STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	R-C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 The survey team entered the facility on 1/10/22 to conduct a Recertification Survey, Complaint Investigation and Revisit Survey. The survey team was onsite 1/10/22 through 1/13/22. Additional information was obtained offsite 1/14/24 through 1/18/22. Therefore, the exit date was 1/18/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1IFV11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 1/10/22 to conduct a recertification survey, complaint investigation and follow-up/revisit survey. The survey team was onsite 1/10/22 through 1/13/22. Additional information was obtained offsite 1/14/22 through 1/18/22. Therefore, the exit date was 1/18/22. 5 of the 14 complaint allegations were substantiated. Tag F689 was corrected as of 1/18/22. However, new tags were cited as a result of the recertification and complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. Event ID# 1IFV11.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility failed	F 558	Maple Grove Nursing and Rehabilitation Center acknowledges receipt of the	2/16/22

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

Electronically Signed | 02/11/2022

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F 558	Continued From page 1 to ensure a resident ' s call light was kept within reach for 1 of 1 resident (Resident #43) reviewed for accommodation of needs. The findings included: Resident #43 was admitted to the facility on 12/21/20 with reentry from a hospital on 11/5/21. The resident ' s cumulative diagnoses included diabetes and heart failure.. A review of Resident #43 ' s annual Minimum Data Set (MDS) dated 11/12/21 revealed he had moderately impaired cognitive skills for daily decision making. The resident was assessed as having the ability to make himself understood and to understand others with clear comprehension. He required extensive assistance for bed mobility, transfers, dressing, toileting, and personal hygiene. The resident needed limited assistance for walking in his room, supervision for locomotion on/off the unit, and was independent with eating. Nursing Progress Notes dated 12/8/21, 12/10/21, 12/11/21 and 12/12/21 reported Resident #43 was alert and oriented in three areas (to person, place and time). A review of Resident #43 ' s comprehensive care plan included the following area of focus: The resident was at risk for falls characterized by a history of falls/ actual falls, injury, and multiple risk factors related to impaired balance (Date Initiated: 12/23/2020). The planned interventions included keeping the resident ' s call light within reach and answering it within a timely manner (Date Initiated: 12/23/20); and, providing frequent reminders to the resident to call for assistance	F 558	Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Nursing and Rehabilitation Center s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. Resident #43 still resides in facility and maintains normal routine. On 1/12/22 resident #43 call light was placed within reach by the hall nurse. Each resident of the facility may be affected by this deficient practice. On 1/18/22 an audit was completed by the (interim) Director of Nursing, the Assistant Director of Nursing, and nurse managers of resident call lights to ensure call lights were placed appropriately, within resident reach. Any identified concerns with call-lights being within resident reach was corrected immediately.	

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F 558	Continued From page 2 before getting up (Date Initiated: 1/25/21). An observation was conducted on 1/10/22 at 2:42 PM as Resident #43 was lying on his bed. The cord for his call light was observed to be tucked under and through the bed frame on the left side of his bed. The call light button was hanging approximately 10 inches below the bed frame and 8 inches off of the floor. A clip attached to the call light cord was lying on the floor. The call light button was not within reach of the resident. At the time of the observation, Resident #43 reported he would need to "call out" for help if he needed assistance from staff. Another observation was conducted on 1/11/22 at 10:38 AM as Resident #43 was sitting on the right side of his bed. His call light cord was under the bed frame on the left side of his bed as previously observed on 1/10/22. The call light button was not accessible to the resident. During an interview conducted with the resident at that time, Resident #43 stated, "The other day looked at it (the call light) and (there was) no red button (used to push and activate the call light)." He reported he didn ' t think the call light worked even if he could reach it. An observation was conducted on 1/12/22 at 8:22 AM as Resident #43 appeared to be asleep in his bed. The resident ' s call light remained tucked under and through the bed frame and was hanging approximately 10" below the bed frame with the call light button approximately 8" off of the floor. On 1/12/22 at 2:00 PM, the resident was in his bed with the call light observed to be tucked under and through the bed frame on the left side	F 558	On 2/1/22 education was completed by the (interim) Director of Nursing and/or the Assistant Director of Nursing to nursing and housekeeping staff to ensure call-light is with-in reach of resident. No nursing or housekeeping staff will be able to work until his/her education for call light within resident reach has been completed. No nursing or housekeeping staff will be eligible to work until he/she has completed the call light is to be within resident reach. The Interim Director of Nursing and/or Assistant Director of Nursing will provide education to all newly hired Licensed Nurses, certified nursing assistance, nurse aide trainees, and housekeeping staff during orientation to ensure call lights are present and within reach for all residents. Agency nurses and certified nursing assistance will be trained during Agency orientation to ensure call lights are present and within reach for all residents. Beginning 1/18/22 Quality assurance and improvement monitoring will be conducted by (interim) Director of Nursing/Assistant Director of Nursing to monitor call light placement to ensure call lights are placed within resident reach 3 times weekly for 4 weeks and then weekly for 2 months to ensure sustained compliance. The audits will be conducted randomly on all shifts and weekends. It will be the responsibility of the (interim) Director of Nursing /Assistant Director of Nursing to ensure sustained compliance. Beginning February 2022, the (interim)	

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F 558	Continued From page 3 of his bed (in the same position as previously observed). The call light button was not within reach of the resident. Upon request, Nurse #1 entered Resident #43 ' s room on 1/12/22 at 2:08 PM. When she entered the room, the resident was awake and alert. His call light was not within reach. The nurse was observed as she retrieved his call light from its current location and placed the call light button on the resident's bed. Resident #43 smiled and stated, "Now I can reach it...thank you!" Upon inquiry, the nurse confirmed the resident could not reach the call light when it was hanging from the frame of the bed. When asked to do so, Resident #43 pushed the call light button to ensure it was in working order. When he pressed the button, the call light above the door of his room lit up. An interview was conducted on 1/13/22 at 12:16 PM with the facility ' s Assistant Director of Nursing (ADON). During the interview, the observations regarding Resident #43's call light not being kept within his reach over an extended period of time were discussed. The ADON reported she had been made aware of the concern and has initiated education with nursing staff to keep the call light within reach of the resident. When asked, the ADON confirmed Resident #43 had the ability to use his call light to request staff assistance.	F 558	Director of Nursing/Assistant Director of Nursing will present the findings of the Call Light Audit to the Executive QA Committee for review monthly for three months to determine trends and/ or issues that may require further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		2/16/22

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F 584	Continued From page 4 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 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 584	On 1/11/22 during annual survey;	

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F 584	Continued From page 5 facility failed to clean and maintain the floors in good repair for 3 of 26 resident rooms (Rooms 115, 133, and 141) and 21 of 24 bathrooms (bathrooms adjacent to Rooms 104, 105, 110, 112, 113, 114, 115, 116, 123, 124, 126, 127, 128, 129, 130, 131, 133, 135, 137, 139, and 141) observed. The findings included: On 1/11/22 at 10:07 AM, an observation of the bathroom adjacent to Room 113 revealed the bathroom flooring appeared to be dirty with large areas of brown discoloration noted. An observation made of the bathroom adjacent to Room 110 on 1/11/22 at 10:36 AM revealed there was approximately ½ inch (") of a dark brown substance on the flooring around the perimeter of the room. An interview and observation was conducted on 1/12/22 at 2:35 PM with the facility ' s Director of Maintenance. During the interview, the Director of Maintenance reported he was currently in charge of the housekeeping staff (in addition to managing the Maintenance Department). Accompanied by the Director of Maintenance, an observation was made of the bathroom adjacent to Room 113. The flooring appeared to be dirty with large areas of brown staining / discoloration noted. Upon viewing the bathroom, the Maintenance Director was asked if this was a maintenance issue or a housekeeping concern. He stated, "Both." The Maintenance Director reported the flooring in the bathroom needed to be stripped and re-waxed. When asked what his thoughts were about the condition of the bathroom, the Maintenance Director stated, "I see	F 584	observations were made by the survey team of floor tiles in resident rooms 115, 133, and 141 were stained and discolored. In addition, observations by the survey team of resident room bathrooms 104, 105, 110, 112, 113, 114, 115, 116, 123, 124, 126, 127, 128, 129, 130, 131, 133, 135, 137, 139, and 141 were stained and discolored. On January 19, 2022, the housekeeping/maintenance director gave directive to the housekeeping department to sweep and mop the identified rooms from survey team observations. Additional residents/resident rooms of the facility could be affected by this deficient practice. On 1/19/22 Maintenance/Housekeeping Director completed and audit of resident room and bathroom floors to identify floor tiles that were in the need of cleaning (sweeping, mopping, stripping and/or waxing) of resident room and/or bathroom floors to maintain a clean, sanitary, and homelike environment. No residents were negatively affected by this practice. On February 11, 2022, the (interim) Administrator educated the housekeeping/maintenance director of expectation of cleaning (sweeping, mopping, removing/replacing caulking, stripping and/or waxing floors) of resident room and/or bathroom floors to maintain a clean, sanitary, and homelike environment. This education included	

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F 584	Continued From page 6 the concern." The Director of Maintenance was then accompanied to Room 110. The bathroom was noted to have a dark brown substance on the flooring around the perimeter of the room. Upon observing the flooring in the bathroom adjacent to Room 110, he reported the floor for this bathroom also needed to be stripped and waxed. On 1/12/22 from 3:20 PM to 3:50 PM and accompanied by the Director of Maintenance, a room to room check of the North Wing of the resident rooms and bathrooms adjacent to these rooms was conducted. Additional concerns related to the cleanliness and condition of the flooring observed during this check included the following: --The shared bathroom for Rooms 104 (and 106): The bathroom flooring was observed to have a white discoloration at the seams of the floor tile. A brown/rust substance was noted around the perimeter of the toilet base. A bead of approximately 1" of caulking was observed around the toilet was stained or discolored with a dark brown substance.. -- The shared bathroom for Rooms 105 (and 107): The bathroom flooring was noted to have approximately a 1" bead of caulk around the toilet with dark brown discoloration. The Maintenance Director stated the floor needed to be stripped and waxed. --Room 112 ' s bathroom: Approximately 4" of a brown substance was noticed under the sink on the bathroom floor. Also, there was a 1" bead of a stained, dark brown substance along the caulking at the base of the toilet. --Room 114 ' s bathroom: The bathroom linoleum around the toilet had a 1" bead of caulking which was discolored with a dark brown substance. The front of the base of the toilet was	F 584	notifying the (interim) Administrator of any resident rooms and/or bathrooms floors that needed replacing due to unremovable stains. On January 19, 2022, the housekeeping/maintenance departments began sweeping, mopping, removing/replacing caulking, stripping, and waxing floors of the identified resident rooms and bathrooms. Any floors not showing improvement from the process of sweeping, mopping, removing/replacing caulking, stripping, and waxing will be reported daily to the (interim) Administrator for additional evaluation & correction. The facility Maintenance Director will monitor each resident room and bathroom weekly x4 weeks, then monthly x2 months to ensure cleaning (sweeping, mopping, caulking is clean & maintained, stripping and/or waxing) of resident room and/or bathroom floors to maintain a clean, sanitary, and homelike environment. Housekeeping/Maintenance Director will keep a log or facility map that will indicate if a floor has been cleaned or renovated. It will be the responsibility of the Housekeeping/Maintenance Director to ensure sustained compliance. Beginning February 2022, the Housekeeping/Maintenance Director will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends	

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F 584	Continued From page 7 also discolored with a lighter brown substance. --Room 115 ' s bathroom: Tile on the flooring at the entrance of the resident ' s room had a tan substance which appeared to be seeping through the seams. This substance was identified by the Director of Maintenance to be glue from the tile flooring. The bathroom flooring was observed to have a brown discoloration approximately 8" wide around the perimeter of the toilet. --Room 116 ' s bathroom: The bathroom floor had linoleum with a brown discoloration around the perimeter of the toilet. --Room 123 ' s bathroom: The bathroom floor tile was observed to have a brown substance approximately 6" wide around the perimeter of the room; also, there was 1/2 to 2" of a brown substance around the base of the toilet and 6 inches up on the base of the toilet itself. --Room 124 ' s bathroom: The bathroom floor had linoleum in place with caulking approximately 1 and 1/2" thick around the base of the toilet with a dark brown discoloration throughout the caulk. --Room 126 ' s bathroom: Tile on the bathroom floor was noted to have approximately 1/2" of dark brown discoloration around the toilet. The Director of Maintenance stated the floor needed to be stripped and waxed. --Room 127 ' s bathroom: The molding placed around the perimeter of the bathroom and adjacent to the floor behind the toilet had approximately 6-inches of a black-brown substance on it. --Room 128 ' s bathroom: The bathroom floor had linoleum with large areas of brown discoloration and approximately 1/2" of a dark brown substance around the perimeter of the toilet. The Director of Maintenance reported tile would likely need to be set on top of the linoleum to provide a lasting "fix" to the problem.	F 584	and/or need for additional monitoring to maintain regulatory compliance.	

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F 584	Continued From page 8	F 584		

--Room 129 ' s bathroom: The bathroom flooring was linoleum and noted to have a brown discoloration around the toilet.
--Room 130 ' s bathroom: The tile in the bathroom had a brown-rust discoloration behind the toilet.
--Room 131 ' s bathroom: The bathroom flooring had a brown discoloration approximately 8 inches around the base of the toilet and within/around the caulking.
--Room 133 ' s bathroom: A black substance was observed at the seams of tile upon entry into the resident ' s room. The bathroom floor required, "more stripping and waxing" according to the Director of Maintenance. A brown discoloration was observed up to 12" around the base of the toilet.
--Room 135 ' s bathroom: The bathroom floor was noted to have white caulking approximately 1-inch around the base of the toilet with dark brown discoloration around the perimeter.
--Room 137 ' s bathroom: The bathroom floor was observed to have a brown substance around the perimeter of the toilet and the caulking. The Director of Maintenance stated the floor needed to be stripped and waxed.
----Room 139 ' s bathroom: A rust-brown discoloration was observed on the linoleum of the bathroom floor around the perimeter of the toilet.
--Room 141 ' s bathroom: The tile floors at the entrance of the room had a black substance at each joint around the tiles. Upon inquiry, the Director of Maintenance reported this was a "glue" that had seeped through the joints. The bathroom of Rm 141 was observed to have up to 2" of a dark brown substance around the perimeter of the toilet. The Director reported the floor needed, "a lot of stripping and waxing."

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F 584	Continued From page 9 An interview was conducted on 1/13/22 at 2:47 PM with the facility ' s Administrator. The 1/12/22 observations made of the flooring in resident rooms and bathrooms with the Director of Maintenance were discussed. When asked what his expectation(s) would be, the Administrator responded by stating he would expect the facility to use, "our standard cleaning procedures." He further stated that if an area of the flooring needed to be stripped or waxed, the problem may be resolved. If it was not resolved and there ultimately were substantial stains that couldn't be removed on the flooring, replacing the floors may be the next alternative to resolve the issues observed.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		2/17/22

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F 609	Continued From page 10 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report a resident-to-resident incident of alleged sexual assault as required, report 2 hours after administration was notified and an investigation within 5 days (Residents #71 and 220) for 2 of 2 sampled residents. Findings included: Resident #71 was admitted to the facility on 2/6/2018 with the diagnosis of dementia. Resident #220 was admitted to the facility on 5/5/2021 with the diagnosis of dementia. Nurses ' note dated 11/18/21 documented "Around 3:45 pm this afternoon (11/18/21), I knocked and went into the resident ' s room (#220) and saw the resident with another male resident (#71) both naked. The male resident was lying on his back on the resident ' s bed while she was sitting towards the right-side, middle of the bed facing the window. When I stepped in, the resident picked up her blouse and covered her chest area. At this point, this nurse called out to staff (aide) on the floor, who came in and helped get the male resident dressed and taken out of the resident's room. When asked what was going on, Resident #220 responded that "stuff	F 609	Resident #202 no longer resides the facility and was discharged on November 19, 2021. Resident #71 continues to reside at facility on secured/dementia unit. Resident #71's care plan and medications were reviewed by DON and attending physician on January 20, 2022. No further socially inappropriate sexual actions from Resident #71 since time of incident. This practice could affect each resident of the facility. The Administrator and Director of Nursing were in-serviced on January 24, 2022 by the corporate representative (Senior Administrator) regarding federal and state reporting requirements. The department management team was also in-serviced by corporate representative (Senior Administrator) on February 14, 2022 regarding reporting of abuse (sexual, verbal, physical, mental & misappropriation of resident property). This education for each individual focuses on immediate reporting. Immediate	

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F 609	Continued From page 11 happens." The Director of Nursing (DON), the Administrator and physician were notified of the incident." The note was written by Nurse #5. The 5-day investigation report fax transmittal documented that it was sent to DHHS on 11/30/21 at 6:34 am. On 1/11/21 at 4:05 pm an interview was conducted with Nurse #5. Nurse #5 stated that he knocked on Resident #220's door to enter for a COVID test at 3:45 pm and found Resident #71 undressed lying on Resident 220 ' s bed and Resident #220 was observed to be undressed, sitting on her bed next to Resident #71 facing the window. Resident #220 grabbed her shirt and covered her chest and looked down as if she was embarrassed. Nurse #5 asked Resident #220 what happened, and the resident stated to me "stuff happens." Nurse #5 stated he knocked on the door and waited for entry. The nurse supervisor and ADON were informed and assessed Resident #220. On 1/13/22 at 12:30 pm an interview was conducted with the Administrator. He stated that he was aware of the resident-to-resident incident on 11/18/21. He did not report the incident to the State as required because he did not think anything had happened between the residents. The Administrator stated he was aware that the residents were undressed on a bed for an undetermined amount of time unobserved and unsupervised and that both residents had cognitive deficit and could not consent to sexual/touching activity of any type, including unwanted. He stated there was no allegation of unwanted contact until the Police called the facility to ask about the incident on 11/28/21. At	F 609	means as soon as you have information /knowledge of and secured the resident's safety. An abuse reporting log was developed and implemented on February 7, 2022 by the Administrator to ensure that reporting of events is occurring timely. This log is maintained by the Administrator. The Administrator will monitor the reporting log weekly (starting February 7, 2022) x4 weeks to ensure reporting is completed timely and accurately. After 4 weeks the Administrator will monitor the log monthly to ensure sustained compliance. It will be the responsibility of the Administrator to ensure and maintain compliance. Any identified issues will be rectified immediately and brought to the quarterly QAPI for further review and evaluation.	

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F 609	Continued From page 12 this time, the Administrator filed the required 5-day investigation report to DHHS on 11/28/21.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the nutrition section of the minimum data set (MDS) for 2 of 5 residents reviewed for Nutrition (Resident #96 and Resident #24). Findings Included: 1.Resident #96 was admitted to the facility 8/16/18 and diagnoses included traumatic brain injury and gastrostomy tube. Review of the physician ' s orders for Resident #96 revealed an order dated 9/2/21 for a name brand enteral feeding formula to be administered at 35 milliliters (ml) an hour for 20 hours a day. Review of a quarterly minimum data set (MDS) dated 12/17/21 for Resident #96 did not identify the resident had a feeding tube. An interview on 1/13/22 at 2:00 pm with the MDS Coordinator revealed the MDS dated 12/17/21 for Resident #96 was coded incorrectly. She stated the nutrition section should have been coded for the resident having a feeding tube. An interview on 1/13/22 at 2:30 pm with the	F 641	Residents #96 and #24 continue to reside in the facility and maintain a normal routine. On January 13, 2022 MDS Nurse recoded Section KO510B to reflect that Resident #96 and Resident #24 have a gastrostomy (feeding) tube in place. No residents were affected due to incorrect coding. This practice could affect each resident with a gastrostomy tube placement. The facility has two other residents that were not identified and both of those resident MDS were correctly coded to reflect gastrostomy tube was in place. This was verified by MDS on January 13, 2022 and January 28, 2022. MDS Nurses were educated by Regional MDS Nurse to ensure they are properly coding gastrostomy tube is present. This education was completed by January 17, 2022. MDS nurse will audit (starting January 24, 2022) of Section K0510B for each resident as their quarterly care plan is updated to ensure proper coding prior to MDS submission.	2/17/22

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F 641	Continued From page 13 Administrator revealed he expected the staff completing the MDS to validate the information coded was accurate. 2. Resident #24 was admitted to the facility 10/16/12 and diagnoses included anoxic brain damage, dysphagia and gastrostomy tube. Review of the physician ' s orders for Resident #24 identified he received routine water flushes and all his medications through a gastrostomy tube. A quarterly minimum data set (MDS) dated 10/28/21 for Resident #24 did not identify the resident had a feeding tube. An interview on 1/13/22 at 9:30 am with the Dietary Manager revealed she had completed the nutrition section for the MDS dated 10/28/21. She stated she did not realize she should have coded a feeding tube for the resident. An interview on 1/13/22 at 2:00 pm with the MDS Coordinator revealed the 10/28/21 MDS for Resident #24 should have been coded for a feeding tube as the resident received all his medications and a routine water flush through the feeding tube. An interview on 1/13/22 at 2:30 pm with the Administrator revealed he expected the staff completing the MDS to validate the information coded was accurate.	F 641	MDS Nurse will audit each MDS completed for accuracy in coding of Section KO510B prior to submission. These audits started on January 24, 2022. Audits will be turned into the Administrator weekly (starting the week of January 24, 2022) for a period of 2 months. It will be the responsibility of the MDS Nurse to ensure sustained compliance. Any identified issues will be corrected / amended immediately to ensure accuracy of the MDS and brought to the quarterly QAPI for further review and recommendation	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		2/18/22

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F 677	Continued From page 14 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 observation, record review, and staff and family interview, the facility failed to provide a haircut (Resident #71) for 1 of 3 activity of daily living dependent residents reviewed. Findings included: Resident #71 was admitted to the facility on 2/6/18 with the diagnosis of dementia. Resident #71 ' s care plan dated 6/29/19 included activities of daily living assistance required for bathing, dressing, and grooming. On 1/10/22 at 10:40 am an observation was done of Resident #71. He was sitting in his wheelchair in a common area. The resident was noted to have long hair, approximately 4 or more inches. Annual Minimum Data Set dated 12/13/21 documented Resident #71 was usually understood/ understands and was severely cognitively impaired. The resident required assistance with activities of daily living. On 1/11/22 at 10:04 am Resident #71 ' s family member was interviewed. She stated she had requested facility staff to provide the resident a haircut. She stated she had asked nursing staff for the resident ' s hair to be cut for the past 6 months. She could not remember which nurse she informed and was not aware that there was not a barber due to COVID. She stated that the resident always had his hair cut.	F 677	Resident #71 continues to reside at facility on secured/dementia unit. Resident #71 had hair cut on January 25, 2022 to an appropriate length as described by the family. Facility will continue to monitor Resident #71 to ensure hair is of appropriate length per family request. This practice could affect each resident of the facility. An original audit was completed (February 17, 2022) by the Activities Director to identify any other resident who is in need or wants their hair groomed. Residents identified in audit had who wished to have their hair cut and trimmed were complete by February 18, 2022. Activities Director will prepare a weekly sign-up sheet/audit sheet for services (effective January 19, 2022) so residents and/or family members can contact her to get on the next week schedule for beauty services. Any identified individual(s) who is in need or requests a haircut will be placed on the next schedule (weekly) to receive hair services. Audits will start on January 19, 2022 and will be conducted by the Activities Director or licensed nurse weekly X4 weeks and then monthly thereafter to ensure the facility is meeting the residents needs in	

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F 677	Continued From page 15 On 1/11/22 at 3:30 pm an interview was conducted with Nurse #5. He stated he noticed Resident #71 had long hair and was not aware the resident ' s family requested a haircut. He stated there currently was no barber to cut hair since COVID. On 1/14/22 at 3:15 pm an interview was conducted with the Activities Coordinator. She stated that there was no beautician and there was a delay finding one due to COVID. She stated the Administrator was looking for a replacement. She was not aware that Resident #71 required a haircut or that family requested a haircut. On 1/14/22 at 3:05 pm an interview was conducted with the Assistant Director of Nursing. She stated there was currently no barber/beautician. The Administrator was working on this. She was not aware that Resident #71 had such long hair (after she observed) or that his family requested a haircut. On 1/14/22 at 3:20 pm an interview was conducted with the Administrator. He stated that the facility currently had no barber and had not had one for a while due to COVID. He stated he was aware that a haircut could be obtained outside of the facility and would look into getting a barber. He stated that he was not aware that Resident #71 ' s hair was long or that the family had informed nursing staff to provide a haircut for the resident.	F 677	regards hair grooming. It will be the responsibility of the Activities Director to ensure sustained compliance. Any identified issues will be corrected immediately and brought to the quarterly QAPI meeting for further review and recommendation	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F 759		2/18/22

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F 759	Continued From page 16 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 33 medication opportunities, resulting in a medication error rate of 9% for 2 of 4 residents (Resident #55 and Resident #93) observed during medication pass. The findings included: 1-a. On 1/13/22 at 8:10 AM, Nurse #3 was observed as she prepared and administered medications to Resident #55. The medications included 2 - 10 milligram (mg) tablets of famotidine (a medication used for the treatment of gastroesophageal reflux disease or heartburn). A review of Resident #55 ' s medication orders included an order written on 1/26/21 for 20 mg famotidine to be administered to the resident as one tablet by mouth once daily. However, an order was received on 11/25/21 to decrease the dose of famotidine to 10 mg given by mouth once every day. An interview was conducted on 1/13/22 at 9:20 AM with Nurse #3. Upon request, Nurse #3 reviewed Resident #55 ' s January 2022 Medication Administration Record (MAR). She confirmed two-10 mg tablets of famotidine were administered to the resident during the med pass observation. The nurse reported the second	F 759	Resident #55 and Resident #93 still reside in facility and maintain normal routine. Resident #93 medications were reviewed by DON on January 25, 2022 and resident #55 medications were reviewed by DON on January 26, 2022 for accuracy and no negative issues. The medication administration record (MAR) was updated accordingly. Resident #55 and Resident #93 did not have any adverse effects related to the medication error. Medication errors could affect each resident of the facility. An audit was completed on January 31, 2022 by Director of Nursing (DON) and Assistant Director of Nursing of each resident's medication administration record to ensure accuracy. Any identified inaccuracies were corrected immediately by the Director of Nursing or Assistant Director of Nursing. Medication usage, cart and medication storage and medication administration review is conducted monthly by consultant Pharmacist (last conducted January 28, 2022). Recommendations by the pharmacist was given to the Director of Nursing and Physician on January 28, 2022 for review and completion. Education will be provided to licensed	

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F 759	Continued From page 17 tablet of 10 mg famotidine appeared to be a duplicate medication. An interview was conducted on 1/13/22 at 12:16 PM with the facility ' s Assistant Director of Nursing (ADON). During the interview, concerns identified during the medication administration observation were discussed. When asked what her expectation was for medication administration, the ADON stated she would expect the nurse or medication aide to read the MARs correctly to ensure the correct medication and dosage were administered to the resident. If the nurse or med aide had a question about an order, he/she could talk with the pharmacy and/or physician for clarification. 1-b. On 1/13/22 at 8:10 AM, Nurse #3 was observed as she prepared and administered medications to Resident #55. The medications administered included one puff of 2.5 micrograms (mcg) Spiriva Respimat (a soft mist inhaler used for maintenance treatment of chronic obstructive pulmonary disease or COPD). A review of Resident #55 ' s physician orders included an order dated 1/26/21 for 2.5 mcg Spiriva Respimat to be administered as two puffs once daily. An interview was conducted on 1/13/22 at 9:20 AM with Nurse #3. Upon request, Nurse #3 reviewed Resident #55 ' s January 2022 Medication Administration Record (MAR). The order indicated two puffs were to be administered once daily. Nurse #3 confirmed only one puff of the inhaler was administered during the med pass observation conducted earlier that morning.	F 759	nurses and medication aides by the Assistant Director of Nursing. This education will review the 5-Rights: 1. Right Drug 2. Right Dose 3. Right Time 4. Right Route 5. Right Person On 1/12/22 education was completed by the Assistant Director of Nursing and RN supervisor for licensed nurses and medication aides on the 5 rights of medication administration as outlined above. The Licensed nurse and medication aide will not be able to work until his/her education for medication administration has been completed. The Director of Nursing and/or Assistant Director of Nursing will provide education to all newly hired Licensed Nurses, and medication aides during orientation to ensure medication administration is done correctly using the 5 rights for medication pass. Agency nurses and medication aides will be trained during Agency orientation to ensure medication is administered using the 5 rights of medication pass as outlined above. Medication administration audits were started on January 21, 2022 (currently continue) and will be performed by Assistant Director of Nursing & Unit Manager to reduce error rate to below 5%. The ADON and/or licensed nurse designee(s) will monitor and audit (effective February 13, 2022) medication administration 3 times weekly on various	

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F 759	Continued From page 18 An interview was conducted on 1/13/22 at 12:16 PM with the facility ' s Assistant Director of Nursing (ADON). During the interview, concerns identified during the medication administration observation were discussed. When asked what her expectation was for medication administration, the ADON stated she would expect the nurse or medication aide to read the MARs correctly to ensure the correct medication and dosage were administered to the resident. If the nurse or med aide had a question about an order, he/she could talk with the pharmacy and/or physician for clarification. 2. On 1/12/22 at 8:40 AM, Nurse #1 was observed as she prepared and administered medications to Resident #93. The medications included one tablet of a combination medication containing 50 milligrams (mg) docusate (a stool softener) and 8.6 mg sennosides (a bowel stimulant) obtained from a stock bottle stored on the medication cart. A review of Resident #93 ' s physician orders included a current order for 8.6 mg sennosides to be given as one tablet by mouth twice daily for constipation. An interview was conducted on 1/12/22 at 2:05 PM with Nurse #1. Upon request, Nurse #1 reviewed Resident #93 ' s January 2022 Medication Administration Record (MAR). The order on the MAR indicated a single ingredient medication containing only 8.6 mg sennosides should have been administered to Resident #93. The nurse pulled the stock bottle containing 50 mg docusate and 8.6 mg sennosides out of the med cart and confirmed medication from this stock bottle had been administered to the	F 759	shifts and weekends for 4 weeks and then weekly on various shifts and weekends for 3 months to ensure sustained compliance. Any identified issues will be corrected immediately. It will be the responsibility of the Administrator to ensure sustained compliance. Beginning February 2022, the (interim) Director of Nursing/Assistant Director of Nursing will present the findings of the Medication Administration Audits to the Executive QA Committee for review monthly for three months to determine trends and/ or issues that may require further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 759	Continued From page 19 resident. The nurse then located another stock bottle stored on the medication cart which contained 8.6 mg sennosides as the sole active ingredient (the medication ordered for Resident #93). When asked if she was previously aware there was a difference between the medications contained in the two stock bottles, she stated, "Now I know." An interview was conducted on 1/13/22 at 12:16 PM with the facility ' s Assistant Director of Nursing (ADON). During the interview, concerns identified during the medication administration observation were discussed. When asked what her expectation was for medication administration, the ADON stated she would expect the nurse or medication aide to read the MARs correctly to ensure the correct medication and dosage were administered to the resident. If the nurse or med aide had a question about an order, he/she could talk with the pharmacy and/or physician for clarification.	F 759		
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	F 761		2/18/22

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F 761	Continued From page 20 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to: 1) Label an injectable medication with a shortened expiration date when stored on 1 of 3 medication carts (Room 104-119 Med Cart); 2) Dispose of a vial labeled for single use only once it had been opened and left on 1 of 3 medication carts (Room 104-119 Med Cart); and, 3) Label a medication with the minimum required labeling, including a resident ' s name and instructions for administration when stored on 1 of 3 med carts (Room 104-119 Med Cart) observed. The findings included: 1) Accompanied by Nurse #4, an observation of the Medication Cart used for Rooms 104-119 was conducted on 1/10/22 at 2:59 PM. The observation revealed an opened multi-dose vial of 200 milligram (mg) per 20 milliliter (ml) 1% lidocaine injectable medication (used as a local anesthetic) was stored on the med cart. The opened vial of lidocaine was not dated as to when it had been opened. Nurse #4 confirmed no opened date was written on the vial of lidocaine.	F 761	No specific resident(s) were identified with this deficient practice. On January 12, 2022, the medication carts on South Hall, SPARC Hall, West Hall and North Hall were examined by the Assistant Director of Nursing and Unit Manager. On January 12, 2022, the medication carts were checked for open vials/bottles to ensure they were labeled with the resident name, instructions for usage and date opened. The carts were examined for any single dose vitals that were opened and still in the med cart. Any negative findings were addressed immediately and disposed of. This practice could affect each resident of the facility. An audit was completed by the ADON and unit manager on January 12, 2022, of each medication cart to remove any medication without appropriate labels or open/expiration dates. Any medication without appropriate identifiers were removed immediately. Storage of drugs and	

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	345448	A. BUILDING _____ B. WING _____	R-C 01/18/2022

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F 761	Continued From page 21 The Center for Disease Control (CDC) Injection Safety practices recommends if a multi-dose vial has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. An interview was conducted on 1/13/22 at 12:16 PM with the facility ' s Assistant Director of Nursing (ADON). During the interview, concerns identified during the observations of the medication storage task were discussed. When asked, the ADON reported she would expect a multi-dose vial of medication to be labeled with the date it had been opened and discarded after 28 days. The ADON stated she was made aware of the med storage observations and the nursing staff was educated on this issue. 2) Accompanied by Nurse #4, an observation of the Medication Cart used for Rooms 104-119 was conducted on 1/10/22 at 2:59 PM. The observation revealed an opened 20 milliliter (ml) vial of sterile water for injection labeled for single use only was stored on the med cart. An interview was conducted on 1/13/22 at 12:16 PM with the facility ' s Assistant Director of Nursing (ADON). During the interview, concerns identified during the observations of the medication storage task were discussed. When asked, the ADON reported she would expect a vial of sterile water for injection to be discarded after being used one time. The ADON stated she was made aware of the med storage observations and the nursing staff was educated on the need for a single dose vial to be discarded	F 761	biologicals will be audited (start date of January 12, 2022) regularly by the Director of Nursing, Assistant Director of Nursing or RN supervisor to ensure proper guidance is met and to sustain the efficacy of said drugs/biologicals. On January 12, 2022 education was provided by the Director of Nursing/Assistant Director of Nursing. The education was provided to all licensed nurses and medication aides regarding labeling of drugs and biologicals to include the appropriate accessory and cautionary instructions, the expiration date when applicable and the date opened. The Director of Nursing and/or Assistant Director of Nursing will provide education to all newly hired Licensed Nurses and medication aides during orientation to ensure all vials/bottles of medication are labeled with resident name, instructions for usage and date opened. Agency nurses and medication aides will be trained during Agency orientation to ensure all vials/bottles of medication are labeled with resident name, instructions for usage and date opened. The Director of Nursing and/or designee will randomly monitor or audit medication rooms and carts 2 times weekly for 4 weeks and then weekly for two months on different shifts and weekends to ensure sustained compliance (auditing started January 12, 2022 and ongoing). It will be the responsibility of the Administrator to ensure sustained compliance. Beginning February 2022, the Director of	

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F 761	Continued From page 22 after one use. 3) Accompanied by Nurse #4, an observation of the Medication Cart used for Rooms 104-119 was conducted on 1/10/22 at 2:59 PM. The observation revealed a medication bottle containing 0.4 milligram (mg) nitroglycerin sublingual (under the tongue) tablets was stored on the med cart. Nitroglycerin is a medication used to relieve anginal (chest) pain. The bottle of nitroglycerin tablets was not labeled with the minimum information required, including the resident's name and instructions for use. At the time of the observation, Nurse #4 reported this medication bottle would normally be labeled. She stated the nitroglycerin tablets may have been left on the cart after being taken from the facility ' s emergency medications. An interview was conducted on 1/13/22 at 12:16 PM with the facility ' s Assistant Director of Nursing (ADON). During the interview, concerns identified during the observations of the medication storage task were discussed. When asked, the ADON reported she would expect a medication such as the bottle containing nitroglycerin tablets to be labeled. The ADON stated she was made aware of this med storage observation. The unlabeled bottle of nitroglycerin tablets was removed from the medication cart and the nursing staff was educated on the need for labeling medications.	F 761	Nursing/Assistant Director of Nursing will present the findings of the Medication Room and Cart Review Audit to the Executive QA Committee for review monthly for three months to determine trends and/ or issues that may require further interventions put into place and to determine the need for further and/or frequency of monitoring.	