemic Changes: On 12/9/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Support, Dietary Service Manager, Therapist, Activities Director, and Social Worker that participates in the MDS assessment process was in serviced /educated by the MDS nurse	

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ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

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F 640	Continued From page 33 able to complete the MDS assessments timely due to the rapid rate of resident admissions and discharges. On 11/18/2021 at 4:09 PM an interview conducted with the Director of Nurses (DON) revealed that the expectation was that all MDS assessments be completed timely and as require by the RAI (Resident Assessment Manual).	F 640	consultant. The education focused on: The facility must encode/transmit resident assessments; Automated data processing requirement- Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility :(i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments.(v) A subset of items upon a resident's transfer, reentry, discharge, and death.(vi) Background (face-sheet) information, if there is no admission assessment. Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. Transmittal requirements. Within 14days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:(i)Admission assessment.(ii) Annual assessment.(iii) Significant change in status assessment.(iv) Significant correction of prior full assessment.(v) Significant correction of prior quarterly assessment.(vi) Quarterly review.(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.(viii) Background (face-sheet)	

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F 640	Continued From page 34	F 640	information, for an initial transmission of MDS data on resident that does not have an admission assessment. Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This in service will be completed by 12/24/2021. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will review weekly, 5 residents electronic records Minimum Data Set (MDS) Quarterly assessments to ensure that the quarterly assessments are completed timely.This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly	

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F 640	Continued From page 35	F 640	QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		12/24/21

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F 655	Continued From page 36 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission with the immediate needs, timelines and measurable objectives to address pressure ulcers, chest tube care and Transmission Based Precautions for 1 of 1 resident reviewed (Resident #383) for care post COVID-19 infection. The facility also failed to develop the baseline care plan within 48 hours of admission to address the immediate needs for dysphagia care and nutrition for 1 of 1 resident reviewed for weight loss (Resident #56). The findings included: 1. Resident #383 was admitted to the facility on 11/01/21 with diagnoses that included acute respiratory failure, diabetes, bronchopleural fistula, hypertension and pressure ulcers. The Admission Minimum Data Set (MDS) assessment for Resident #383 was in progress and was not completed at the time of the investigation.	F 655	F 655 Baseline Care Plan A corrective action was taken in order to ensure that the baseline care plan for resident #56 was complete and accurately reflected the resident□s current level of functioning, special needs and interventions to ensure that staff members would be correctly guided in providing appropriate and safe care for resident. A copy of the baseline care plan was provided to the resident on 12/13/2021 This was completed on 12/13/2021 by the Minimum Data Set Nurse. A corrective action was taken in order to ensure that the baseline care plan for resident #383 was complete and accurately reflected the resident□s current level of functioning, special needs and interventions to ensure that staff members would be correctly guided in providing appropriate and safe care for resident. A copy of the baseline care plan was provided to the resident on	

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F 655	Continued From page 37	F 655		

Review of the Physician admission note dated 11/02/21 indicated the Resident #383 was alert and oriented.

Record review of the History and Physical dated 11/02/21 indicated Resident #383 had a catheter in the left upper chest for a bronchopleural fistula and a sacral wound.

The Wound Nurse was interviewed on 11/17/21 at 10:00 AM and stated Resident #383 was admitted with wounds that covered both buttocks.

An interview was conducted with Resident #383 on 11/15/21 at 4:15 PM regarding the baseline care plan. He acknowledged there was a meeting shortly after admission with the Social Worker, but he had not signed or received a care plan or medication list.

An interview was conducted with MDS nurse #1 on 11/18/21 at 11:52 AM regarding the baseline care plan for Resident #383. She stated that the MDS nurses were not involved in the baseline care plans for residents and did not participate in the 72 hour meeting. The 72 hour meeting was done routinely following admission with the resident and family/Responsible Party to review the plan of care

An interview was conducted with MDS nurse #2 on 11/18/21 at 12:02 PM regarding baseline care plans. She stated they tried to initiate a care plan within 48 hours and may not get everything done because of the volume of admissions and discharges at the facility. She noted she did not participate in the 72 hour meetings.

An interview was conducted on 11/18/21 at 2:35

12/13/2021. This was completed on 12/13/2021 by the Minimum Data Set Nurse.

Corrective action for residents with the potential to be affected by the alleged deficient practice.
All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents who were admitted to the facility during the past 30 days was completed in order to ensure that each resident has an appropriate and up to date base line care plan in place.This audit was completed on 12/13/2021 by the Director of Nursing.
A copy of the baseline care plan was provided to 40 other residents by the Director of Nursing and assistant Director of Nursing on 12/15/2021.

Systemic Changes
On 12/15/2021 the Director of Nursing provided in-service education to the facility Minimum Data Set Nurse on the requirements for Baseline Care Plan completion and was completed on 12/17/2021. This education included the importance of ensuring that all residents have a Baseline Care Plan implemented within the first 48 hours after admission to the facility. The Baseline Care Plan must include the minimum healthcare information necessary to properly care for a resident including, but not limited to following:
" Initial goals based on admission orders
" Physician orders

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F 655	Continued From page 38 PM with the Social Worker (SW). She said it was brought to her attention yesterday by other surveyors that the care plan and medication list should be given out to the resident or responsible party, and that was not part of the 72 hour meeting in the past. The SW noted these meetings usually consisted of the SW, Rehabilitation Director and typically they have a nurse in the meeting. She was asked about Resident #383 and said she recalled meeting with the resident and his family member. She noted they discussed resources for discharge. No care plan or medication list was shared in the 72 hour meetings per SW. However, if they requested a care plan or medication list, they directed them to nursing if they were not there. An interview was conducted with the Quality Assurance (QA) Nurse Consultant on 11/18/21 at 3:26 PM. She stated someone from the MDS department or the nursing team printed the baseline care plan out and the family or the Responsible Party(RP) would sign it and receive a copy. She was informed that the MDS nurses and Social Worker had stated the baseline care plan was not done or provided to the resident and/or RP. The QA nurse stated her expectation was that the baseline care plan was completed and shared with the family/RP. She further noted the pressure ulcer and chest tube for Resident #383 should have been included on the care plan. An interview with the Director of Nursing (DON) was done on 11/18/21 at 5:11 PM regarding baseline care plans. She stated she was aware that baseline care plans were not being done correctly, and they would have a new process of paper care plans soon. The DON added the residents and the RP had not been signing care	F 655	" Dietary orders " Therapy services " Social services needs " PASARR recommendation, if applicable The educational material included the fact that the care plan is a tool used to communicate resident□s condition, needs, preferences, strengths, special needs to the interdisciplinary team and primarily frontline staff, and that in order to provide the highest quality of care possible and to ensure residents□ needs are met, the care plans must be person-centered and an accurate and current reflection of resident□s condition and needs. This information has been integrated into the standard orientation training for new Minimum Data Set Nurses. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On 12/27/2021 The Director of Nursing or designee will conduct audits to ensure that all newly admitted residents have a Baseline Care Plan initiated within 48 hours of admission to facility. The Quality Assurance tool entitled Baseline Care Plans QA Tool will be completed weekly for 4 weeks then monthly for 2 months or until sustained compliance has been achieved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and	

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F 655	Continued From page 39 plans, and the baseline care plan was the beginning of the comprehensive care plan and they were working to improve the process. 2. Resident #56 was admitted to the facility on 09/01/21 with diagnoses that included dysphagia, stroke, heart failure and diabetes. The Minimum Data Set (MDS) assessment completed on admission 9/8/21 indicated Resident #56 was cognitively impaired. He had weakness on his right side and was dependent on staff for assistance. For Activities of Daily Living (ADL) he required extensive assistance of 1 person with transfers, bed mobility, dressing, toileting and bathing. He was impaired on the right side and was unsteady on his feet. He was also assessed as needing limited assistance and 1 person to assist with meals and noted he would cough or choke with swallowing. An interview with The Support Nurse for the 600 unit was conducted on 11/18/21 at 11:44 AM and stated she assisted Resident #56 with lunch yesterday. She noted he needed to be fed as he could not feed himself. An interview was conducted with MDS nurse #1 on 11/18/21 at 11:52 AM regarding the baseline care plan for Resident #56. She stated that MDS was not involved in the baseline care plan for residents and did not participate in the 72 hour meeting. MDS nurse #2 was interviewed on 11/18/21 at 12:02 PM regarding baseline care plans. She stated she was part time and tried to initiate a care plan within 48 hours and may not get everything done because of the volume of	F 655	ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	

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F 655	Continued From page 40	F 655		

admissions and discharges.

An interview was conducted on 11/18/21 at 2:35 PM with the Social Worker (SW). She said it was brought to our attention yesterday by other surveyors that the care plan and medication list should be given out to the resident or responsible party, and that was not part of the 72 hour meeting in the past. The SW noted these meetings usually consisted of the SW, Rehabilitation Director and typically they have a nurse in the meeting. She was asked about Resident #56 and said she recalled meeting with the resident and his family member with the Therapy Director. She noted they discussed rehabilitation and resources for discharge. No care plan or medication list was shared in the 72 hour meetings she said, however if they requested a care plan or medication list they directed them to nursing.

An interview was done with the Quality Assurance Nurse Consultant on 11/18/21 at 3:26 PM. She stated someone from the MDS department or the nursing team printed the baseline care plan out and the family or the Responsible Party would sign it and be given a copy. She was informed that the MDS nurses and Social Worker had stated the baseline care plan was not done and provided to the resident and/or RP. The QA nurse stated her expectation was that the baseline care plan was completed and shared with the family/RP.

An interview with the Director of Nursing (DON) on 11/18/21 at 5:11 PM regarding baseline care plans. She stated she was aware that baseline care plans were not being done correctly, and they would have a new process of paper care

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F 655	Continued From page 41 plans soon. The DON added the residents and the RP had not been signing care plans, and the baseline care plan was the beginning of the comprehensive care plan and they were working to improve the process.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		12/24/21

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F 656	Continued From page 42 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan for right hand splint management for 1 of 1 resident (Resident #56) reviewed for positioning. The findings included: Resident #56 was admitted to the facility on 09/01/21 with diagnoses that included stroke and hemiplegia (paralysis on one side of his body) following a cerebral infarction. The Minimum Data Set (MDS) assessment completed on admission 9/8/21 indicated Resident #56 was cognitively impaired. He had weakness on one side and was dependent on staff for assistance. A Physician Order for Resident #56 dated 10/03/21 was written for the Certified Nurse Assistant to put the patient's right resting hand splint on during day hours as tolerated. Resident #56's care plan which was last reviewed on 11/11/21 and did not address Resident #56's use of the hand splint for contracture management.	F 656	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F656 Develop/Implement Comprehensive Care Plan Corrective Action: Resident #56: Care plan reviewed and updated on 12/3/2021 by Minimum Data Set Nurse. Identification of other residents who may be involved with this practice: All current residents with splints have the potential to be affected by the alleged practice. On 12/13/2021 through 12/15/2021 an audit was completed by the Director of Nursing and MDS Coordinators, to ensure that a care plan was implemented for current residents	

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F 656	Continued From page 43 Support Nurse #1/Unit Manager for Resident #56's unit was interviewed on 11/18/21 at 11:44 AM and said he was moved to her unit last week and she had not had time to go through his orders. She noted the Unit Manager and the MDS nurse should have updated the care plan to include the splint. She said she was not aware of the splint and it should be on the care plan if ordered. An interview was done with MDS nurse #1 on 11/18/21 at 11:52 AM regarding the splint not being on the care plan for Resident #56. She stated if there was an order for a splint it should have been entered on the care plan. She noted it was her responsibility to check for new orders and she believed she missed that new order. An interview was done on 11/18/21 at 5:11 PM with the Director of Nursing (DON) regarding Resident #56's order to wear the arm splint and for the NAs to apply it during the day. She stated the splint should have been placed on the care plan and acknowledged it was not.	F 656	with splints. 17 of current resident have splints ordered. All current residents with splints have updated care plans. This was completed on 12/15/2021 Minimum Data Set (MDS) Coordinator. Systemic Changes: On 12/10/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators, Dietary Service Manager, Therapist, Activities Director, and Social Worker that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident□s highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident□s exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident□s representative□s on the residents goals for admission and desired outcomes, the resident□s	

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F 656	Continued From page 44	F 656	preference and potential for future discharge, and discharge plans. A comprehensive person centered care plan must be implemented for all residents requiring catheter care and must be developed for all resident□s receiving activities of daily living that identifies the type of care needed for activities of daily living. This in service will be completed by 12/24/2021. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: On 12/27/2021 The Director of Nursing and/or Assistant Director of Nursing will observe 5 resident□s requiring splints to ensure that care plan is implemented. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life	

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F 656	Continued From page 45	F 656	Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse.	
F 677 SS=E	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 observations, resident and staff interviews, and record review, the facility failed to provide incontinent care during meal service for 1 of 6 residents (Resident #477) and failed to provide routine incontinence care for 2 of 6 residents (Resident #122, and Resident #42) reviewed for activities of daily living (ADL). Findings included: 1. Resident #477 was admitted on 10/07/2021. Resident #477 had diagnoses that included femur fracture, diabetes, and anxiety. A review of the admission Minimum Data Set (MDS) dated 10/14/2021 revealed Resident #477 was cognitively intact. Urinary and bowel continence status were not completed on the MDS. A review of the ADL care plan dated 10/29/2021 revealed Resident #477 required assistance with ADL care and was incontinent of bowel and bladder. Interventions included instructions to	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F-677 ADL Care Provided for Dependent Residents Corrective Action for Affected Residents For resident# 447 incontient care provided by nurse aide on 11/16/2021 For resident #42 incontinent care provide by nurse aide on 11/15/2021 For resident #122 incontinent care	12/24/21

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F 677	Continued From page 46 check on her frequently and provide incontinence care as needed. While touring the 400 hall and walking past Resident #477's room on 11/16/21 at 9:30 AM she was observed calling out for assistance and her call light was activated. NA #11 was observed passing breakfast trays to the residents on the 400- hall. A continuous observation and interview were completed from 9:31 AM until 9:43 AM of Resident #477. The room had noticeable and lingering odor of feces. Resident #477 stated she needed to be cleaned up. She was observed sitting in bed with her breakfast meal to the side on her bedside table. She voiced that she ate her breakfast meal while soiled and had not been assisted with incontinence care. Resident #477 indicated she had been waiting for approximately 1 to 2 hours for incontinence care. At 9:35 AM Nurse #10 was observed pushing the linen cart to Resident #477's room door. She entered Resident #477's room but did not provide incontinence care. Nurse #10 turned Resident #477's call light off. At 9:40 AM Resident #477 stated Nurse #10 told her she was getting someone to assist her with incontinence care. At 9:43 AM NA #11 entered Resident #477's room to provide incontinence care to Resident #477. In an interview on 11/16/21 at 2:24 PM NA #11 revealed she was the only aide on the hall that shift. She stated that she had provided incontinence care for Resident #477 at 7:00 AM that morning. She indicated she was frequently unable to complete all the required tasks in an 8-hour shift. NA #11 revealed she and Nurse #10 were aware Resident #477 needed incontinence	F 677	provided by nurse aide on 11/15/2021 on day shift on 11/15/2021 and 11/16/2021 -Nurse Manager monitored hall during lunch and dinner to ensure call light being answered during meals and incontinent care being provided as needed. Corrective Action for Potentially Affected Residents All residents who need assistance with toileting have the potential to be affected by this alleged deficient practice. On 12/1/2021 12/3/2021 , 12/6/2021 the DON and nurse manger performed audits for incontinency care needs during meals. Additional audits will be on conducted on all three shifts including weekends for incontinent care by the DON and Nurse Manager. Any resident identified with toileting or incontinent needs were promptly toileted or care provided by the assigned CNA. Systemic Changes On 12/13/2021 the Director of Nursing began in-servicing all current full time, part time and PRN Nurses and CNA's. This in-service included the following topics: " ADL Care, Call Lights, and Care Need Requirements " Toileting before, during, and after meal times The Director of Nursing will ensure that any Nurse or CNA who has not received this training by 12/18/2021 will not be allowed to work until the training is	

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F 677	Continued From page 47 care, but she delivered the meal trays to all the residents on 400-hall before she assisted Resident #477 with incontinence care. NA#11 verbalized that if a resident requested incontinence care during a mealtime, she passed all the trays and then provided incontinence care. A telephone interview was conducted with Nurse #10 on 11/19/2021 at 10:27 AM. She revealed she answered Resident #477's call light and did not provide incontinence care herself. Nurse # 10 stated she instructed NA #11 to provide the incontinence care because she was running behind on obtaining blood sugars and administering medications to the other residents on the hall. In an interview on 11/18/2021 at 7:56 AM the Regional Director of Oprations explained resident care should take priority. He stated it was a delicate situation when a resident had an incontinent episode during meal service, but the incontinent resident should have been taken care of. In an interview on 11/18/2021 at 3:15 PM the Director of Nursing verbalized residents should be provided incontinence care during meal service, so they have a dignified meal experience. 2. Resident # 122 was admitted to the facility on 8/25/2015 and her diagnoses included kidney disease, diabetes, and heart disease. A quarterly Minimum Data Set assessment dated 10/27/2021 indicated Resident #122 was cognitively intact and required total assistance with toileting. The assessment further revealed	F 677	completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance On 12/27/2021 The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring ADL care. The monitoring will include reviewing a sample of residents prior to and during meal time for toileting and incontinent care needs. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by to ensure their needs are met. Quality Of Life/Quality Assurance Committee. Reports will be given by the Director of Nursing to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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Resident #122 was always incontinent of bowel and bladder.

Resident #122's Care Plan dated 5/22/2021 stated she was incontinent of bowel and bladder.

An interview was conducted with Resident #122 on 11/15/2021 at 11:31 am and she stated she was not assisted with incontinence care from Sunday, 11/14/2021, morning until this morning, 11/15/2021. Resident #122 stated they did not usually have enough staff to provide incontinence care.

During an interview with Nurse Aide #6 on 11/15/2021 at 12:07 pm she stated she started her shift at 7:00 am and found Resident #122's brief and bedding were soaked through with urine and Resident #122 told her she had not been changed since yesterday.

An interview was conducted with Nurse #5 on 11/17/2021 at 5:05 am and he stated there was not enough Nurse Aides on the 11:00 pm to 7:00 am shift, but they did try to work together. He stated the residents were not changed as much as they should be because they only had time to complete 2 rounds.

During an interview with Nurse #7 on 11/18/2021 at 2:01 pm she stated she was the nurse on the 200-hall on Sunday, 11/14/2021, on the 7:00 pm to 7:00 am shift. She stated she was not aware Resident #122 had not been changed during her shift, but she said the Nurse Aides were very short staffed. She stated they usually had 3 Nurse Aides caring for 90 residents. Nurse #7 stated they should be doing an incontinence round every two hours, but they usually were only

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F 677	Continued From page 49	F 677		

able to complete 2 incontinence rounds on the 11:00 pm to 7:00 am shift.

Nurse Aide #2 was interviewed on 11/18/2021 at 2:31 pm and stated she had worked Sunday, 11/14/2021, on the 3:00 pm to 11:00 pm and the 11:00 pm to 7:00 am shift on the 200 hall. She stated she did not work at the facility fulltime and only filled in when they need assistance. She stated she did not know Resident #122 that well. Nurse Aide #2 stated did 2 rounds during the 3:00 pm to 11:00 pm and 11:00 pm to 7:00 am shift that evening. She stated the residents who were incontinent should be changed every two hours, but they were short staffed, and it was a lot to get done.

An interview was conducted with the Director of Nursing on 11/18/2021 at 3:51 pm and she stated the Nursing Department was staffing challenged. The Director of Nursing stated she felt the staff were taking short cuts to get things done and the staff should be providing incontinence care every 2 hours.

3. Resident #42 was admitted to the facility on 2/20/2019. Her diagnoses included kidney disease and heart disease.

A quarterly Minimum Data Set Assessment dated 8/13/2021 indicated Resident #42 was cognitively intact and required total assistance with toileting.

Resident #42's Care Plan dated 9/15/2021 indicated she required total assistance with toileting and was incontinent of bowel and bladder.

On 11/15/2021 at 10:30 am an interview was

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F 677	Continued From page 50 conducted with Resident #42, and she stated she had to wait to be changed for up to 6 hours and she stated she did not get her shower because the staff were so short staffed. Resident #42 stated the staff not providing incontinence care happened daily. An interview was conducted with Nurse #5 on 11/17/2021 at 5:05 am and he stated there was not enough Nurse Aides on the 11:00 pm to 7:00 am shift, but they did try to work together. He stated the residents were not changed as much as they should be because they only had time to complete 2 rounds. An interview was conducted with the Director of Nursing on 11/18/2021 at 3:51 pm and she stated the Nursing Department was staffing challenged. The Director of Nursing stated she felt the staff were taking short cuts to get things done and that she did need more staff. The Director of Nursing stated Resident #42 should be assisted with incontinence care every 2 hours and whenever needed.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		12/24/21

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F 688	Continued From page 51 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and Nurse Practitioner interviews, the facility failed to apply an arm splint as ordered to a resident following a stroke for 1 of 2 residents (Resident #56) reviewed for range of motion. The findings included: Resident #56 was admitted to the facility on 09/01/21 with diagnoses that included stroke. The Minimum Data Set (MDS) assessment completed on admission 9/8/21 indicated Resident #56 was cognitively impaired. He had weakness on his right side and was dependent on staff for assistance. He required extensive assistance with his Activities of Daily Living (ADL). He had no behaviors or rejection of care. Review of the physician orders for Resident #56 revealed an order written on 10/03/21 for the Certified Nurse Assistant (CNA)/Nurse Aide (NA) to put patient's right resting hand splint on during day hours as tolerated. The care plan for Resident #56 initiated on 09/02/21 and revised on 11/11/21 did not include the splint. Resident #56's NA Kardex/care guide did not	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F688 Increase/Prevent Decrease in ROM/Mobility Corrective action for affected residents. On 11/18/2021, the Nurse Manager obtained a right hand splint and applied it to resident #56 right hand. Corrective action for potentially affected residents. Residents who utilize a splint for contractures have the potential to be affected. On 12/10/2021, the Minimum Data Set Nurse audited all current residents for contractures. This was completed by assessing the resident□s extremities and placing them through ROM to determine if a contracture were present. If a new or worsening contracture was noted, a	

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F 688	Continued From page 52 include information about the splint application. An observation completed on 11/15/21 at 12:15 PM revealed the splint was not on. There was a sign at the head of Resident #56's bed that noted the splint was to be on his arm during the day. An interview was done on 11/15/21 at 3:18 PM with a family member of Resident #56 that visited frequently. She stated he was supposed to have the splint on, but they never had it on him when she came in to visit. An observation was done on 11/17/21 at 9:33 AM of Resident #56. He was lying in bed with no splint on his arm. NA #10 was interviewed on 11/17/21 at 9:33 AM regarding Resident #56. She stated she was not aware of the splint until she read the sign above his bed when she was feeding him breakfast. She noted she had not cared for him previously and was not given the information in change of shift report. The Rehabilitation Director/Occupational Therapist that worked with Resident #56 frequently was interviewed on 11/17/21 at 9:46 AM. She stated she had spent a lot of time with him when he was on the rehabilitation unit. She stated she did not know about any refusals of the splint and it should be on during the day as tolerated. Resident #56 was observed on 11/18/21 at 10:30 AM lying in bed, with no splint was on his arm. NA #12 was interviewed on 11/18/21 at 10:34 AM regarding Resident #56's splint. She stated she	F 688	therapy referral will be initiated by the Nurse Manager. This process will be completed by 12/17/2021. On 12/13/2021, the nurse managers audited all current residents to establish which residents had MD orders for devices such as a splint, brace, palm guard, or hand roll. This was accomplished by auditing orders and care plan task for those devices. Once it was determined who needed a splint, brace, palm guard, or hand roll, the nurse managers and Minimum Data Set (MDS)nurse ensured the device were in place, had an MD order, CNA task, and care plan. This process will be completed by 12/17/2021. Systemic changes On 12/13/2021, the Director of Nursing began an in-service education to all full time, part time, and as needed nurses and CNA□s. Topics included: ¿ The importance for applying splints, palm guards, hand rolls as ordered by the MD. ¿ Inspecting skin at least daily or more frequently as ordered for irritation, redness or skin breakdown. ¿ What to do when the device cannot be located. The Director of Nursing will ensure that any Nurse or CNA who has not received this training by 12/18/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality	

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F 688	Continued From page 53 did not usually work with him and she had just read the sign and was going to put it on. The Support Nurse/Unit Manager for Resident #56's unit was interviewed on 11/18/21 at 11:44 AM regarding his order for the arm splint. She was informed he had been observed for 3 out of 4 days this week without the splint on. She said he was moved from the rehabilitation unit to long term care a week ago on 11/11/21 and they had not reviewed his orders yet. She added that usually they reviewed the orders faster, but it had been very busy with the COVID outbreak. She noted she was not aware of the order for the arm splint, and it should have been on the care plan if ordered. An interview was done on 11/18/21 at 5:11 PM with the Director of Nursing (DON) regarding Resident #56's order to wear the arm splint and for the NAs to apply it during the day. She stated the splint should have been placed on the care plan, and in the NA's documentation system so the NAs would see it. She reviewed both the care plan and the NA's documentation system and acknowledged it was not in either. She stated the NAs would not know to place it on the resident. She noted the splint should have been put on as ordered. An interview was done on 11/18/21 at 5:59 PM with the Nurse Practitioner regarding Resident #56's arm splint. She said the splint should be on his arm as it was ordered.	F 688	Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance On 12/27/2021 The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Splint and Brace use. The monitoring will include reviewing a sample of residents who require a splint or brace to ensure it is applied and removed per MD orders. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by to ensure their needs are met. Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		12/24/21

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F 690	Continued From page 54 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff and nurse practitioner interviews the facility failed to provide the treatment needed for a urinary tract infection (UTI) by not administering one dose of a	F 690	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	

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ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 55 three-day prescription for 1 of 1 resident (Resident #61) reviewed for UTI's. The Findings included: Resident #61 was admitted to the facility on 9/24/21 with a diagnosis which included Alzheimer's Disease. The Admission Minimum Data Set (MDS) dated 10/1/21 revealed Resident #61 had moderately impaired cognition and was occasionally incontinent of urine and did not require a urinary catheter. A record review revealed Resident #61 received an order by the Nurse Practitioner #1 (NP) on 11/5/21 for a UTI. The order read 'Ceftriaxone Sodium Solution (an antibiotic used to treat batcterial infections) Reconstituted 1 GM Inject 1 gram intramuscularly every 24 hours for UTI for 3 Days'. The order start date was 11/5/21 with an end date on 11/8/21. A further review showed that Nurse #3 confirmed the order on 11/6/21 at 10:26 AM. A review of the medication administration record (MAR) revealed Resident #61 received the medication for her UTI on 11/6/21 and 11/7/21. The MAR on 11/5/21 was blank with no X in the box and 11/6/21 and 11/7/21 had showed that the medication was given. 11/8/21 had an X in the box. A progress note dated 11/7/21 read; Resident on Intramuscular antibiotic therapy, second dose given with no reaction noted. Resident's temperature 97.8 and taking fluid well. An interview was completed with Nurse #2 on 11/8/21 at 10:28 AM who stated the order was to	F 690	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F690 Bowel/Bladder Incontinence, Catheter, UTI Corrective action for resident(s) affected by the alleged deficient practice: Resident #61 Resident received order for Ceftriaxone 1G intramuscularly every 24 hrs. x 3 days , medication was given for 2 doses on 11/6/2021 ,11/7/2021,the Nurse Practitioner was notified of missed dose on 11/18/2021 with surveyor interview. On 11/19/2021 the Nurse Practoneer assessed resident with no adverse effects. No further action was ordered by the Nurse Practitioner Corrective Action for Potentially Affected Residents. All residents in the facility who are currently receiving antibiotics have the potential to be affected. Beginning on 12/10/2021, the Unit Support Nurses audited all pending orders requiring confirmation for current residents. No other issues with antibiotics were noted no other corrections were indicated. This was completed by 12/13/2021. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/13/2021, the Director of Nursing began an in-service education to all full time, part time, and as needed nurses.	

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F 690	Continued From page 56 be started on 11/5/21 and indicated it was for three days. Nurse #2 further explained that because the order was confirmed on the 6th and not on the start date of 11/5/21, the third dose did not show up on the MAR and therefore an X is shown in the box for 11/8/21 as the order was only for three days. Nurse #2 reiterated it should have started on 11/5/21. An interview was completed with the DON on 11/18/21 at 4:53 PM who reviewed the medication in the electronic record and indicated the medication should have been started on 11/5/21. An interview was completed with NP #1 on 11/18/21 at 4:03 PM who was asked if Resident #61 only recieved two doses of the anitibiotic would that cause a problem? The NP stated, "the medication for Resident #61's UTI was for three days and should have been given for three days". An interview was completed Nurse #3 on 11/18/21 at 5:19 PM who stated that she did not work on the hall that Resident #61 was on but saw the electronic physicians order that had not yet been processed and confirmed the order on 11/6/21. Nurse #3 stated that she confirmed the order so the medication would be available to administer. An interview was completed with the Director of Nursing (DON) on 11/19/21 at 1:05 PM who stated it was her expectation that if someone was to receive three doses of medication, they should get three doses. The DON further explained the process is that the nurse was to confirm all orders on their shift before they go home.	F 690	Topics included: " Orders confirmation and initiation of medication as soon as possible upon availability " Pharmacy process for ordering medication including backup pharmacy " Process and frequency of confirming new orders in Point Click Care The Director of Nursing will ensure that any Nurse who has not received this training by 12/18/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance- 12/27/2021 The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Monitoring Orders Confirmation/ Medication Administration. The monitoring will include reviewing a sample of residents with new orders for antibiotic to ensure timely administration. This will be completed weekly for 4 weeks then monthly x 2 months or until resolved to ensure medications are administered without delay. Reports will be given to the Monthly	

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F 690	Continued From page 57	F 690	Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker, and Maintenance Director.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Nurse Practitioner interviews, the facility failed to reassess to determine if current weight loss	F 692	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	12/24/21

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F 692	Continued From page 58 interventions were effective for a resident with significant weight loss who continued to lose weight (Resident #56). This was for 1 of 2 residents reviewed for nutrition (Resident #56). The findings include: Resident #56 was admitted to the facility on 09/01/21 with diagnoses that included stroke, dysphagia, heart failure and diabetes. Record review indicated Resident #56's weight as 176.6 pounds (lbs.) on admission 09/01/21. Review of the physician orders for Resident #56 revealed an order written 09/01/21 for a pureed cardiac diet with honey thick-moderately thickened liquids. The orders noted the resident was to be fed as needed and monitored during eating. The Minimum Data Set (MDS) assessment completed on admission 9/8/21 indicated Resident #56 was cognitively impaired. He had weakness on his right side and was dependent on staff for assistance. The MDS assessment indicated he required limited assistance of 1 person with eating. He also required extensive assistance with his Activities of Daily Living (ADL). It noted he would cough or choke with eating. He had no behaviors or rejection of care. Record review of the Dietician Nutritional Assessment completed on 09/13/21 indicated Resident #56 did not have significant weight loss, he ate 50-75% of his meals and the albumin/pre-albumin (protein) level was 2.5. The care plan for Resident #56 initiated on	F 692	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F692 Nutrition/Hydration Status Maintenance 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #56-On 11/18/2021 resident reweighed. Dietician, MD and RP notified. Magic Cup increased to twice daily. On 12/14/2021 the Resident added to a weekly weight meeting and was reweighed on 12/14/2021 for monitoring. On 12/14/2021 the resident's wife was updated and requested hospice consult. 12/15/2021 Registered dietitian consulted with NP and new orders received for magic cup to be increased to three time a day and to continue weekly weights. Action for residents with the potential to be affected by the alleged deficient practice. On 12/14/2021 An audit of all current resident weights and chart review to determine residents with significant weight loss was completed by Register Dietitian and Director of Nursing for weight loss of 5lbs or greater in the last 30 days. On 12/14/2021 the Director of Nursing and Registered dietitian reviewed all current resident weights From 12/14/2021 to 12/21/2021 3 residents were identified	

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F 692	Continued From page 59 09/13/21 identified a potential nutritional problem related to thickened liquids. Interventions included to serve supplements as ordered, monitor intake and record each meal, maintain weight for 90 days and the dietician was to evaluate and make diet change recommendations as needed. Record review indicated the weight recorded for Resident #56 on 09/17/21 was 176.0 lbs. Resident #56's weight on 09/29/21 was documented as 167.8 lbs. Record review of a weight alert note for Resident #56 was documented by the Director of Nursing (DON) on 10/7/21 at 12:21 PM following a weight loss meeting. It noted a weight alert from 09/29/21 for a -3% change from the last weight and a -3% change over 30 days. Interventions were to provide a frozen fortified ice cream each day. Review of the Physician orders indicated a frozen fortified ice cream was ordered once a day for weight loss on 10/07/21. No additional supplements were ordered. Review of the October 2021 and November 2021 Medication Administration Record indicated the resident was taking the frozen fortified supplement once each day. The weight for Resident #56 completed on 11/06/21 was 160.6 lbs. This indicated a 9% loss in 2 months. The care plan for Resident #56 was revised on 11/11/21. No care areas were noted for actual	F 692	with significant weight loss . On 12/15/2021 one resident received an order on to increase his med pass. The second resident received an order on 12/21/2021 to receive a new med pass supplement. The third resident receives hospice services and no new interventions was ordered by the MD with family and hospice approval as weight loss is anticipated. On 12/14/2021 The facility established a weekly weight meeting to monitor all residents with significant weight loss, notification of weight losses of 5 lbs. or more , reweight for residents with a 5 lb. weight loss from their last weight, initiation of appropriate interventions, and appropriate monitoring to prevent further weight loss. Weight meeting will be attended by the Director of Nursing , Wound Nurse, and Registered dietitian. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/13/2021 The Director of Nursing (DON) and/or designee will educate all nursing staff regarding the importance of notification of weight losses of 5 lbs. or more and initiation interventions and monitoring to prevent further weight loss. The Director of Nursing, Dietary Manager and Minimum Data Set Nurse will conduct weekly weight review to determine if new interventions are needed. The Director of Nursing will ensure that any staff who has not received this training as of 12/18/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard	

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F 692	Continued From page 60 weight loss or interventions that he required feeding on the care plan. An interview was done on 11/18/21 at 5:59 PM with the Nurse Practitioner regarding Resident #56's weight loss. She stated initially when he was admitted his albumin (protein) level was 6.4 which indicated he was malnourished. She said she had ordered a liquid protein supplement three times a day. Review of the Medication Administration Record for October and November did not indicate liquid protein supplements three times a day were ordered or given. An interview was done with the Dietician on 11/18/21 at 11:13 AM about Resident #56's weight loss since admission. She stated she had completed an assessment on 09/13/21 and they had a weight loss meeting regarding him on 10/07/21. She added that a frozen fortified ice cream supplement was ordered once a day on 10/07/21. She was asked if she had completed any follow-up for Resident #56 since the 10/07/21 meeting, and she stated no. She said there was a weight meeting on 11/4/21 and Resident #56 was not discussed as his weight in November had not been done for the month at that time. The dietician stated that Resident #56 should have triggered for weight loss in the electronic record but did not since the November weight wasn't done prior to the meeting. She noted they would likely have a meeting before the end of November, but no date was set. She added that the weight meetings were done monthly or at least every other month. She was informed of the ongoing weight loss and asked if there should be any interventions with his continued weight loss.	F 692	orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. QUALITY ASSURANCE- On 12/27/2021 The Director of Nursing (DON) and/or designee will review 10 resident□s most current weight weekly using the QA tool for monitoring Weights Loss to ensure accuracy of documentation, notification and implementation of interventions as appropriate. Audits will be completed on each resident weekly x 4 weeks, then monthly x 3months. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	

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F 692	Continued From page 61	F 692		

She noted she would have dietary ask his food preferences and would see if they would increase his daily frozen fortified ice cream. She was asked if she had not been contacted by the surveyor if she would have been aware of the weight loss for Resident #56. She stated if they had a weight loss meeting, she would have been. She was asked about the care plan not addressing the weight loss. She indicated that either she or a dietary technician should have updated the care plan. She said she was at the facility monthly and would come more if needed.

An interview was conducted on 11/18/21 at 11:44 AM with the Unit Manager for Resident #56. She stated the resident had been moved from the rehabilitation unit to long term care a week ago and she was not too familiar with him and had not reviewed his orders yet. She said yesterday was the first time she assisted him with meals and fed him. The Unit Manager revealed she thought he could feed himself after his meal was set up, but he could not at all. She noted he needed to be fed and she made it known to others. She stated he ate all but a few bites of the frozen fortified ice cream. She said the weight loss should be on the care plan and she had not reviewed it. The Unit manager stated the Unit Manager from the rehabilitation unit and the MDS nurse should have updated the care plan to include the weight loss.

An interview was done on 11/17/21 at 9:33 AM of Resident #56 with Nurse Aide (NA) #10. She stated he ate about 50% of his breakfast, which was within range of the dietitian's assessment. She noted she had not cared for him before and had brought his tray in for him. She was not aware he needed fed.

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F 692	Continued From page 62 An observation was done on 11/18/21 at 1:45 PM of Resident #56 eating lunch. The Unit Manager was feeding him pureed food and thickened liquids. The resident ate 90% of his meal. An interview was done on 11/18/21 at 5:11 PM with the Director of Nursing regarding Resident #56's weight loss and care plan. She stated normally the MDS nurses or nursing entered it on the care plan. The DON said the weight loss should display on the medical record dashboard to alert the dietitian and MDS nurses. She was asked if she would have expected the dietitian to follow up on the ongoing weight loss and the DON said she would expect the dietitian to intervene. The DON revealed there was a Performance Improvement Plan (PIP) in place for weight loss. She indicated they were doing audits and monitoring weights and had updated the QAPI (Quality Assessment and Performance Improvement) process. She stated the PIP did not work, it started 03/06/21 and had been extended now until 12/31/21. She stated there was no final completion date.	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		12/24/21

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F 725	Continued From page 63 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interviews, and staff interviews the facility failed to provide sufficient staff to ensure the 2 of 6 residents (Residents #122 and 142) were allowed a choice regarding; failed to provide incontinence care due for 2 of 6 residents (Resident #122 and Resident #42) reviewed for activities of daily living; failed to complete an admission Minimum Data Set (MDS) for 3 of 5 residents (Resident #475, Resident #477, and Resident #383); and failed to complete a quarterly Minimum Data Set Assessment (MDS within 14 days of the Assessment Reference Dates (ARD) for 3 of 5 residents reviewed for quarterly MDS completion (Resident #2, Resident #13 and Resident #17). Findings included: This tag is cross referenced to: 1. F561: Based on record review and staff	F 725	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F725- SUFFICIENT STAFFING Corrective action for affected residents. For resident # 142, #122: Incontinent care provided by nurse aide on 11/17/2021 For resident□s #_383, #475, and #477: Quarterly minimum data set completed, submitted and accepted on 11/17/2021 by MDS nurse For resident # _#2, and13, and #17:	

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F 725	Continued From page 64 interviews the facility failed to provide showers for 2 of 6 residents, Resident #122 and Resident #42 reviewed for being allowed choices regarding bathing. 2. F677: Based on observation, resident and staff interviews, and record review the facility failed to provide incontinence care during meal service for 1 of 6 residents (Resident #477) and failed to provide routine incontinence care for 2 of 6 residents (Resident #122 and Resident #42) reviewed for activities of daily living (ADL). 3. F626: Based on record review and staff interviews the facility failed to complete an admission Minimum Data Set (MDS) for 3 of 5 residents (Resident #475, #477, #383) reviewed for resident assessments. 4. F640: Based on medical record review and staff interviews, the facility failed to complete a quarterly Minimum Data Assessments (MDS) within 14 days of the Assessment Reference Dates (ARD) for 3 of 5 residents reviewed for quarterly MDS completion (Resident #2, Resident #13 and Resident #17). On 11/17/2021 at 6:35 am the Director of Nursing was interviewed and stated the staff still think the facility can staff like they did before the pandemic but that was not possible anymore. The Director of Nursing stated she felt the facility was staffing challenged and she would like to have good staff to resident ratios and they constantly worked on bringing in new staff. During an interview with the Regional Director of Operations on 11/18/2021 at 11:11 am he stated the company approaches staff shortages by	F 725	Quarterly minimum data set completed, submitted, and accepted on 12/7/2021 by the Minimum Data Set (MDS) nurse Corrective action for potentially affected residents. On 12/10/2021 a 100% review of staffing ratios and assignments were completed by the Director of Nursing, Administrator, and Nurse Management team. The facility has hired a housekeeping supervisor, 2 housekeepers, one LPN, 2 medication aides,and one nurse aide. The facility will utilize an MDS float nurse for additional coverage.The facility staffing is based on ratios and acuity. Systemic changes On 12/13/2021, the Director of Nursing began an in-service education to all full time, part time, and as needed MDS nurses, registered nurses , licensed nurses, and nurse aides. Topics included: " The importance of staff call-outs, notification to Director of Nursing/Administrator, staffing assignments and evaluating staff ratios to meet resident needs, specifically incontinent care. " The Administrator and Director of Nursing will review daily staffing sheets at the morning stand up meeting to ensure staff is scheduled to meet the ADL and Assessment needs of the residents. " The education focused on: The facility must encode/transmit resident assessments; Automated data processing requirement- Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 65 offering new hire bonuses, increasing the wage scales, recruiting, and employee staff appreciation celebrations. The Regional Director of Operations also stated the facility utilizes their therapy department to assist with getting residents up in the morning to help out the nursing staff.	F 725	following information for each resident in the facility:(i) Admission assessment.(ii) Annual assessment updates.(iii) Significant change in status assessments. (iv) Quarterly review assessments.(v) A subset of items upon a resident's transfer, reentry, discharge, and death.(vi) Background (face-sheet) information, if there is no admission assessment. Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. Transmittal requirements. The Director of Nursing will ensure that any Nurse or nurse aide who has not received this training as of 12 /18/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance 12/27/2021 The Director of Nursing or the Administrator will monitor this issue using the Survey Quality Assurance Tool for Sufficient Staffing. The review will consist of at reviewing staffing ratios and assignments at least three times a week for 4 weeks, then weekly for 8 weeks or until resolved by the Quality of life/Quality	

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F 725	Continued From page 66	F 725	Assurance Committee; a review of staffing schedules, staffing ratios, and assignments to include resident acuity, and reviewing for any grievance reports related to staffing. Interventions will be implemented as appropriate. In addition, the MDS schedule will be reviewed to ensure annual and quarterly assessments are completed and submitted timely. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		12/24/21

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F 761	Continued From page 67 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications from one of two medication storage rooms inspected for medication storage (100/200 Hall Medication Room). Findings included: An observation of the 100/200 Hall Medication Room conducted on 11/18/21 at 4:45 PM revealed 2 1680 milliliter (ml) bottles of 10 gram (gm) per 15 ml of lactulose (a medication to treat constipation or liver disease) with an expiration date of 06/2021 (June of 2021). Further observation revealed a third 1680 ml bottle of lactulose with an expiration date of 04/2021 (April of 2021). During an interview conducted with the Director of Nursing (DON) on 11/18/21 at 5:42 PM she stated the lactulose was for a resident who received medications from a different pharmacy. She said the pharmacy would routinely send an excessive amount of medications and the resident did not utilize the volume of medication the pharmacy sent. She explained there was a cabinet full of medication for that resident from the pharmacy. She said they have requested to	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F-761 Label/Store Drugs & Biologicals Corrective action for affected residents. The resident identified in survey (no number)with expired medications and excess medications were discarded on 11/18/2021 by the Director of Nursing . 11/18/2021 the Director of Nursing (DON)notified the residents pharmacy that the facility staff (DON)will notify them when the new supply is to be sent. Corrective action for residents with the potential to be affected by the alleged deficient practice.-All residents in the facility who take medications or	

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F 761	Continued From page 68 the pharmacy to not send such large quantities of medications for the resident and had even tried to return some of the medications, but the pharmacy keeps sending the medication and they had refused the facility's attempts to return the medications. She stated the lactulose was overstock for the resident and they would audit the other medications for the resident to make sure no other medications were expired and again attempt to return medications to the pharmacy which weren't being used. She further stated she expected for nurses to dispose of expired medications, and she will institute an audit process to make sure there were no further occurrences of expired medications in the medications rooms. An interview was conducted with the Corporate Quality Assurance (QA) Nurse on 11/18/21 at 5:50 PM. She stated the expired lactulose was a resident who had a different pharmacy. She explained the medications for that resident would be audited and the excess medications would be returned to the pharmacy. She further stated the medication rooms would be audited for expired medications and a process to remove medications which were going to expire would be put into place.	F 761	supplements have the potential to be affected. Beginning on 12/10/2021 the Unit Support Nurses audited all med rooms to identify any expired medications or resident medications that had discharged. All Expired or discharged residents' medications were immediately removed and discarded. This was completed by 12/10/2021. Beginning on 12/10/2021 the Unit support Nurse and Central Supply Clerk completed an audit of the central supply storage to identify any expired medications or undated medications or supplements. No expired or undated medications or supplements were identified This was completed on 12/10/2021. On 12/22/2021 All medication carts were audited by the Director of Nursing and LPN support nurse for expired medications , or medications the for residents that had discharged from the facility. All expired medications or discharged resident medications were removed for the medication carts. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 12/13/2021 the Director of Nursing began education for central supply clerk and all full time, part time and PRN registered nurse, licensed nurse, medication aide on the following : Checking medications for expiration prior to opening. Dating medications and supplements	

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F 761	Continued From page 69	F 761	when opening Med room , Med cart, and central supply medication storage audit for , excessive resident medications, expired meds or medications of discharged residents. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The director of nursing will assure that any nurse or medication aide (full-time, part-time or PRN) who does not receive scheduled in-service training by 12/18/2021 will not be allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On 12/27/2021 The Director of Nursing or designee will monitor compliance utilizing the Medication storage Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The DON or designee will monitor for compliance with labeling medications and supplements with a date when opened and ensuring the medication room is free of expired medications, excessive resident medications, and medications of discharged residents. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program	

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F 761	Continued From page 70	F 761	reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, a resident council meeting, a test tray, resident and staff interviews, the facility failed to provide food that was appetizing for 8 of 8 residents (Resident #45, Resident #112, Resident #26, Resident #55, Resident #114, Resident #101, Resident #91, and Resident #747) reviewed for food palatability. The findings included: A. Resident #747 was admitted to the facility on 11/10/2021. Resident #747 was interviewed on 11/15/2021 at 10:43 AM. She indicated that the food was served very cold. A follow up interview and observation was conducted on 11/15/2021 at 1:27	F 804	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F804 Nutritive Value/Appear, Palatable/Prefer Temp	12/24/21

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F 804	Continued From page 71 PM. Resident #747 was observed in her room with her lunch tray on the bedside table. Upon interview she stated that the chicken fingers and the sweet potato fries were lukewarm and dry. During an interview and observation on 11/16/21 at 8:39 AM, Resident #747 stated that her breakfast was delivered 7 minutes prior and the eggs were lukewarm and the sausage was cold. Resident #747 was observed adding butter to her grits. A hard dried film was observed on the grits and the butter did not melt. Minimal condensation was noted in the lid of the dome plate cover. B. A resident council meeting was held on 11/17/21 at 2:46 PM. The following residents, Resident #45, Resident #112, Resident #26, Resident #55, Resident #114, Resident #101, Resident #91, verbalized that the meals were cold. Resident #101 stated the grits were "too cold to melt butter" and "were hard as a brick". C. A test tray was requested on 11/17/2021 at 8:00 AM from dietary staff as they plated 400 hall resident meal trays. At 8:08 AM the last resident tray was plated for 400 hall. The test tray was assembled and added to the food cart for the 400 hall. At 8:10 AM the food cart for the 400 hall left the kitchen and arrived on the 400 hall at 8:12 AM. The 400 hall food cart was observed to sit on the hall. The facility staff was then observed going to the food cart and started delivering meal trays to the residents until the last tray was delivered at 8:27 AM. The doors on the food cart were observed to be open throughout meal tray delivery. The test tray was removed and transported to the adjacent dining area to complete the test tray evaluation with the Dietary Manager (DM). At 8:30 AM the tray items were	F 804	1. Corrective action for affected residents. On 11/15/2021 ,11/16/2021 , 11/17/2021 the residents were offered new food tray or food to be warmed. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. The kitchen sent test rays 12/8/2021 on 100 hall, 12/9/2021 on 200 hall, and 12/13/2021 on 400 hall and were found to be in compliance. On 12/14/2021, the Dietary Service Director completed an in-service to discuss dining experience with dietary staff and meal procedures with nursing/assistant nursing staff. on 12/17/2021 the QA nurse consultant completed a random sample interview with Residents to ensure hot food is delivered per expectations with no other concerns noted. 3. Systemic changes In-service education was provided and completed on 12/14/2021 by the dietary manager to all full time, part time, and as needed dietary staff. Topics included: " Meal objectives and procedures " Test Tray completion " Focus on dining experience Test Trays will be completed to ensure satisfactory dining experience 5 x a week Dietary Manager will attend resident council as invited and follow up with any	

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F 804	Continued From page 72 evaluated by the DM and Surveyor. The DM and Surveyor tasted the meal tray inclusive of eggs. The DM and Surveyor agreed the eggs were cool. In an interview on 11/17/2021 at 8:35 AM the DM revealed there were some food palatability concerns from residents when she resumed her duties as DM a few months ago but there were less more recently. She explained she did not develop a formal action plan to address the concerns of the residents. The DM indicated she tasted the food daily before it was served to the residents to ensure palatability. In an interview with the Regional Director of Operations on 11/18/2021 at 7:56 AM, he explained food palatability was "tough." He stated cold food should not occur. He also indicated staff should pass trays out to residents while food was hot.	F 804	food complaints as identified. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. On 12/27/2021 The Dietary Service Director or designee will complete a test tray 5 x a week x 2 weeks, 2 x a week x 2 weeks, and then monthly x 2 months using the Dietary QA Audit. Monitoring will include reviewing food items for appearance and taste as well as visiting with residents once a week to discuss food temperature and palpability. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
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	F 812		12/24/21

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F 812	Continued From page 73 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 interview, the facility failed to remove fresh fruit, vegetables and thawed meat stored ready for use with signs of spoilage and undated in 1 of 1 walk in cooler, 1 of 1 reach in cooler, and the facility failed to remove expired nutritional supplements stored ready for use from two of two medication storage rooms (100/200 Hall Medication Room and the 300/400 Hall Medication Room). This practice had the potential to affect food and nutritional supplements served to residents. The findings included: 1. An initial tour was completed on 11/15/2021 at 9:55 AM with the Dietary Manager (DM). The initial tour revealed the following problems 4 small tomatoes observed in a storage box in the walk in cooler with signs of spoilage (darkbrown mushy spots). 4 bananas observed in a storage box in the walk	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F812__ Food Procurement, Store, Prepare, Serve-Sanitary Corrective action for affected residents On 11/15/2021, Foods undated and with signs of spoilage were discarded from walk in cooler by Dietary Manager On 11/18/2021, expired nutritional supplements discarded from medication room by Director of Nursing Corrective Action for Potentially Affected	

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F 812	Continued From page 74 in cooler with signs of spoilage (large black, brown mushy areas). 1 individual bag of pre-chopped raw potatoes with ¼ of bag remaining. The bag was in thewalk in cooler opened and undated. The remaining chopped potato pieces were observed to be submerged in a thick brown liquid. 1 zip top bag of raw chicken breast resting on a sheet pan in the walk in cooler. The bag was open and undated. The chicken was submerged in a thick pink liquid. This liquid was also present outside the bag in the sheet pan. 1 cut cucumber located in the reach in cooler was covered in plastic wrap was not labeled and dated. An interview 11/15/2021 at 10:00 AM with the DM revealed she last checked the walk-in refrigerators on 11/12/2021. She explained that staff were aware to check the refrigerators daily for signs of spoilage and to make sure items were labeled and dated. The DM expressed the cook on the weekend should have checked the refrigerator as well for signs of spoilage and made sure items were properly labeled and dated. The Administrator was not available for interview. 2a. An observation of the 100/200 Hall Medication Room conducted on 11/18/21 at 4:45 PM revealed a 30-ounce (oz) bottle of sugar free protein nutritional supplement with an expiration date of 10/23/21. 2b. An observation of the 300/400 Hall Medication Room conducted on 11/18/21 at 5:01 PM revealed 8 8 oz cartons of therapeutic nutritional supplement designed for residents who	F 812	Residents. All current residents have the potential to be affected by the alleged deficient practice. On 12/10/2021 the Unit Coordinators completed 100% inspection of all medication rooms to check for expired supplements and any expired supplements noted were discarded. On 12/8/2021, the Dietary Manager completed inspection of all walk in coolers and all food items were properly stored. Any food items noted without a date or signs of spoilage were removed and discarded. Systemic Changes On 12/10/2021 the Director of Nursing and Dietary Manager began In-service education to all registered nurses, licensed nurses, nurse aides, and dietary staff full time, part time, and as needed staff on checking for and discarding expired supplements and all food items must be stored, dated and discarded per NC State Regulations and Food Safety, Food Storage Policy reviewed. The Director of Nursing will ensure that any staff who has not received this training by 12/18/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.	

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F 812	Continued From page 75 were on dialysis with an expiration date of 9/1/21. The cartons were contained in a box which was sitting on top of a box of non-expired supplements on the counter. An interview was conducted on 5/20/21 at 5:06 PM with the Central Supply Coordinator. She stated the there were no residents on the 300/400 hall who were on dialysis and she did not know how come they were in the medication room for that unit. She said it was a brand of supplement which they carried and due to there having been no residents on dialysis on the unit, she did not believe anyone was receiving it. She said it must have been in there from a past resident and it was not moved or discarded after the resident left the unit or facility. During an interview conducted with the Director of Nursing (DON) on 11/18/21 at 5:42 PM she stated the sugar free protein nutritional supplement should have been disposed of and there were no residents on dialysis on the 100/200 hall receiving dialysis and was not sure how come the nutritional supplement for dialysis residents was in the medication room. She further stated she expected for nurses to dispose of expired supplements, and she will institute an audit process to make sure there were no further occurrences of expired medications in the medications rooms. An interview was conducted with the Corporate Quality Assurance (QA) Nurse on 11/18/21 at 5:50 PM. She stated the medication rooms would be audited for expired supplements and a process to remove supplements which were going to expire would be put into place.	F 812	Quality Assurance On 12/27/2021 The Dietary Manager will monitor food storage weekly x 2 weeks then monthly x3 months using the Dietary QA Audit Tool. Monitoring will include auditing all resident rooms, and nourishment rooms in which food is stored. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Performance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Maintenance Director, Environmental Services Director, and the Dietary Manager	

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F 835	Continued From page 76	F 835		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to provide effective oversight to ensure there was sufficient housekeeping staff to provide a clean and sanitary interior for 5 of 6 hallways (100, 200, 300, 400 and 500 Halls). Findings included: This tag is cross referenced to: F584- Based on observation, record review, and staff interviews the facility failed to maintain clean walls on 4 of 4 hallways (Hallways 100, 200, 300, and 400), clean privacy curtains on 2 of 18 rooms (Rooms 209 and 214), clean resident bathrooms in 1 of 3 resident rooms (Room 507), functioning paper towel dispensers in 2 of 3 bathrooms (Rooms 507 and 514) and dusting of the over the bed lights in 3 of 3 resident rooms (Rooms 504, 507, and 514) reviewed for environment. The facility failed to maintain a clean environment for 5 of 6 hallways (Hallways 100, 200 300, 400 and 500). The Administrator was unavailable for interview during the survey. An interview was conducted with the Regional	F 835	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F835 Administration Corrective Action for Affected Residents On 11/15/2021, The Regional Director of Operations and Regional Nurse Consultant were able to secure additional housekeeping staffing from other company sites. In addition, internal departmental staff assisted housekeeping staff to provide effective oversight and ensure there was sufficient housekeeping staff to provide a clean and sanitary interior for 5 of 6 hallways throughout the dates of the survey (11/15/2021-11/19/2021). Corrective Action for Potentially Affected Residents	12/24/21

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F 835	Continued From page 77 Director of Operations on 11/18/2021 at 11:11 am and he stated the Housekeeping Manager resigned two weeks ago. The Regional Director of Operations indicated he did not know the schedule for the housekeeping staff followed to clean the halls, but they should be kept clean. The Regional Director of Operations stated the facility was actively recruiting for a Housekeeping Manager and housekeeping staff.	F 835	On 11/15/2021, The Regional Director of Operations and Regional Nurse Consultant were able to secure additional housekeeping staffing from other company sites. In addition, internal departmental staff assisted housekeeping staff to provide effective oversight and ensure there was sufficient housekeeping staff to provide a clean and sanitary interior for 5 of 6 hallways throughout the dates of the survey (11/15/2021-11/19/2021). Systemic Changes The Administrator was in serviced on 12/17/2021 by the President/Regional Director of Operations regarding the importance of providing effective departmental oversight to ensure there was sufficient housekeeping staff to provide a clean and sanitary interior for 5 of 6 hallways. Quality Assurance On 12/27/2021 The President/Regional Director of Operations, Clinical Nurse consultant and/or Regional Quality Assessment Nurse will review the housekeeping supervision and staffing schedule worksheet to ensure effective oversight and sufficient staffing, via in person or electronically, weekly for 4 weeks and monthly for 2 months to ensure the plan is updated and intact. The emergency preparedness plan will be brought to the Facility QA team meetings for review by the QA team. Any incidents of non-compliance will result in continued reviews.	
F 880 SS=F	Infection Prevention & Control	F 880		12/24/21

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F 880	Continued From page 78 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 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 79 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 review, staff interviews, facility policy review and the Centers for Disease Control (CDC) COVID-19 Tracker for Mecklenburg county transmission rate, the facility failed to immediately implement Transmission Based Precautions (TBP) for 2 of 2 COVID-19 positive residents (Resident #86 and Resident #31), failed to implement COVID-19 screening policy when 2 of 2 employees reported symptoms of COVID-19 (Receptionist #1 - chills, muscle and	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged	

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F 880	Continued From page 80 body aches, headache and sore throat, Nurse #1 - cough, muscle and body aches) were allowed to work and then tested positive for Covid -19 during their shift, failed to follow CDC guidance regarding appropriate Personal Protective Equipment (PPE) for counties of substantial to high county transmission rates when 3 of 3 staff members (Nurse #10, Nursing Assistant #2 (NA), Medication Technician #1) failed to wear eye protection when entering resident rooms (Resident #86, Room #401 and Resident #19); additionally 3 of 3 staff (NA #6, NA #4 and NA #9) failed to wear the appropriate PPE (gown, gloves and N-95 mask when entering Residents Rooms (Resident #31 & Resident #383) with Enhance Droplet Precautions (EDP), failed to utilize hand sanitizer or wash their hands when 2 of 2 staff (NA #8 and NA #9) were delivering meal trays for 18 of 18 residents (Resident #4, Resident #12, Resident #43, Resident #78, Resident #82, Resident #93, Resident #100, Resident #109, Resident #111, Resident #118, Resident #116, Resident #374, Resident #376, Resident #377, Resident #378, Resident #381,Resident #387 and Resident #383. These practices had the potential to affect all residents who receive care from the facility staff. This failure occurred during a COVID-19 pandemic. The findings included: A review of the CDC titled "Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) Antigen Testing in Long Term Care Facilities" updated January 7, 2021 indicated 'if an Antigen test is positive, perform confirmatory Nucleic acid amplifications tests (NAAT). Residents should be placed on TBD in a single room or, if single rooms are not available,	F 880	deficiencies cited have been or will be corrected by the date or dates indicated. F880 INFECTION CONTROL Corrective action for affected residents. For resident #31 and #86- On 11/16/2021 Enhanced Isolation precautions initiated to include signage on doors for affected resident and isolation cart with appropriate PPE placed outside room by Director of Nursing. For staff (receptionist #1 and nurse #1- On 11/8/2021 staff excluded from work upon identifying positive Covid-19 test result For NA#3 NA#4, NA#6, NA#9, Med Tech#1 and Nurse#10 on 11/17/2021, Director of Nursing provided staff with appropriate PPE For NA#6 and NA #8 On 11/17/2021 the Director of Nursing completed Education related to hand hygiene Corrective Action for Potentially Affected Residents. All current residents and staff have potential to be affected by deficient infection control practices. On 12/10/2021 the Infection Control licensed nurse completed Infection Control Rounds to determine if deficient practices noted related to hand hygiene, donning/doffing of appropriate PPE, placement of signage for resident on isolation precaution, and proper screening technique for staff. No deficient practices were identified. Systemic Changes On 12/15/2021, a root cause analysis was	

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F 880	Continued From page 81	F 880		

remain in their current room pending results of confirmatory testing. Confirmatory testing refers to as reverse transcriptase polymerase chain reaction (RT-PCR) test'.
A review of the vaccination status for staff and residents revealed 65% of staff were fully vaccinated and 88.4% of residents were fully vaccinated.

1. A record review revealed Resident #86 had a positive Antigen Covid-19 test on 11/16/21 at 1:49 PM. Resident #86 was fully vaccinated as well as Resident #86's roommate.

A record review revealed Resident #86 results of the positive RT-PCR test was returned on the morning of 11/17/21.

An observation on 11/16/21 at 2:48 PM of Resident #86 in room #110 B revealed Resident #86 was not placed on Enhanced Droplet Precautions and remained in her room with no sign on her door or PPE outside of room or on the door.

An observation on 11/17/21 at 9:13 AM and 10:00 AM of room 110 revealed Resident #86 had not been placed on Enhanced droplet precautions with no sign on her door or PPE outside of room or on the door.

An interview was completed on 11/17/21 at 9:53 AM with the Director of Nursing (DON) who stated that two residents one on the 100 hall and one on the 200 had a positive antigen test. The DON indicated that neither resident was symptomatic, and the facility was awaiting the RT-PCR test to come back.

completed for failure to perform hand hygiene, initiating Transmission based isolation precautions, utilizing proper PPE, and screening process by the Director of Nursing.

The root cause for failure to provide hand hygiene between the passes of trays was lack of staffing, lack of knowledge, and lack of supervision and monitoring.
The root cause found for lack of initiating isolation precaution was lack of knowledge and assigned responsibility related to initiating transmission based precautions for COVID-19 positive residents.
The root cause found for deficient practice related to screening process questions was lack of knowledge and understanding of the screening process and failure to identify those that did not pass the screening process.
The root cause analysis related the deficient practice of staff not utilizing personal protective equipment was due to lack of knowledge, lack of understanding, lack of staffing, perceptions of availability, lack of more comfortable options, lack of oversight and accountability.
On 12/13/2021 the Director of Nursing/Infection Control Nurse began education with all facility staff on hand hygiene, appropriate PPE, and pre-entrance screening process.
On 12/13/2021 the Director of Nursing /Infection Control nurse began education with all nurses on initiating isolation precautions.
On 12/15/2021 the Corporate Quality

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F 880	Continued From page 82 An interview on 11/17/21 at 10:02 AM with Nurse #8 who stated that "we found out today that Resident #86 had Covid-19" An observation and interview on 11/17/21 at 10:04 AM with Nursing Assistant #7 (NA) observed hanging an Enhanced droplet precautions sign on the door of room 110. NA #7 stated the Central Supply staff member had informed her 10 minutes ago to come and hang a sign on the door of room 110 and to get a cart with PPE supplies. An interview was completed on 11/17/21 at 10:13 AM with NA#1 who was asked if she was aware of any positive Covid-19 residents and replied that she was not aware of anyone today who had it but did know that Resident #86 had a pending RT-PCR test but did not know today that she had a confirmed test. An interview was completed on 11/17/21 at 10:14 AM with Nurse #9 who stated that lab results came back today that Resident #86 had a confirmed RT-PCR test. An interview was completed on 11/17/21 at 2:36 PM with the DON who stated that if a resident is positive with a rapid antigen test it was her expectation that EDP signs should have been put on the door with an Antigen positive test result. A telephone interview was completed on 11/17/21 at 7:21 PM with NA #2 who stated that she worked on 11/16/21 from 3-11 PM. NA #2 was asked if she was aware of any positive Covid-19 test on her hall and she stated that she was not aware of any positive Covid -19 tests. NA #2 was asked if she provided care to Resident #86 and	F 880	Assurance (QA) nurse consultant completed COVID policy education for the administrator and director of nursing which included hand hygiene, initiating isolation precautions, appropriate PPE, and screening policy based on Centers for disease control (CDC) guidelines. On 12/15/2021 the Director of Nursing/Management nurse team began skills validations of both hand hygiene and the screening process for all facility staff. Beginning on 12/20/2021 the Director of Nursing (DON) began skills validation for all staff on wearing appropriate PPE before entering transmission based precautions rooms. Beginning on 12/20/2021 the DON will begin skills validations for all nurse on initiating transmission based precautions. On 12/15/2021, the Director of Nursing/Assistant Director of Nursing began in person education using provided" you tube " videos: Preparing Nursing Homes and Assisted Living Facilities for Covid-19 , Clean Hands, Initiating isolation precautions, Appropriate PPE use, and Screening process. This education will be incorporated into new hire training for all staff. Education and skills validation for all facility Registered nurses, Licensed practical nurse, medication aides, nursing aides, nonclinical staff, department heads, therapy department, environmental services, maintenance and dietary staff	

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F 880	Continued From page 83 she stated she had provided care to Resident #86 and there were no signs on Resident #86's door for EDP. An interview was completed with the DON on 11/19/21 at 1:05 PM who stated that EDP should have been initiated at the time of a positive Antigen test, and PPE would be placed outside of the rooms or on the door for each room. "It was not done in this case as we were busy trying to get other rooms ready on the Covid hallway and it was a mistake amongst several staff". 2. A review of the policy titled "Covid-19 Testing Policy" revised 10/21/21 read in part, Healthcare Personnel who exhibit signs or symptoms should be tested within 24 hours of the onset of symptoms/signs. The employee should be excluded from work until results are obtained. On 11/18/21 a review of the screening from the electronic screening kiosk revealed Nurse #1 recorded Covid-19 symptoms of a cough, muscle, and body aches. Receptionist #1 recorded Covid-19 symptoms of a chills, Muscle or body aches, headache, and sore throat. Neither Nurse #1 nor Receptionist #1 had a fever. On 11/18/21 a review of Nurse #1's time stamped work hours for November 8, 2021 revealed Nurse #1 worked from 6:39 AM to 1:54 PM. A review of Receptionist #1's time stamped work hours revealed Receptionist #1 worked from 7:59 AM to 11:06AM. A review of Nurse #1 and Receptionist #1 Covid-19 tests revealed on November 8, 2021 during routine testing for unvaccinated staff, Nurse #1 and Receptionist #1 tested positive for	F 880	will be completed by 12/24/2021. Quality Assurance Beginning 12/27/2021 the Administrator, Director of Nursing or designee will observe and monitor hand hygiene during tray pass for 2 day shift and 2 evening shift 3 x a week to ensure that proper hand hygiene is occurring. This audit will be completed weekly x4 and then monthly x3. Beginning 12/27/2021, the Administrator, Director of Nursing or designee will observe and monitor isolation precautions using QA screening tool for Monitoring Isolation Precautions 5 x week to ensure Isolation Precautions initiated and utilization of proper PPE per facility policy and CDC guidelines. This audit will be completed weekly x 4 then monthly x 3. Beginning 12/27/2021, the Administrator, Director of Nursing or designee will observe and monitor screening using QA screening form 5 day shift and 5 evening shift 5 x a week to ensure that staff screening is occurring prior to entering patient care area. This audit will be completed weekly x4 and then monthly x3.QA Reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Infection Control Nurse, Minimum Data Set Registered Nurse, Environmental	

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F 880	Continued From page 84 Covid -19 and were sent home. An interview was completed with Nurse #1 on 11/17/21 at 8:37 PM who stated that she was tested on November 8, 2021 as part of her routine testing. She stated that she recorded on the electronic screening kiosk that she had a cough, but specified, it was more of a tickle in her throat, and reported muscle aches as she had been feeling a little run down over the weekend. Nurse #1 stated the way she had been feeling was not something she would have called out of work for. Nurse #1 stated that no one came and spoke with her about her symptoms prior to her starting her shift and she began working. Nurse #1 stated when the facility learned her Antigen test was positive, she was immediately sent home. An interview was completed with Receptionist #1 on 11/17/21 at 8:13 PM who stated that she was tested on November 8, 2021 as part of her routine testing. She stated that on 11/8/2021 she recorded on the electronic screening kiosk that she had nausea and a headache. Receptionist #1 stated no one had spoken to her regarding her symptoms prior to her starting her shift and she began working. She stated as soon as the Administrator learned of her positive Antigen test, she immediately locked the front door to stop all access of people coming in the front door and spoke to Receptionist #1 regarding her symptoms and inquired if she had been recently exposed to someone with Covid-19 and was sent home. An interview was completed with the DON on 11/18/21 at 2:31 PM who indicated when an employee enters symptoms on the electronic screening kiosk and alert goes to the	F 880	Services Director, Social Services Director, Dietary Manager, Health Information Manager, and Activities Director, Maintenance Director and Rehab Director.	

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Administrator and the DON which will state the employee (listing their name) attempted to check in and needs approval, and to please click on the hyperlink for more details. The Administrator or the DON would click on the hyperlink which would bring up the staff and the symptoms they recorded. The DON stated that we would call the employee and assess their symptoms, such as if they have been exposed to someone with Covid-19, when their last Covid-19 test was depending on the status of employee (if they were vaccinated or not or if we are testing due to an outbreak) and ask them about their symptoms. We can then approve or reject, have them tested and send them home if the test was positive. The DON stated she had not been getting the email alerts until the 9th of November and was not sure why. An observation of the DON's email alerts confirmed she had not gotten any emails on the 8th of November.

A phone call was then placed to the Administrator during the DON interview. The Administrator was asked if she had gotten an email alert for Receptionist #1 or Nurse #1. The Administrator checked her email alerts and stated that she did not get an alert for Receptionist #1 but did get an alert for Nurse #1. The Administrator stated that she did approve Nurse #1 to work without speaking to her as she had been cleared by her Physician to return to work. The Administrator stated reporting of symptoms alone is not an exclusion to keep someone from working and that it requires additional information. For Nurse #1 the Physician note was the additional information. A review of the return-to-work note indicated Nurse #1 was cleared to come back to work on 10/21/21.

An interview was completed with the DON on

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11/19/21 at 1:05 PM who stated that if staff record symptoms prior to their shift they should be contacted right away and review their symptoms with administration and get tested right away.

3. On 11/15/21,11/16/2021 and 11/17/21 the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker was reviewed. The CDC Covid-19 Data Tracker revealed that the county where the facility was located had a substantial to high level of community transmission for COVID-19.
CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated on 9/10/2021 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for Healthcare Personnel (HCP):
* If SARS- CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), Healthcare Personnel (HCP) working in facilities working in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.

An observation on 11/16/21 at 8:57 AM of Nurse #10 who was observed entering and administering medications to the Resident in room 401 without eye protection. An interview was completed with Nurse #10 revealed she thought her glasses were sufficient for eye protection.

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A telephone interview was completed on 11/17/21 at 7:21 PM with NA #2 who indicated she would not normally wear eye protection such as a face shield or goggles when in a resident's room and had not been told to wear eye protection unless there was a sign on the door for EDP.

An Interview was completed with the DON on 11/17/21 at 2:37 PM who sated "staff should wear eye protection or goggles during all patient care when in a resident's room".

4. Review of the Facility policy revised 03/2021 'Infection Prevention and Control Standards' stated in part... all employees will receive infection control training on appropriate technique for hand hygiene, when to use PPE and general infection control.

The Centers for Disease Control and Prevention (CDC) guidelines updated 01/2020 stated in part The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap immediately before touching a patient and after touching a patient or the patient's immediate environment.

The Centers for Disease Control and Prevention (CDC) guidelines updated 09/10/21 noted to ensure everyone is aware of recommended Infection Control Practices (IPC) in the facility, which included to post visual alert icons such as signs or posters at the entrance and in strategic places with instructions about current IPC recommendations.

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A walk through of the COVID-19 unit was done on 11/15/21 at 4:45 PM with the Director of Nursing (DON). There were no signs to indicate the Transmission-Based Precautions (TBP) on the zippered plastic wall entrances from either side. The DON stated they had put new walls up on Saturday 11/13/21 and the signs were on the plastic barriers, and she would ensure the signs were replaced. During the tour it was also noted that the TBP signs were not on the doors of residents' rooms that had tested positive for COVID-19 for Resident #119, #108 or #115.

The Maintenance Director was interviewed on 11/16/21 at 9:40 AM. He stated the plastic wall barriers for the COVID-19 unit went up initially on Friday 11/12/21. He said the signs were put on the plastic barriers, but when he came to work on Monday 11/15/21 at 9:30 AM, there were no signs posted.

An interview was done with the Director of Nursing on 11/17/21 at 2:36 PM regarding infection control. She noted the signs for TBP should be on the residents' doors or the entrances of the COVID-19 unit.

5. An observation was done on 11/15/21 at 1:06 PM of Nurse Aide (NA) #9 passing lunch trays on the 300 hall. NA #9 delivered the lunch trays to Residents #376 and #377. She then delivered the lunch tray and brought the partially eaten breakfast tray from Resident #377's room, placed it in the dietary cart and continued to deliver lunch trays to Resident # 378, Resident #374, Resident #116, Resident #381. NA #9 did not perform hand hygiene between the resident rooms. She

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then proceeded to go into Resident #383's room and deliver his lunch tray. Resident #383 was in Enhanced Droplet Precautions due to being a new admission that was not vaccinated for COVID-19. NA #9 had a surgical mask and eye protection on and did not wear gloves or a gown as she entered the room. She failed to perform hand hygiene upon exit from the room. She proceeded to take a lunch tray into Resident #387's room and did not perform hand hygiene upon exit.

An interview was conducted with NA #9 on 11/15/21 at 1:20 PM regarding hand hygiene. She stated usually she did not do hand hygiene when passing trays. She acknowledged that she had not put a gown, N-95 mask or gloves when entering Resident #383's room with the Enhanced Droplet Precautions. She stated she had worn all the required personal protective equipment (PPE) when she performed patient care for him but not when passing meal trays. She stated there were not enough gowns available in the room for that.

An observation was done of the PPE cart located inside Resident #383's room on 11/15/21 at 1:30 PM. There was a sleeve of N-95 masks which contained approximately 10 masks, a package of 5 gowns and the box of gloves was ½ full.

A follow-up interview was completed on 11/15/21 at 3:07 PM with NA #9 about the availability of PPE. She stated she had 15 residents on the hall by herself and she said most of the time there was not enough staff. She said the gowns were stocked in the cart but frequently they ran out. She said the supplies were locked and the nurse had the key.

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An additional interview was completed with NA #9 on 11/16/21 at 3:08 PM regarding hand hygiene. She noted she would use the alcohol based hand sanitizer (ABHS) sometimes, but only when her hands were sticky, not with each tray delivered to the room. She said it was too hard to do hand hygiene with each tray passed with being short staffed and in a hurry.

An interview was conducted with Support Nurse #1 and the DON on 11/17/21 at 2:36 PM, both who were responsible for Infection Control for the facility. The DON was asked about hand hygiene requirements and she stated it should be done going into every resident's room and coming out. She stated that a N-95 mask, gown and gloves should have been worn when entering the EDP isolation room.

6. On 11/15/2021, 11/16/2021 and 11/17/2021 the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker was reviewed and revealed the county where the facility was located had a substantial to high level of community transmission for COVID-19.

CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated on 9/10/2021 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for Healthcare Personnel (HCP):

If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptoms and exposure history), Healthcare Personnel (HCP) working in facilities working in counties

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with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including: Eye Protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.

During an observation on 11/17/2021 at 12:11 pm Medication Technician #1 entered Resident #19's room and started a nebulizer breathing treatment without goggles or a face shield on.

On 11/17/2021 at 12:22 pm Medication Technician #1 was interviewed and stated she did not wear goggles or a face shield because they hurt her face and she cannot see well with them on.

During an interview with the Director of Nursing on 11/18/2021 at 3:56 pm she stated that all staff should wear the correct personal protective equipment when providing patient care. The Director of Nursing stated the Medication Technician should have worn goggles or a face shield when providing direct patient care.

7. A review of the CDC titled "SARS-CoV-2 Antigen Testing in Long Term Care Facilities" updated January 7, 2021 indicated 'if an Antigen test is positive, perform confirmatory Nucleic acid amplifications tests (NAAT). Residents should be placed on TBD in a single room or, if single rooms are not available, remain in their current room pending results of confirmatory testing. Confirmatory testing refers to as reverse transcriptase polymerase chain reaction (RT-PCR) test'.
Resident #31's record review revealed she had a laboratory test on 11/16/2021 at 7:21 pm for a

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F 880	Continued From page 92 Positive SARS-CoV-2RNA PCR test. During an observation and interview on 11/17/2021 at 11:57 am resident room #211 had an enhanced droplet precautions sign on the door. An enhance droplet precautions sign had not been observed on the door to room #211 during observations made on 11/16/2021. Nurse Aide #6 was observed leaving room #211 without gloves or a gown. Nurse Aide #6 stated she had not seen the enhanced precautions sign on the door and no one had told her either resident in room #211 was on enhanced droplet precautions. Nurse Aide #6 stated she had been in the room before the observation also and had not donned a gown or gloves. On 11/17/2021 at 11:59 am an interview was conducted with Nurse #11 and she stated she was responsible for completing the rapid, Antigen COVID-19 tests on the residents. Nurse #11 stated she tested Resident #31, who resides in room #211, on 11/16/2021 at 2:53 pm and she was positive. Nurse #11 stated she immediately obtained a Polymerase Chain Reaction test (PCR) test for Resident #31, to confirm she was positive, and sent it to the laboratory. Nurse #11 stated she expected the results of the PCR test to be back from the laboratory today, 11/17/2021. Nurse #11 stated residents who have a positive rapid COVID-19 test are not quarantined until they move to the quarantine unit and they are not moved until the PCR test returns from the laboratory as a positive test. Nurse Aide #4 was observed on 11/17/2021 at 12:45 pm entering and leaving room #211 without donning a gown and gloves.	F 880		

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When interviewed on 11/17/2021 at 12:46 am Nurse Aide #4 stated no one had told her Resident #31, who resided in room #211, had a positive Antigen COVID-19 test on 11/16/2021 and she did not see the enhanced droplet precautions sign on the door. Nurse Aide #4 stated she would have worn a gown and gloves while in room #211 if someone had told her Resident #31 had a positive Antigen COVID-19 test or if she had seen the enhanced droplet precautions sign on the door.

During an interview with the Director of Nursing on 11/17/2021 at 2:37 pm and she stated the facility tested all residents 2 times a week using the Antigen COVID-19 test because the county positivity rate was 5.11 % and the facility had positive staff cases recently. The Director of Nursing stated Nurse #11 is responsible for obtaining the Antigen COVID-19 tests. The Director of Nursing indicated the facility obtains a PCR test if a resident or staff member has a positive Antigen COVID-19 test. The Director of Nursing stated the facility's policy was to wait until a positive PCR test before placing a resident on enhanced droplet precautions. She stated she usually has the staff place the enhanced droplet precautions sign on the resident's door after a resident has a positive Antigen COVID-19 test, although it is not the facility's policy, and she thought the staff placed a sign on room #211 door after Resident #31 had the positive Antigen COVID-19 test on 11/16/2021.

On 11/17/2021 at 8:01 pm an interview with Nurse Aide #3 was conducted and she stated on 11/16/2021 she worked from 5:00 pm until 11:00 pm on the 200-hall. Nurse Aide #3 stated there was not an enhanced droplet precautions sign on

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Resident #31's door and she had entered the room several times to pick up her dinner meal tray, bring her towels and put ice in her cooler. Nurse Aide #3 stated she had entered Resident #31's room without donning a gown and gloves because she was not made aware of Resident #31 having a positive Antigen COVID-19 test.

8. A continuous observation was conducted of meal service for the 500 hall on 11/15/21 at 12:47 PM through 1:33 PM. Nursing Assistant (NA) #8 was observed to open the meal cart and remove the meal tray for room 502 bed B. No hand hygiene was observed. NA #8 did not wear gloves while passing trays.

Nurse Aide #8 was observed to enter room 502 and began to set up the meal tray for bed B, Resident #4. Nurse Aide #6 rearranged personal items on the resident ' s over the bed tray, adjusted the resident ' s over the bed table to it would be positioned in front of the resident, and opened containers on the resident ' s meal tray. The NA left room 502. No hand hygiene was observed.

NA #8 was further observed to pass trays to rooms 503 (Resident #93), 505 (Resident #100), 507 (Resident #43), 510 (Resident #12 and Resident #111), 512 (Resident #109), 516 (Resident #82), and 514 (Resident #78 and Resident #118) on the 500 hall, pulling trays from the meal cart, going into resident's rooms, setting up meal trays, and then exiting the rooms to pass another meal tray. No hand hygiene was observed before or after passing the meal trays.

NA #8 was observed to don disposable gloves. She then removed the disposable gloves and

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washed her hands after assisting to pull up a resident who was in bed in room 604. No other hand hygiene or glove application was observed during the meal service by NA #8.

During an interview conducted on 11/15/21 at 1:33PM with NA #8 she stated she had not washed her hands, nor used hand sanitizer, during the entire time she had been passing lunch trays up until the point she had washed her hands after assisting with positioning the resident in bed in room 604. She stated she had touched resident personal items in their rooms, such as over the bed tables, controls to raise the head of the bed up and down, and other personal items on their over their over the bed tray, along with items on the residents ' meal trays. The NA stated she should have used hand sanitizer in between delivering, assisting, and setting up each resident for their meal tray.

An interview on 11/18/21 at 5:42 PM with the Director of Nursing (DON) revealed staff should be washing their hands or using alcohol-based hand sanitizer or washing their hands between passing each tray for residents during meal pass.

An interview on 11/18/21 at 5:50 PM with the Regional Director of Operation revealed the employee should have either washed their hands or used hand sanitizer between each meal tray and he expected staff would complete hand hygiene between residents when passing out meal trays.