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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 12/20/21 through 12/22/21. Three (3) of the thirty-seven (37) allegations were substantiated. Event ID# WS6V11.	F 000		
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. This REQUIREMENT is not met as evidenced by:	F 561		1/21/22

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

Electronically Signed | 01/19/2022

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F 561	Continued From page 1 Based on observations, record review, resident and staff interview the facility failed to honor a resident's preference for showers for 3 of 8 residents reviewed for activities of daily living (Resident #1, Resident #3, and Resident #4). The findings included: 1. Resident #1 was admitted to the facility on 10/20/21 with diagnoses that included: orthopedic aftercare, acute respiratory failure, and chronic kidney disease stage 4. There was a 5-day Minimum Data Set (MDS) dated 11/16/21 that revealed that Resident #1 was cognitively intact and required extensive assistance with bathing. Review of Resident #1's active care plans revealed no care plan for activities of daily living including bathing/showers. Review of a hard copy preference sheet with no date noted indicated that Resident #1 preferred a shower two times a week on Monday and Friday on second shift. Review of a hard copy of the current shower schedule with no date noted indicated that Resident #1 was scheduled to receive a shower two times a week on Monday and Friday on second shift. Review of a hard copy document titled "Documentation Survey Report" for December 2021 revealed that Resident #1 had received no showers for the month of December 2021. An interview and observation were conducted	F 561	1. Administrator initiated facility-wide audit on 12.20.2021 of current resident to evaluate shower preference and plan of care updated accordingly by the MDS Coordinator for Resident #1, #3 and #4. Identified residents have since discharged from the facility. 2. On 12.20.2021, the designated nursing staff completed interviews with current facility residents and/or resident representative to obtain bathing preferences. Bathing preferences for type (shower, bed bath) and frequency were added to master resident bathing schedule, task list and Kardex accordingly. 3. Education provided to current facility and agency licensed nurses and nurse aides by DON or SDC on 1.18.2022 thru 1.20.2022. Education is ongoing for newly hired facility and agency licensed nurses and nurse aides and will be a part of the orientation. The licensed nurse will be responsible for obtaining resident bathing preferences upon admission and with changes in resident condition or preference. The DON or nurse designee will update the master bathing schedule, resident task list and kardex accordingly. The nurse supervisor will monitor the master bathing schedule against electronic POC care records to ensure resident preference is being honored. Ambassador rounds have also been implemented five times weekly and will be conducted by department heads. Rounds are designed to monitor for resident	

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F 561	Continued From page 2 with Resident #1 on 12/20/21 at 9:18 AM. Resident #1 was resting in bed drinking her coffee. She stated that after she came to the facility the staff came around and asked her about how and when she wanted her showers. She stated that she had stated 2 showers a week was fine with her, but she preferred them in the evening before bed as that helped her sleep. Resident #1 stated that she had been in the facility approximately 5 weeks and has not had a shower since she had been in the facility and she felt "very grungy." Resident #1's hair appeared to be very shiny almost wet. Review of the daily assignment sheets revealed the following: 12/03/21 and 12/06/21 Nurse Aide (NA) #1 was taking care of Resident #1. 12/13/21 Temporary Aide (TA) #1 was taking care of Resident #1. 12/17/21 NA #3 was taking care of Resident #1. TA #1 was interviewed on 12/20/21 at 1:15 PM. TA #1 stated that he had worked at the facility since 12/02/21 and stated he was still in orientation which meant he worked with another staff member. TA #1 explained the last few days he was allowed to work by himself with someone overseeing the task he completed. TA #1 stated that the facility had a shower schedule and the schedule told him which residents were to be bathed. TA #1 stated he did not do showers because he was male and of most of the residents were female. TA #1 confirmed that he was assigned to care for female residents including Resident #1 but did not shower them because he was male. An attempt to speak to NA #1 was made on 12/20/21 at 1:26 PM without success.	F 561	bathing preferences. Any requested changes will be communicated to the licensed nurse and to the IDT during morning meeting. 4. The DON or nurse supervisor will monitor five (5) residents for bathing preferences per Ambassador rounds, Master Bathing Schedule, task list and Kardex review. Audits will be completed five (5) times weekly for 4 weeks, then two (2) times weekly for 8 weeks, then randomly thereafter. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with resident bath preferences. 5. Date of Compliance: 1.21.2022	

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An attempt to speak to NA #2 was made on 12/20/21 at 3:34 PM without success.

Shower Aide (SA) #1 and #2 were interviewed together on 12/20/21 at 1:37 PM. SA #1 stated that they had a shower book in each shower room that told them which showers were due on which days. She stated that the shower team completed showers for all 3 shifts if there was a shower team assigned. SA #1 stated that the shower schedule had not been updated in a while and there were residents that were discharged that were still on the schedule and some of the newer residents were not on the schedule. SA #1 and SA #2 both confirmed that prior to 12/20/21 they had never showered Resident #1 but could not say why they had not showered her. SA #2 stated that at times there was no shower team and the nurse aides on the hall would be responsible for completing the showers but if there was a shower team then they were responsible for completing the showers for all 3 shifts.

The Director of Nursing (DON) was interviewed via phone on 12/20/21 at 4:26 PM. The DON stated she had only been at the facility for approximately one month. When she arrived at the facility the Unit Manager (UM) oversaw the shower schedule, but the UM quit on 12/10/21. She indicated the facility had been attempting to work on getting the shower schedule updated and implemented. The DON stated that she expected showers to be given as the resident preferred and she knew that they had to continue to work on the process to get it where she wanted it to be.

The Administrator was interviewed on 12/20/21 at

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5:26 PM. The Administrator stated she had only been at the facility for one full week. She stated that she knew there was work to be done but expected preferences to be obtained and honored. The Administrator stated that she was going to initiate ambassador rounds (rounds completed by management staff to check on the residents daily) to ensure that each resident received the shower/bath of their choice and immediately address any issues at the time they occurred.

2. Resident #4 was admitted to the facility on 11/12/21 with diagnosis that included fracture of right ankle.

The admission Minimum Data Set (MDS) assessment dated 11/18/21 revealed Resident #4 was cognitively intact and required physical help limited to transfers only for bathing and one-person physical assist. The MDS also indicated the Resident was frequently incontinent of urine and had a colostomy.

Resident #4's care plan dated 11/15/21 revealed the Resident had a self-care performance deficit related to a fracture of her right ankle. The goal to maintain her current level of function in mobility and transfers would be attained by encouraging her to use the call light and to participate in skilled therapies.

A review of an undated typed hard copy shower preference sheet indicated Resident #4 preferred her showers on Friday and Sunday on third shift.

A review of a hard copy document titled "Documentation Survey Report" for December 2021 indicated Resident #4 received no showers for the month of December 2021.

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A review of Resident #4's medical record revealed there had been no documented refusals of showers since admission on 11/12/21.

An interview and observation were made of Resident #4 on 12/20/21 at 10:20 AM. The Resident was lying in bed and stated she had recently finished her breakfast and was waiting for her therapy session. Resident #4 explained that she was despondent and did not know what to do about it because after she was admitted to the facility someone asked her how many showers, she wanted a week what time of day she preferred to receive them. The Resident stated she told the person that twice a week was fine with her and the time of day did not matter to her as long as she received her showers. The Resident continued to explain that she had been in the facility for over 5 weeks and had yet to receive one shower or even have her hair washed. While fingering through her dry hair the Resident stated, "if that don't make you feel nasty and sticky then I don't know what would." Resident #4's hair was dry and stiff and stuck to her head. The Resident continued to explain that she had wipes to wipe herself off with but that was not like having a good shower.

On 12/20/21 at 2:35 PM a second interview was conducted with Resident #4. During the interview the Resident explained that she had never been informed that she was scheduled for showers on Fridays and Sundays on third shift. The Resident stated she would not have settled for Fridays and Sundays because they were only two days apart, but she would have agreed with getting her showers on third shift because she was a night owl.

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On 12/20/21 at 1:35 PM Shower Aide (SA) #1 and SA #2 were interviewed together. The SAs explained that they had a preferred shower list which was kept in a notebook in the shower room that they went by that told them which resident showers were due on certain days. They stated if there was a shower team scheduled for that day, they would complete the showers due for all three shifts and if there was not a shower team scheduled for the day then the aides on the hall were responsible for giving the showers for all three shifts. SA #1 stated that the shower schedule had not been updated in a while because there were residents who had been discharged that were still listed on the schedule. Both SAs confirmed they had never given Resident #4 a shower.

On 12/20/21 at 2:20 PM an interview was conducted with Nurse Aide (NA) #5. The NA explained that Resident #4 was alert and oriented and could voice her needs. The NA confirmed that she worked with Resident #4 on Sunday 12/05/21 and explained that the shower team was responsible for providing showers when a team was available. The NA stated that she could not explain why Resident #4 did not received a shower that day and reported she has never given the Resident a shower.

During an interview with Nurse Aide (NA) #14 on 12/20/21 at 3:30 PM she explained that the first time worked with Resident #4 was on Friday 12/17/21 and found the Resident to be alert and oriented. The NA explained that the shower team was responsible for providing showers when one was available but could not provide a reason for why Resident #4 did not receive a shower on

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12/17/21. The NA confirmed that she did not give the Resident a shower that day.

An interview was conducted with Nurse Aide (NA) #3 on 12/20/21 at 3:45 PM. The NA confirmed she worked with Resident #4 on Friday 12/03/21 and Friday 12/10/21 but had never given the Resident a shower. The NA explained that she worked with Resident #4 while the Resident was in the COVID unit and the facility did not allow showers to be given on the COVID unit.

An interview was conducted with Nurse Aide (NA) #2 at 5:20 PM on 12/20/21. The NA confirmed working with Resident #4 on Friday 12/17/21 on third shift. The NA explained that he had never given Resident #4 a shower because they do not give showers during the night and that they only gave showers from 7:00 AM to 7:00 PM.

During an interview with Nurse Aide (NA) #12 on 12/21/21 at 9:35 AM she confirmed that she worked with Resident #4 on Sunday 12/12/21 on third shift. The NA explained that she had never given Resident #4 a shower because the facility did not provide showers to the residents who resided on the COVID unit.

An interview was conducted with Nurse Aide (NA) #7 on 12/21/21 at 10:25 AM. Informed the NA that she was assigned to work with Resident #4 on Friday 12/03/21 and Friday 12/10/21. The NA explained that she did not remember Resident #4 therefore, she could not remember if she had given the Resident a shower.

On 12/21/21 at 11:05 AM an interview was conducted with Medication Aide (MA) #1 who also worked as a Nurse Aide. The NA was assigned to

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complete showers on Friday 12/17/21 and Sunday 12/19/21. The NA explained she remembered offering Resident #4 a shower one day and the Resident refused. The NA stated when the residents refused showers, they were supposed to report the refusals to the Nurse so they could document the refusal in the residents' medical record. The NA stated she has never given Resident #4 a shower.

An interview was conducted with Nurse Aide (NA) #11 on 12/21/21 at 12:10 PM. The NA who worked with Resident #4 on Friday 12/10/21 explained the facility did not give showers on third shift therefore she did not give Resident #4 a shower.

During an interview with Nurse Aide (NA) #10 on 12/21/21 at 3:15 PM she was reminded that she worked with Resident #4 on Sunday 12/05/21 and Sunday 12/19/21. The NA explained that the shower team would have showered the Resident if they were available. The NA continued to explain that she was never assigned to the shower team and therefore had never given Resident #4 a shower.

An interview was conducted with Nurse Aide (NA) #4 on 12/21/21 at 3:20 PM. The NA confirmed she worked with Resident #4 on Sunday 12/19/21 and stated she did not give the Resident a shower because there was a shower team scheduled to give showers. The NA stated she did not know if Resident #4 received a shower that day.

During an interview with Nurse Aide (NA) #17 on 12/21/21 at 4:40 PM she confirmed she worked with Resident #4 on Sunday 12/19/21 but did not

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give the Resident a shower because the shower team would have given the showers if a shower team was scheduled.

An interview was conducted with Nurse Aide (NA) #15 on 12/22/21 at 8:00 AM. The NA confirmed she was assigned to give showers on Sunday 12/19/21 but stated that did not mean she was able to give all the showers that were due. The NA stated she had never given Resident #4 a shower.

During an interview with Nurse Aide (NA) #13 on 12/22/21 at 8:45 AM she confirmed she had worked with Resident #4 on Sunday 12/12/21, Friday 12/17/21 and Sunday 12/19/21 but explained that since she was agency staff the facility did not allow them to shower the residents. The NA stated she has never given Resident #4 a shower.

An interview was conducted with Temporary Aide (TA) #1 on 12/22/21 at 11:00 AM who confirmed he worked with Resident #4 on Sunday 12/19/21. The TA explained he had only been employed for 3 weeks and had never given Resident #4 a shower. The TA stated if a shower team was available, they were responsible for providing the showers.

Numerous attempts were made to interview Nurse Aides #9 and #16 but the attempts were unsuccessful.

The Director of Nursing (DON) was interviewed via phone on 12/20/21 at 4:26 PM. The DON explained she had only been at the facility for approximately one month. When she arrived at the facility the Unit Manager (UM) oversaw the

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shower schedule, but the UM quit on 12/10/21. She indicated the facility had been attempting to work on getting the shower schedule updated and implemented. The DON stated that she expected showers to be given as the resident preferred and she knew that they had to continue to work on the process to get it where she wanted it to be.

The Administrator was interviewed on 12/20/21 at 5:26 PM. The Administrator stated she had only been at the facility for one full week. She stated that she knew there was work to be done but expected preferences to be obtained and honored. The Administrator stated that she was going to initiate ambassador rounds (rounds completed by management staff to check on the residents daily) to ensure that each resident received the shower/bath of their choice and immediately address any issues at the time they occurred.

3. Resident #3 was admitted to the facility on 1/6/2021 with diagnoses of heart failure and chronic obstructive pulmonary disease. Resident #3 was not present in the facility at the time of survey.

The quarterly Minimum Data Set dated 9/29/20221 revealed he was cognitively intact for daily decision making. He required limited assistance of 1 person for personal hygiene and extensive assistance of 1 person for bathing.

Review of Resident #3's admission preference sheet (no date included) revealed his preference for showers on 1st shift on Wednesday, Friday, and Sunday. He was to receive a bed bath on all other days.

Review of Resident #3's care plan revealed a

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focused care plan dated 11/1/2021 for activities of daily living (ADL) self-care performance deficit. Interventions included: encourage resident to participate to the fullest extent possible with each interaction; extensive assist by 1 staff with personal hygiene and oral care; use short, simple instructions such as hold your washcloth in your hand, put soap on your washcloth, wash your face, to promote independence; provide sponge bath when a full bath or shower cannot be tolerated; check nail length, trim and clean on bath day and as necessary; report any changes to the nurse; and avoid scrubbing and pat dry sensitive skin.

Review of Resident #3's November 2021 shower log revealed showers were not documented as given for Resident #3 on 11/5/2021 through 11/9/2021, 11/13/2021, 11/18/2021, 11/19/2021, 11/22/2021, 11/24/2021, and 11/26/2021 through 11/30/2021. The log disclosed no documentation for 11/6/2021, 11/8/2021, 11/19/2021, 11/29/2021 and 11/30/2021.

Interview with Nurse Aide (NA) #5 on 12/20/2021 at 2:28 PM revealed she had worked at the facility since the third week of November 2021. Review of staff assignments indicated NA #5 was assigned to Resident #3 on 11/27/2021. NA #5 stated she was familiar with Resident #3 and recalled he did not refuse care. NA #5 disclosed Resident #3 wanted to be as independent as possible and would insist on completing as much of his bath as he was able. NA #5 could not provide an explanation for the documentation that bathing did not occur for Resident #3 on 11/27/2021.

Interview with NA #4 on 12/22/2021 at 3:20 PM

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revealed she was familiar with Resident #3 and was assigned to his care on 11/7/2021 and 11/28/2021. NA #4 indicated the resident preferred to complete all he could on his own with his bathing, but he was not capable of completing the process alone. NA #4 disclosed she did not recall why she documented a shower or bed bath did not occur for Resident #3 on 11/7/2021 and 11/28/2021.

Attempts to interview NA #6 and Medication Aide #1 (who also worked as a NA), and NA #18 were unsuccessful. NA # 6 was assigned to Resident #3 on 11/13/2021. A shower or bed bath was documented as did not occur for 11/13/2021. Medication Aide #1 was assigned to Resident #3 on 11/9/2021 and 11/24/2021. A shower or bed bath was documented as did not occur for Resident #3 for 11/9/2021 and 11/24/2021. NA #18 was assigned to care for Resident #3 on 11/5/2021, 11/18/2021, 11/22/2021 and 11/26/2021. Documentation showed activity did not occur for Resident #3 on 11/5/2021, 11/18/2021, 11/22/2021 and 11/26/2021.

A joint interview with Shower Aide (SA) #1 and #2 on 12/20/2021 at 1:37 PM revealed they were familiar with Resident #3. Both SA #1 and SA #2 could not explain why Resident #3 had documented missed showers and bed baths in November. The SAs stated a shower schedule was in each shower room which listed residents scheduled for a shower on each day. Review of the shower schedule with the SAs revealed the list had not been updated and included names of residents no longer in the facility. Resident #3 was not on the shower schedule. The SAs did not know who was responsible for maintaining the shower schedule or updating it when residents

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F 561	Continued From page 13 were admitted or discharged. The SAs indicated when no shower team was available, Nurse Aides (NA) on the hall were responsible for completing showers. Telephone interview with the Director of Nursing (DON) on 11/20/2021 at 4:26 PM revealed she had been the DON for less than a month. The DON indicated the current shower schedule put in place by prior leadership was to be maintained by the Unit Manager (UM) and audited by the Social Worker (SW). The UM quit on 12/10/2021 and the SW quit on 12/17/2021. The DON stated her expectation of showers was for every resident to receive showers according to their preferences. The DON verbalized the shower schedule was a work in progress. Interview with the Administrator revealed she had been employed at the facility for 6 business days. She was aware showers had been missed in the facility and she had started a performance improvement plan to address it. The Administrator stated a separate shower team had been initiated for the COVID unit to ensure those residents received showers per their preference. The Administrator revealed she planned to initiate an ambassador program to help ensure residents received showers per their preference and help address issues as they arose. The Administrator indicated she would expect shower preferences be obtained on admission and maintained by a clinical team member going forward.	F 561		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		1/21/22

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F 655	Continued From page 14 §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). §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.	F 655		

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F 655	Continued From page 15 (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 interview the facility failed to develop and implement a baseline care plan that addressed the resident's activities of daily living for 1 of 8 residents reviewed for activities of daily living (Resident #1). The findings included: Resident #1 was admitted to the facility on 10/20/21 and recently readmitted on 11/23/21 with diagnoses that included: orthopedic aftercare following amputation, acute respiratory failure, chronic kidney disease and others. Review of a Baseline Care plan document dated 10/20/21 read in part, Functional Status: eating required set up help only. Personal hygiene, toilet use, dressing, bathing, bed mobility, transfer, walking and locomotion all indicated "not assessed." The functional status part of the baseline care plan was completed by Nurse #1. The former Director of Nursing (DON) had signed and indicated she had reviewed the care plan. Review of a 5-day Minimum Data Set (MDS) dated 11/16/21 indicated Resident #1 was cognitively intact for daily decision making and required extensive assistance with bed mobility, dressing, toilet use, and bathing. Nurse #1 was interviewed via phone on 12/21/21 at 8:43 AM. Nurse #1 stated that she only worked at the facility a few hours a couple of nights a week. During her time in the facility, she assisted	F 655	1. On 12.29.21, the Baseline Care Plan was reviewed by the IDT for Resident #1 on 12.29.2021. No edits made due to the resident being deceased. 2. On 12.29.21 residents admitted from 12.28.21 □ 1.15.22 were reviewed by the Nurse Leadership to ensure baseline care plans have been completed to include information necessary to care for residents. At this time baseline care plans have been updated as appropriate. 3. Education to be completed by 1.20.2022. Educator will be the DON and nurse manager. Target audience will be current licensed nurses and IDT members. Education will include on completion of the baseline care plan within 48 hours for all resident admissions and will include information necessary to deliver resident care. Information includes but, is not limited to initial goals of the resident, current medications, dietary orders, and any treatments or services necessary to meet resident care needs. Education will be ongoing for new hires, agency, and IDT members. The licensed nurse will be responsible for initiating the Baseline Care Plan within 48 hours of admission and the nurse leadership team will review and revise for completeness and accuracy during morning clinical meeting.	

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with admissions as needed. She stated that the Admission packet included lots of assessments and included baseline care plans. Nurse #1 stated she did not recall Resident #1 but stated the baseline care plan was a simple form to fill out. You just had to answer a series of questions on a form and by answering those questions the baseline care plan was initiated. Nurse #1 stated that when she selected "not assessed" for most of Resident #1's activities of daily living it indicated that she had not completed the skill with the resident. She added that the DON or Unit Manager would generally come back to the baseline care plan and fill in any information not captured on the initial completion of the baseline care plan.

An attempt to speak to the former DON was made on 12/21/21 at 9:03 AM without success.

MDS Nurse #1 was interviewed on 12/21/21 at 9:05 AM. She stated that the nursing staff started the baseline care plan immediately when the resident admitted to the facility. She stated she was not directly involved with the completion of the baseline care plan but indicated the baseline care plan should include activity of daily living information, so the staff knew how to care for the new admission.

The DON was interviewed on 12/21/21 at 11:15 AM. The DON stated that she had only been at the facility for approximately a month. She stated that she could not speak to the facility's policy but stated baseline care plans should include the amount of assistance required for all activities of daily living for all new admissions, to ensure that resident care could be provided until the comprehensive care plan could be completed.

4. The DON or nurse designee will complete monitoring of new admissions for baseline care plan completeness within 48 hours. Audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 8 weeks, then randomly thereafter. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with baseline care plans.

5. Date of Compliance: 1.21.2022

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F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed demonstrate Medication Aide (MA)competency when MA #1 was observed dispensing medications from the unit dose packages and bottles into her hand for	F 726	1. Identified medication aide completed a medication aide competency and was reeducated by DON on proper medication administration on 1.12.2022.	1/21/22

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F 726	Continued From page 18 3 of 3 residents observed during medication pass (Residents #5, #6 and #7). The finding included: 1.a. Resident #5 was admitted to the facility on 09/05/20. On 12/20/21 at 9:25 AM a continuous observation was made of Medication Aide (MA) #1 preparing and administering medication to Resident #5. The MA was observed to remove a total of 10 different medications from both bubble pack cards and bottle dispensing systems and place the medications into her ungloved hand before putting the medications into the medicine cup sitting on top of the medication cart. In between each medication the MA dispensed into her ungloved hand, the MA touched the mouse to electronically navigate to each individual medication order from the medication administrator record. The MA used hand sanitizer after she had given the medications to Resident #5 when she returned to the medication cart. b. Resident #6 was admitted to the facility on 12/24/16. On 12/20/21 at 9:35 AM a continuous observation was made of Medication Aide (MA) #1 preparing and administering medication to Resident #6. The MA was observed to remove a total of 5 different medications from both bubble pack cards and bottle dispensing systems and place the medications into her ungloved hand before putting the medications into the medicine cup sitting on top of the medication cart. In between each medication the MA dispensed into her ungloved hand, the MA touched the mouse to	F 726	2. The staff development coordinator (SDC) or nurse manager will complete observational audits with current facility medication aides by 1.20.2022 to validate medication administration competency and practices as appropriate. 3. Education on Medication Administration will be completed with current facility and agency licensed nurses and medication aides by 1.21.2022. The facility does not employ agency medication aides. Education will be ongoing for all newly hired licensed nurses, medication aides, and for agency licensed nurses. The SDC be responsible for completing competencies for Medication Administration for facility licensed nurses and medication aides upon hire, annually and as needed to maintain proper medication administration practices. 4. Staff Development Coordinator (SDC) or nurse designee will be responsible for conducting observational audits for 2 Medication Aides or licensed nurses 5 times weekly for 4 weeks, then twice weekly for 8 weeks and randomly thereafter. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with medication administration practices. 5. Date of Compliance: 1.21.2022	

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electronically navigate to each individual medication order from the medication administrator record. The MA used hand sanitizer after she had given the medications to Resident #6 when she returned to the medication cart.

c. Resident #7 was admitted to the facility on 10/29/20.

On 12/20/21 at 9:45 AM a continuous observation was made of Medication Aide (MA) #1 preparing and administering medication to Resident #7. The MA was observed to remove a total of 9 different medications from both bubble pack cards and bottle dispensing systems and place the medications into her ungloved hand before putting the medications into the medicine cup sitting on top of the medication cart. The MA also reached into the drawer of the medication cart and rummaged through various types of medications to locate Resident #7's inhaler and placed the inhaler on the top of the medication cart. In between each medication the MA dispensed into her ungloved hand, the MA touched the mouse to electronically navigate to each individual medication order from the medication administrator record. The MA used hand sanitizer after she had given the medications to Resident #7 when she returned to the medication cart.

An interview was conducted with Medication Aide (MA) #1 on 12/20/21 at 9:55 AM. The MA explained that she was taught to dispense the medications in her hands before she put the medication into the medicine cup. She continued to explain that she did not like to pop the medication directly into the medication cup because the medications tended to bounce out of

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F 726	Continued From page 20 the cup. The MA stated that she had been observed for medication pass procedures by the facility Director of Nursing as recent as the summer (2021) and performed the medication pass procedure the same way and was not corrected. An interview with Nurse #2 on 12/20/21 at 10:00 AM revealed she had observed MA #1 dispensing the medications from the source into her hands a couple of times and reminded her that she should dispense them directly into the medication cup. The Nurse explained that dispensing the medication into a medicine cup was basic procedure for passing medications. During an interview with the former Director of Nursing (DON) on 12/20/21 at 4:45 PM she explained that she conducted a medication administration pass with MA #1 back in the summer (2021) and observed the MA to dispense the medications in her bare hands. The DON stated she corrected the MA to dispense the medications directly into the medicine cup as per the facility's proper procedure. An interview was conducted with the Administrator on 12/20/21 at 5:25 PM. The Administrator stated her expectation was that the Medication Aide and all the staff who administer medications perform the procedure the way the facility's medication administration policy directed.	F 726		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		1/21/22

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

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F 842	Continued From page 22 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain a complete and accurate medical record by failing to document a resident's return from the emergency room and failed to document the resident's death for 1 of 3 (Resident #2) residents reviewed for professional standards. The findings included: a. Resident #2 was admitted to the facility on 07/01/11 and most recently readmitted on 10/07/21. Review of a nurse's note dated 10/23/21 at 5:55	F 842	1. Resident #2 expired and corrective action is not applicable. 2. The DON and nurse manager are to review transfers and discharges for previous 30 days from 12.16.21 thru 1.15.22 to identify any trends in documentation. Updates and revisions made as appropriate and applicable to reflect residents complete medical record. This is to be completed by 1.17.22. 3. By 1.20.22, the DON and nurse manager completed education with current facility and agency licensed	

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F 842	Continued From page 23 PM read in part, Resident #2 was voicing complaints of chest pain and shortness of breath. Nitroglycerin (used to treat chest pain) was given times three with negative results. Ativan (used to treat anxiety) was given with negative results. Resident #2 was requesting to be send to the Emergency Room (ER). Vital signs: 169/83, 97.1, 78, 20 and 91%. On call notified and order was given to send Resident #2 to the ER for evaluation. The nurse's note was signed by Nurse #2. Review of an aftercare summary dated 10/23/21 from the local ER read in part, the plan was to discharge with patient continue current medications. He says he feels better and more relaxed currently. The summary was electronically signed by the ER physician. Review of Resident #2's medial record at the facility revealed no further documentation since the nursing note dated 10/23/21 when Resident #2 was sent to the ER. b. Review of Death Tracking Record MDS dated 10/30/21 indicated that Resident #2 had expired in the facility. Nurse #2 was interviewed on 12/20/21 at 2:25 PM and confirmed that she was working on 10/23/21 when Resident #2 complained of chest pain and shortness of breath and was sent to the ER. Nurse #2 stated that Resident #2 had not returned to the facility before the end of her shift and was not sure when he did return to the facility. Nurse #2 also stated that Resident #2 died in the facility about a week later, but she was not working when he passed away. She added that it should be documented in his chart when he	F 842	nurses on the documentation requirements for resident transfers and discharges. Newly hired facility and agency licensed nurses will receive education during orientation. The licensed nurse will be responsible for completing documentation of all resident transfers and discharges. The DON and clinical team will review resident medical record for documentation completeness and accuracy for resident transfers and discharges (planned or unplanned) during daily clinical meeting. 4. Resident medical records for transfers and discharges will be monitored for completeness and accuracy by the DON or nurse supervisor 5 times a week for 4 weeks then, 2 times a week for 8 weeks. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with resident medical records. 5. Date of compliance: 1.21.22	

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F 842	Continued From page 24	F 842		

returned from the ER and when he passed away.

Nurse #3 was interviewed on 12/20/21 at 3:41 PM. Nurse #3 confirmed that she worked the night shift on 10/23/21 when Resident #2 was sent to the ER. She confirmed that when she reported for her shift at 7:00 PM Resident #2 was not in the facility but could not recall if he returned later in the shift or not.

An attempt to speak to Nurse #4 on 12/20/21 at 3:45 PM but was unsuccessful. Nurse #4 was scheduled to work on 10/24/21 from 7:00 AM to 11:00 PM.

An attempt to speak to Nurse #5 on 12/20/21 at 3:47 but was unsuccessful. Nurse #5 was scheduled to work on 10/24/21 11:00 PM to 7:00 AM.

Nurse #6 was interviewed on 12/20/21 at 4:02 PM. Nurse #6 confirmed that she was working on 10/30/21 when Resident #2 passed away. She stated she was working a double shift 3:00 PM to 11:00 PM and then from 11:00 PM to 7:00 AM. Nurse #6 stated at approximately 12:55 AM NA #19 came and reported that it did not look like Resident #2 was breathing, so she rushed to his room and confirmed that he had passed away. She stated that his skin was warm, but he had no heart sounds or pulse. She went on to say that after she confirmed Resident #2 had expired, she notified the family and filled out the appropriate form. She stated that she was an agency nurse and was not sure which form to fill out, so she asked another agency nurse and together they found the appropriate form an filled it out to give to the funeral home when they arrived to pick up Resident #2. Nurse #6 confirmed that she did not

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	345133	A. BUILDING _____ B. WING _____	C 12/22/2021

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F 842	Continued From page 25 document the events in Resident #2's medical record because she thought that the charge nurse would do that, and she was not aware that she should make a nurse note. The former Director of Nursing (DON) was interviewed on 12/20/21 at 4:21 PM. The former DON stated that when a resident passed away there was a progress note to be written and a release form that was filled out and given to the funeral home. The former DON confirmed that she was aware that there was no documentation in Resident #2's medical record and stated she had asked the staff multiple times to go back, and document and they did not do it. She added she was not in the facility at the time of his death so she could not document the event. The current DON was interviewed on 12/21/21 at 11:15 AM. The DON stated that she had only been at the facility for a month and was not familiar with Resident #2. She stated that anytime a resident passed away there should be a change in condition documented and a progress note completed in addition to the release form that was given to the funeral home.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		1/21/22

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

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

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

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F 880	Continued From page 27 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, staff interviews and record reviews, the facility failed to follow infection control policies when a personal care aide (PCA #1) failed to doff personal protective equipment (PPE) and perform hand hygiene when she exited a resident room labeled Enhanced Droplet Contact Precautions (EDCP) after providing nailcare. The facility failed to ensure required PPE was donned when two nurse aides (Shower Aide #1 and Shower Aide #2) performed a shower for a resident who was under EDCP and a medication aide (MA #1) administered medication to a resident on EDCP. These observations were made for 4 of 4 staff observed for infection control practices. Findings included: A review of the facility's Personal Protective Equipment policy dated 11/1/20 indicated PPE included the use of gowns, gloves, face	F 880	1. Root Cause Analysis: On 1.17.2022 the IDT team and Medical Director conducted the RCA PIP meeting to discuss findings of F880 and to determine root cause of deficient infection control practices utilizing the Five Whys Tool. The facility identified that the primary root cause of the deficient practice was due to the center not having a designated IP consistently staffed who could focus on infection control. 2. 1.18.2022 thru 1.20.2022, the Director of Nursing (DON)or Staff Development Coordinator (SDC) provided 1:1 reeducation and completed skills competency validation with PCA #1, Shower Aide #1 and #2 and MA #1 on proper personal protective equipment (PPE) and hand hygiene. No harm to residents resulted as a result of this	

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protection (face shield or goggles), and respiratory protection. It further revealed gloves were to be worn as part of universal precautions, hand hygiene should be performed before and after application, and discarded after each encounter.

The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic (updated 9/10/21) read in part: "Implement Universal Use of Personal Protective Equipment for HCP: If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below:" The list of PPE included "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."

1. An observation on 12/20/21 at 9:32 AM revealed MA#1 administered medications to Resident # 8. Resident #8's door indicated he was on EDCP which signage illustrated the use of a gown, gloves, eye protection, and a face mask when caring for the resident. During the observation, MA #1 was observed to wear a face mask, eye protection improperly placed on top of her head, not covering her eyes, and was not observed to don gloves or a gown before entering the room to administer the medications to Resident #8. MA #1 was observed to hand a cup containing medication and a cup with liquid to Resident #8 while she stood in front of him conversing as he swallowed his medications. She

deficient infection prevention practices.

3. 1.8.2022, the DON performed facility-wide infection prevention rounds via visual observation of staff performing hand hygiene, donning, and doffing, and during patient care practices. During the observational audit the auditor identified trends and to ensure proper infection prevention practices are being followed. All concerns that were identified have been documented and education was extended.

4. 1.18.2022 – 1.21.2022, the DON and Staff Development Coordinator (SDC) provided education to current facility staff and agency staff on proper hand hygiene, and donning/doffing of PPE per resident transmission-based precautions. Education also included transmission-based precautions as appropriate and per resident plan of care to prevent the spread of infection. Newly hired staff and agency staff will receive education during orientation. Additionally, each person previously mentioned will become SPICE certified by 1.21.2021 and the SDC will be the facility designated Infection Preventionist (IP). The IP will be responsible for conducting ongoing infection surveillance rounds and ongoing education to staff on any concerns or changes to infection prevention guidance and practices.

5. The DON and SDC will be responsible for conducting infection control rounding audits via observation of

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then exited the room and returned to her medication cart with the empty medication cup and disposed of it on the side of the cart.

An interview with Medication Aide #1 on 12/22/21 at 1:21 PM revealed she was assigned to administer medication to Resident #8 on 12/20/21 during day shift. She acknowledged Resident #8 was on EDCP which required use of full PPE (gown, gloves, mask, and eye protection). MA #1 stated when she administered the medication to Resident #8 on 12/20/20 she did not think about donning full PPE because she was not going all the way into the room but explained she had been trained on EDCP and don/doffing of PPE and to follow all instructions on posted isolation signage.

2. An observation on 12/20/21 at 9:48 AM revealed Shower Aide #1 and Shower Aide #2 enter the shower room to aide Resident #9 in bathing. Both shower aides were observed to wear a facemask and eye protection; however, neither aide donned a gown or gloves while performing bathing activities for Resident #9 who was on EDCP isolation according to signage posted outside her door.

An interview with Shower Aide #1 and Shower Aide #2 on 12/20/21 at 1:37 PM revealed they were assigned to provide showers to residents on 12/20/21 during day shift. Both shower aides indicated they had only been trained to wear a face mask and eye wear (which they explained they were required to always wear in the facility) when providing showers. Both aides stated they were only trained to don a gown or gloves when caring for a resident in the room despite Resident #9 being on EDCP and had not thought a gown or gloves were needed while providing bathing.

hand hygiene and PPE donning/doffing of staff during resident care. Audits will be completed for eight (8) staff members 5 times a week for 12 weeks. Results of audits will be reported by the IP during monthly QAPI and changes will be made to the plan as necessary to maintain compliance with Infection Prevention practices and guidelines.

6. Compliance date: 1.21.2022

7. Attestation of Infection Control has been attached, and is signed by DON, SDC and Administrator to validate accuracy of the educations and POC timeline information.

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3. An observation on 12/20/21 at 9:45 AM revealed Personal Care Aide (PCA #1) at the bedside of Resident #10 who was on EDCP performing nail care. PCA #1 was observed to be wearing a gown, gloves, face mask, and eye protection. After completion of nail care for Resident #10, PCA #1 exited the room wearing full PPE and carrying nail care supplies. PCA #1 was observed to place the nail care supplies on a cooler outside the room. PCA #1 then re-entered the room and obtained a pitcher from Resident #10 and returned to the cooler in the hallway. With her soiled gloved hand, she opened the cooler lid and obtained fresh ice from inside placing it in the cup and returning to Resident #10's bedside. PCA #1 then doffed her PPE and exited the room and began to document on a piece of paper. PCA #1 was not observed to perform hand hygiene before proceeding down the hallway to the nurses' station.

An interview with PCA #1 on 12/21/21 at 4:42 PM revealed she was trained on PPE and transmission-based precautions; however, forgot to doff her gown and gloves when she exited Resident #10's room who was on EDCP and donning clean PPE before returning to the resident room. PCA #1 also explained she should not have placed the soiled nail care supplies on the ice cooler nor obtain fresh ice from the cooler while wearing contaminated PPE.

An interview with the Director of Nursing on 12/20/21 at 4:26 PM revealed she had only been at the facility approximately a month but confirmed all staff had been trained on donning/doffing of PPE and to follow instructions posted on all isolation signage.

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F 880	Continued From page 31 An interview with the Administrator on 12/20/21 at 5:26 PM revealed she was new to the facility and had only been there about a week; however, she explained staff had been trained in proper application of PPE and what PPE was required when caring for residents on EDCP which included a gown, gloves, face mask, and eye protection anytime staff are in the room or make any contact with the resident on this form of precautions to include nail care, showers, medication administration, meal delivery, and transporting in the hallway.	F 880		