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	345384	A. BUILDING ______ B. WING ______	C 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	**4351 SOUTH MAIN STREET FARMVILLE, NC 27828**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 01/18/22 through 01/24/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #8N3211.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 01/18/22 to conduct a recertification and complaint survey and exited on 01/24/22. Additional information was obtained on 01/27/22. Therefore, the exit date was changed to 01/27/22. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/30/21 and was removed on 01/22/22. An extended survey was conducted. Four of the 13 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550		2/23/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/11/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and resident interview, the facility failed to treat Resident #34 with dignity and respect by placing	F 550	1.Resident #34-bathroom door has been placed to allow for privacy.	

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F 550	Continued From page 2 the resident in a semi-private room in which the bathroom door was unable to close completely when she utilized her walker to get into the bathroom resulting in the resident being able to be seen by her roommate and persons passing by in the hallway causing her to feel embarrassed. This was for 1 of 1 reviewed for dignity. Findings included: Resident #34 was admitted to the facility on 11-30-21 with multiple diagnoses that included diabetes. The admission Minimum Data Set (MDS) dated 12-3-21 revealed Resident #34 was cognitively intact and required supervision with toileting. The MDS also coded Resident #34 as occasionally incontinent of urine. Resident #34 was interviewed and observed on 1-18-22 at 11:00am. The resident stated she was concerned about not having privacy while she used the bathroom. Observation of the bathroom revealed the door was approximately 12 inches from the toilet which faced the door, and the sink was approximately 3 inches from the toilet. Resident #34 stated when she used her walker to go to the bathroom, she cannot shut the door because there was not enough room in the bathroom for her walker, so she had to leave the walker in the doorway preventing the door from closing. She stated she was "embarrassed" to use the bathroom because her roommate could see her and anyone walking down the hall could see her if they looked in the room. Resident #34 explained she had discussed the issue with the Director of Social Services, but nothing had been	F 550	2.All resident bathroom doors will be inspected to ensure that residents will have and maintain privacy. 3.Maintenance Director educated on resident rights and dignity by Social Service Director 2/10/22. Staff educated on resident rights and dignity and completing work orders for maintenance. Education conducted by DHS Nurse Manager and/ or Social Service beginning 2/10/22 4.Administrator and/or Designee will review all resident bathroom doors weekly x4 weeks, monthly x3 months. 5.Findings will be reported to the Quality Assurance Improvement Performance committee monthly by the Maintenance Director. 6.Date of compliance 2/23/22	

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F 550	Continued From page 3 done. An interview with the Director of Social Services/Admissions occurred on 1-20-22 at 10:36am. The Director of Social Services stated when Resident #34 was admitted she was in a room where she could use the bathroom in privacy but due to the need for room changes, Resident #34 was placed in her current room. She acknowledged she was aware Resident #34 was not able to close her bathroom door when she used the toilet causing a dignity issue and that Resident #34 had discussed the issue with her and informed her, she was embarrassed, but the Director of Social Services stated due to the facility's census there was nowhere to move Resident #34. She explained the facility had offered Resident #34 a different room last week, but the resident had not decided. Resident #34 was interviewed on 1-20-22 at 1:50pm. The resident stated the facility had not offered any alternative rooms until today. She stated today (1-20-22) the facility offered her 2 alternative rooms to move to and she was going to look at each room. Resident #34 stated she was relieved she was going to have privacy now when she used the bathroom. The Administrator was interviewed on 1-20-22 at 4:42pm. The Administrator discussed staff needing to find accommodations for residents needs prior to moving a resident to another room. He also stated he expected every resident to have privacy.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		2/23/22

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§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable

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sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews, the facility failed to (1) maintain walls, faucets, lighting, blinds, and doors in good repair for 6 of 8 resident rooms (Rooms 1, 2, 3, 13, 14 and 20) and failed to (2) maintain a clean-living environment for 4 of 8 resident rooms (Rooms 1, 2, 3, and 6) observed for environment.

Findings included:

1.Observation of resident rooms revealed the facility failed to maintain walls, faucets, lighting, and doors in good repair for the following resident rooms:

a. Observation of room 1 occurred on 1-18-22 at 9:50am. The observation revealed a hole in the wall by the heat/air unit exposing insulation, 2 of the 3 knobs for the bathtub were broken off and the face plate for the bathtub plumbing was broken showing the inside of the wall.

A second observation of room 1 occurred on 1-20-22 at 9:40am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed a hole in the wall by the heat/air unit exposing insulation, 2 of the 3 knobs for the bathtub were broken off and the face plate for the bathtub plumbing was broken showing the inside of the wall.

The Maintenance Director was interviewed on 1-20-22 at 9:42am. The Maintenance Director stated he was aware of the needed repairs but had not had time to have them completed.

F 584

1.Maintenance Director completed repairs in rooms 1 exposed insulation 2/8/22.

2.Maintenance Director completed repair in room 1 broken knob bathtub, broken faceplate and plumbing 2/8/22

3.Maintenance Director completed repair in room 2 of loose metal plate 2/9/22

4.Maintenance director repaired the cord of overhead light room 2 on 2/8/22

5.Maintenance director has completed painting room 3 2/15/22

6. Maintenance Director replaced faucet in room 3 2/11/22

7.Maintenance Director will have repair of hole around plug outlet in room13 completed by 2/23/22

8.Maintenance director installed door on bathroom in room 14 2/8/22

9.Maintenance Director completed painting around window in room 20 2/15/22

10.Maintenance Director replaced toilet paper holder room 1 2/8/22.

11.Housekeeping cleaned walls and side rail 2/8/22

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b. Room 2 was observed on 1-18-22 at 9:55am and revealed a metal plate by the door was loose from the wall allowing the sharp edges of the plate and screws to be away from the wall, the overhead light for bed A did not have a cord attached to allow the resident to use the light, and the window blinds were broken.

The second observation of room 2 occurred on 1-20-22 at 9:45am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed a metal plate by the door was loose from the wall allowing the sharp edges of the plate and screws to be away from the wall, the overhead light for bed A did not have a cord attached to allow the resident to use the light, and the window blinds were broken.

The Maintenance Director was interviewed on 1-20-22 at 9:47am. The Maintenance Director stated he was aware of the needed repairs but had not had time to have them completed.

c. An observation of room 3 occurred on 1-18-22 at 9:58am. The observation revealed there was paint chipping off the windowsill in the resident bathroom leaving large areas of loose paint and the faucet to the sink was dripping even though the water was turned off.

A second observation of room 3 occurred on 1-20-22 at 9:50am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed there was paint chipping off the windowsill in the resident bathroom leaving large areas of loose paint and the faucet to the sink was dripping even though the water was turned off.

12.Maintenance Director and Housekeeping Supervisor completed inspection of all resident rooms on 2/8/22 for all needed repairs and cleanliness and make repairs as needed.

13.Maintenance Director and Housekeeping Supervisor educated by Administrator 2/10/22 on completing repairs and maintaining a clean environment for residents. Housekeeping staff educated on proper cleaning of resident rooms by housekeeping Supervisor Beginning 2/10/22.

14.Administrator and/or designee will monitor rooms for any needed repairs and cleanliness 5x/week for 2 weeks, weekly x4 weeks and monthly x3 months.

15.Findings will be reported to the Quality Assurance Improvement Performance committee monthly by the Maintenance Director and Housekeeping Supervisor

16.Date of compliance 2/23/22.

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F 584	Continued From page 7 The Maintenance Director was interviewed on 1-20-22 at 9:52am. The Maintenance Director stated he was aware of the needed repairs but had not had time to have them completed and that he was waiting for a part to come in to fix the sink. d. Room 13 was observed on 1-18-22 at 10:32am. The observation revealed a hole around a plug outlet allowing the outlet to be pulled from the wall. A second observation of room 13 occurred on 1-20-22 at 9:55am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed a hole around a plug outlet allowing the outlet to be pulled from the wall. The Maintenance Director was interviewed on 1-20-22 at 9:57am. The Maintenance Director stated he had replaced the outlet this week and did not have time to re-plaster around the outlet to secure it. e. An observation of room 14 was conducted on 1-19-22 at 8:28am. The observation revealed there was no bathroom door present, but a sheet taped to the door frame. The second observation of room 14 occurred on 1-20-22 at 10:00am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed there was no bathroom door present, but a sheet taped to the door frame. The Maintenance Director was interviewed on 1-20-22 at 10:02am. The Maintenance Director stated the size of the door was not a typical size and the only place that had the door was a place	F 584		

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in Jacksonville NC and he did not have time to go to Jacksonville to purchase the door.

f. Room 20 was observed on 1-18-22 at 2:00pm. The observation revealed there was paint peeling off the wall by the window allowing the plaster to show.

The second observation of room 20 occurred on 1-20-22 at 10:05am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed there was there was paint peeling off the wall by the window allowing the plaster to show.

The Maintenance Director was interviewed on 1-20-22 at 10:07am. The Maintenance Director stated he was aware of the needed repairs but had not had time to have them completed.

2. Observation of resident rooms revealed the facility failed to maintain a clean-living environment for the following resident rooms:

a. Observation of room 1 occurred on 1-18-22 at 9:50am. The observation revealed all 4 walls had black, brown, and opaque substance dripped on the walls and the toilet paper holder was rusted. A second observation of room 1 occurred on 1-20-22 at 9:40am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed all 4 walls had black, brown, and opaque substance dripped on the walls and the toilet paper holder was rusted.

The Housekeeping Supervisor was interviewed on 1-20-22 at 9:43am. The Housekeeping Supervisor stated the housekeeping staff were to check for any spillage on the walls when they

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cleaned the room daily and wipe the walls as needed.

b. Room 2 was observed on 1-18-22 at 9:55am and revealed black, brown and opaque substance on all 4 walls.

The second observation of room 2 occurred on 1-20-22 at 9:45am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed black, brown, and opaque substance on all 4 walls.

The Housekeeping Supervisor was interviewed on 1-20-22 at 9:48am. The Housekeeping Supervisor stated the housekeeping staff were to check for any spillage on the walls when they cleaned the room daily and wipe the walls as needed.

c. An observation of room 3 occurred on 1-18-22 at 9:58am. The observation revealed the top of the bed side rails contained a black and brown substance.

A second observation of room 3 occurred on 1-20-22 at 9:50am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed the top of the bed side rails contained a black and brown substance.

The Housekeeping Supervisor was interviewed on 1-20-22 at 9:53am. The Housekeeping Supervisor stated the housekeeping staff had tried to clean the area, but the black and brown substance would not come off. She added she could try another cleaning agent.

d. Room #6 was observed on 1-18-22 at

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F 584	Continued From page 10 10:00am. The observation revealed the tops of the bed side rails contained a brown substance. During a second observation of room 6 on 1-20-22 at 10:08am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed the tops of the bed side rails contained a brown substance. The Housekeeping Supervisor was interviewed on 1-20-22 at 10:10am. The Housekeeping Supervisor stated the housekeeping staff had tried to clean the area, but the black and brown substance would not come off. She added she could try another cleaning agent. During an interview with the Administrator on 1-20-22 at 4:42pm, he stated he expected all needed repairs to be completed and each resident have a safe clean environment.	F 584		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		2/23/22

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F 600	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interview, the facility neglected to protect a resident (Resident #5) who was severely cognitively impaired from sexual abuse from another resident (Resident #11) who was moderately cognitively impaired. The facility also failed to immediately intervene to protect Resident #5 when the sexual abuse was first observed. This occurred for 1 of 2 residents reviewed for abuse. On 10-30-21 Resident #11 was observed in Resident #5's room by Nursing Assistant (NA) #1 kissing Resident #5 with his hand down Resident #5's brief and again on 12-30-21 Resident #11 was observed by Nurse #1 in Resident #5's room touching Resident #5's breasts. Immediate Jeopardy began on 10-30-21 when staff failed to implement interventions to protect Resident #5 from being sexually abused by Resident #11. Immediate Jeopardy was removed on 1-22-22 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" no actual harm with potential for more than minimal harm that is not Immediate Jeopardy to ensure monitoring systems put in place are effective. Findings included: Resident #5 was admitted to the facility on 12-30-20 with multiple diagnoses that included vascular dementia, cognitive communication deficit and muscle weakness.	F 600	1.Residents #5 and #11 no longer reside in facility. Nurse Aide #1 was educated on Abuse /Neglect on 10/30/21. 2.The facility will identify predatory behaviors on admission through behavior monitoring tool for 72 hours after admission. The Interdisciplinary Team will review the 72-hour behavior monitoring tool and if any behaviors are noted, then the behavior monitoring tool will continue and interventions will be put into place for exhibited behaviors. Newly identified Residents exhibiting predatory behavior will immediately be placed on 1 on 1, behavior monitoring, and appropriate alternate placement, with family / Responsible Party permission, will be sought, the family/RP would have a 30-day notice prior to transfer and that they would also be provided with appeal rights, and the Administrator, Director of Health Services, and Social Services will be notified immediately. If Family Member / Responsible party is not agreeable with alternate placement the resident will remain on 1:1 until inappropriate behavior has been deemed resolved by physician / psychiatric intervention. 3.All Staff educated on Abuse/Neglect with emphasis on predatory behavior on 1/21/22 by Social Service and Nurse Manager. Staff on leave of absence will be educated prior to their next scheduled shift. Education will be incorporated into the orientation process.	

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PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

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F 600	Continued From page 12 The quarterly Minimum Data Set (MDS) dated 10-8-21 Revealed Resident #5 was severely cognitively impaired. Resident #11 was admitted to the facility on 8-26-20 with multiple diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 10-24-21 revealed Resident #11 was moderately cognitively impaired and showed no coding for behavioral issues or wandering. The MDS documented Resident #11 required supervision with one person for bed mobility, transfers, walking in his room, walking in the corridor. 1a. Review of the investigation report completed by the interim Director of Nursing dated 10-30-21 at 11:39am revealed Resident #11 was observed in Resident #5's room kissing her and fondling her vaginal area. The report indicated Resident #5 was assessed for injury and no injury was indicated. Documentation showed law enforcement and the facility's Medical Director were notified. The incident report also documented Resident #11 was placed on a 1:1 observation with no further interventions documented. A telephone interview occurred with Nursing Assistant (NA) #1 on 1-20-22 at 1:20pm. The NA explained she had been walking down the hall on 10-30-21 to another resident room when she glanced into Resident #5's room and saw Resident #11 leaning over Resident #5 kissing her and Resident #11 had his hand down Resident #5's brief. NA #1 revealed she had not immediately intervened when she observed the sexual abuse. She indicated she left Resident	F 600	4.Behavior monitoring will be reviewed 5x/week x2 weeks, weekly x4, monthly x3 months by DHS and/or designee. 5.Results will be reported to the Quality Assurance Improvement Performance committee monthly by the DHS and/or designee. 6.Date of compliance 2/23/22	

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F 600	Continued From page 13 #11 with Resident #5 and she went to inform Nurse #1. NA #1 stated she did not enter the room because she wanted a witness to what she was seeing. She explained they returned to the room within 1-2 minutes and saw Resident #11 standing in the middle of the room and then he just walked out. NA #1 stated Nurse #1 asked Resident #11 what he was doing but that Resident #11 would not speak. The NA clarified that Resident #11 walked around in the facility, but she had not seen him going into other resident rooms before. She stated she spoke with Resident #5 who told her a man was in her room touching her and pointed to her vaginal area. The NA said the resident did not appear to be upset or anxious. Nurse #1 was interviewed by telephone on 1-19-22 at 4:20pm. The nurse stated she did not see Resident #11 kissing or fondling Resident #5 on 10-30-21 when she entered Resident #5's room Resident #11 was in the middle of the room standing there not saying anything. Nurse #1 said she tried to ask Resident #11 what he was doing but he would not speak, and he walked out of the room. She stated she alerted the Administrator and called Nurse #2 to come and assist with the assessment of Resident #5 for any injuries. Nurse #1 stated Resident #5 spoke to NA #1 about what happened but said Resident #5 did not appear to be upset. Nurse #2 was interviewed on 1-20-22 at 11:30am. Nurse #2 acknowledged she had examined Resident #5 on 10-30-21. She explained she performed an external exam of Resident #5's vaginal area for any bleeding, scratches or other trauma. She stated she did not find any trauma to Resident #5's vaginal area. Nurse #2 said	F 600		

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Resident #5 did not express any feelings or dialogue on what had happened.

The facility's investigation dated 11-3-21 completed by the interim Director of Nursing revealed Resident #11 was interviewed by the facility's Social Services Director on 11-1-21 and documentation indicated Resident #11 did not remember entering Resident #5's room on 10-30-21 or touching Resident #5 on 10-30-21.

The Social Services Director also documented an interview with Resident #5 on 11-2-21. The documentation indicated Resident #5 was confused and discussed a visit she had with her husband over the weekend of 10-30-21.

The interim Director of Nurses (DON) was interviewed on 1-20-22 at 11:55am. The DON discussed Resident #11 was kept on a 1:1 observation until approximately 11-4-21. She explained from 10-31-21 through 11-3-21, Resident #11's family removed him from the facility during the day and he would return in the evening. She also explained Resident #11 was removed from the 1:1 observation because he was not exhibiting behaviors to continue a 1:1 observation.

Resident #11's care plan dated 11-12-21 revealed a problem that he had behavioral symptoms towards others, was seen inappropriately touching a female resident. The goal listed for the problem; Resident #11 will not inappropriately touch another resident. The interventions were in part; monitor resident location in the building, maintain a calm, slow understandable approach with the resident, obtain a psychiatric consult/psychosocial therapy as needed.

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Review of Resident #5's medical record revealed her last visit with psychiatric services was 11-19-21. The documentation from this visit indicated a medication follow up and did not discuss the sexual abuse that had occurred on 10-30-21. There was no Physician documentation in the medical record regarding the sexual abuse.

Review of Resident #11's medical record revealed no documentation from psychiatric services or other Physician documentation regarding the sexual abuse.

1b. Review of the 24-hour investigation report completed by the interim Director of Nursing dated 12-30-21 at 3:00pm revealed Resident #11 entered Resident #5's room and was observed touching Resident #5's breast. Documentation indicated law enforcement and the facility's Medical Director were notified. The report documented Resident #11 was placed on a 1:1 observation.

Review of Resident #5's nursing note completed by Nurse #3 on 12-30-21 at 3:57pm revealed Resident #5's family was notified of the incident and the family requested Resident #5 be sent to the emergency room for further evaluation.

Resident #5's nursing note completed by Nurse #1 dated 12-30-21 at 4:00pm revealed a skin assessment was performed with no abnormalities. The nurse (Nurse #1) documented Resident #5 was resting quietly in bed with no voiced complaints of pain or discomfort.

Nursing documentation completed by Nurse #3 dated 12-30-21 at 5:08pm indicated Resident #5

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was transferred to the emergency room by ambulance for further evaluation.

Review of Resident #11's nursing notes completed by Nurse #1 and Nurse #3 from 12-30-21 to 12-31-21 revealed on 12-30-21 Resident #11 was placed on a 1:1 observation and his family notified of the incident. Documentation on 12-31-21 revealed Resident #11 was discharged to family at 8:00am on 12-31-21.

Nurse #1 was interviewed by telephone on 1-19-22 at 4:20pm. The nurse explained she was walking down the hall to another resident room when she glanced into Resident #5's room and saw Resident #5's shirt pulled up and her breasts exposed, and Resident #11 was touching them. Nurse #1 revealed she had not immediately intervened when she observed the sexual abuse. She explained she did not enter the room but called down the hall for another nurse (Nurse #2) and when the other nurse arrived approximately 1-2 minutes later, they entered the room and stopped Resident #11. She stated Resident #11 had told her he was checking on Resident #5's pain then he left the room. Nurse #1 said she contacted the Social Worker who contacted the Administrator and interim Director of Nursing. She stated Resident #11 was placed on a 1:1 observation until his discharge on 12-31-21. She stated she had asked Resident #5 about the incident but Resident #5 did not say anything regarding the incident or show any emotions.

The interim Director of Nurses (DON) was interviewed on 1-20-22 at 11:55am. The DON discussed Resident #11 was discharged on 12-31-21 because the facility could not meet the

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needs of the resident but could not explain the discharge any further.

The facility's Medical Director was interviewed by telephone on 1-20-22 at 9:54am. The Medical Director verified he was aware of the incidents that occurred on 10-30-21 and 12-30-21. He discussed Resident #5's mental capacity and the likelihood that the resident was unaware of what was happening and would not have suffered any trauma. He also discussed Resident #11 being agitated at times and the sexual abuse on Resident #5 was part of his confusion. The Medical Director stated it was common to remove 1:1 observation after a couple of days if the resident no longer showed agitation. He explained that Resident #11 had no further behavioral issues for several days after 10-30-21 which was why the 1:1 observation after the 10-30-21 incident was ceased.

The Administrator was notified of Immediate Jeopardy on 1-21-22 at 10:08am

The facility provided a credible allegation of Immediate Jeopardy removal dated 1-22-22.

The entity's removal plan must include the following:

"   Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

The facility failed to protect Resident #5 from being inappropriately touched by Resident #11 on 10-30-21 and 12-30-21.

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On 10-30-21 at 11:39am, Nursing Assistant (NA) #1 witnessed Resident #11 kissing Resident #5 on her face and fondling Resident #5's vaginal area. NA #1 failed to immediately intervene when the sexual assault was observed, and she left Resident #5 in the room with Resident #11 to get the nurse (Nurse #2). A 24 hour and 5-day report were submitted to the state. The local Police Department was notified on 10-30-21 at approximately 1:45pm and an incident reported filed. The physician was notified at 12:20pm on 10-30-21.

Resident #11 was placed on 1:1 supervision for approximately 2 weeks. Resident was removed from 1:1 due to resident having no wandering behaviors for this timeframe.

On 12-30-21 at 3:00pm, Nurse #1 witnessed Resident #11 in Resident #5's room touching Resident #5's breasts. Resident #11 was escorted out of Resident #5's room and placed on 1:1 supervision until he was discharged on 12-31-21. A 24 hour and 5-day report were submitted to the state. The Police Department was notified on 12-30-21 at 3:20pm and an incident reported filed. The Physician was notified at 3:30pm on 12-30-21. Psychiatric Triage via phone, occurred at 4:39pm on 12/30/21 and recommended maintaining 1:1 until resident is discharged home with family on 12/31/21.

All residents are at risk for the current deficient practice.

" Specify the action the entity will take to alter the process or system failure to prevent a serious

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adverse outcome from occurring or recurring, and when the action will be complete.

NA #1 continues to work at the facility and was educated 10/30/21 by Nurse manager on abuse / neglect and immediately intervening when abuse/neglect is occurring.

On 10/30/21 the Nurse Manager began and completed education, either in-person or by phone, on intervening when resident abuse is occurring at the time of the occurrence. All employees have been educated on intervening when abuse/neglect occur. The education was completed on 10/31/21.

On 12/30/21 the Social Worker completed an audit via resident observation and record review of all residents in the facility regarding 1. Does the resident have a tendency to touch others, 2. Does resident wandering into or out of other resident rooms? There were no residents who were noted to wander in and out of other residents' rooms. No residents were identified as having a tendency to touch others.

On 1/21/22 Social Worker and Charge Nurse interviewed alert and oriented residents regarding the following questions: "Have you ever been abuse in any way since admission", "Have you noticed other residents roaming in and out of your room since your admission to facility", and "Are you fearful of any resident previously or currently residing in the facility". One of thirty residents interviewed stated another resident wandered into her room one time, but she was not fearful.

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On 1/21/22 the Charge Nurse and Social Worker observed the non-interview able residents for signs and/or symptoms of the resident appearing tearful, fearful or afraid. One resident appeared tearful, but this is baseline behavior for this resident.

The facility will identify predatory behaviors on admission through behavior monitoring tool for 72 hours after admission. The Interdisciplinary Team will review the 72-hour behavior monitoring tool and if any behaviors are noted, then the behavior monitoring tool will continue and interventions will be put into place for exhibited behaviors. Newly identified Residents exhibiting predatory behavior will immediately be placed on 1 on 1, behavior monitoring, and appropriate alternate placement, with family / Responsible Party permission, will be sought, the family/RP would have a 30-day notice prior to transfer and that they would also be provided with appeal rights, and the Administrator, Director of Health Services, and Social Services will be notified immediately. If Family Member / Responsible party is not agreeable with alternate placement the resident will remain on 1:1 until inappropriate behavior has been deemed resolved by physician / psychiatric intervention.

On 1/21/22 the Social Service Coordinator, Administrator and/or Nurse Managers began education for all staff on Abuse/Neglect with focus on Predatory Behavior, 40 of 75 employees have completed the education. This education incudes immediate removal of the resident from other resident area, reporting issue immediately to Charge Nurse, Administrator, Director of Nursing and Social Worker. The remaining 35 employees will be educated prior to their next scheduled

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F 600	Continued From page 21 shift. Employees who have not completed the education by 12:01 am 1/22/22 will be removed from the schedule until abuse/neglect education with focus on predatory behaviors is completed. This education has been incorporated in the general orientation process for all new employees. Date of alleged immediate jeopardy removal: 1/22/22 The facility's credible allegation of Immediate Jeopardy was validated on 1/24/22 with interviews with facility staff including nursing staff, dietary and housekeeping staff as well as activities staff. The staff verbalized receipt of education on monitoring for aggressive or predatory behaviors of residents, to intervene immediately and to report immediately. A sample of residents stated they were questioned about abuse as well as educated on reporting abuse. The staff education documentation, audits and monitoring were reviewed. The facilities date of immediate jeopardy removal of 1/22/22 was validated.	F 600		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 622		2/23/22

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because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's

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F 622	Continued From page 23 medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to allow a resident to remain in the	F 622	1.Resident #11 no longer resides in facility.	

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F 622	Continued From page 24 facility and provide written documentation which stated the reason the facility could not meet the resident's needs for 1 of 2 residents (Resident #11) reviewed for transfer and discharge. Findings included: Resident #11 was admitted to the facility on 8-26-20 with multiple diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 10-24-21 revealed Resident #11 was moderately cognitively impaired and did not code Resident #11 with any behaviors or wandering. Review of the facility's investigation report dated 11-3-21 revealed on 10-30-21 Resident #11 was found in a female resident room kissing her and fondling her vaginal area. Resident #11's care plan dated 11-12-21 revealed a goal that discharge planning would begin upon admission. The intervention for the goal was in part; facilitate discharge to an Assisted Living facility when resident was ready. The care plan also had a goal that Resident #11 would not touch another resident. The interventions for the goal were in part; monitor resident location in the building. Review of the 24- hour investigation report completed by the interim Director of Nursing dated 12-30-21 at 3:00pm revealed Resident #11 entered Resident #5's room and was observed touching Resident #5's breast. The report documented Resident #11 was placed on a 1:1 observation.	F 622	2.The facility will notify Resident requiring an involuntary transfer or discharge. The resident and/or responsible party will receive written notification at least 30 days before the planned discharge. Written transfer/ discharge notice will include reason for discharge, effective date of discharge, appeal rights and contact information for the Office of the State Long term Care Ombudsman. The Ombudsman will also receive notification of the notification/ discharge. Residents with unplanned discharge will receive Notice of transfer/ discharge. Written transfer/ discharge notice will include reason for discharge, effective date of discharge, appeal rights and contact information for the Office of the State Long term Care Ombudsman. The Ombudsman will also receive notification of the notification/ discharge. 3.Social Service educated on transfer/discharge process By Administrator 1/21/22. 4.Transfer/ Discharge notices will be reviewed by Administrator weekly x4 weeks, monthly x3. 5.Findings will be reported to the Quality Assurance Improvement Performance committee monthly by the Administrator and/or designee. 6.Date of compliance 2/23/22.	

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Documentation from the facility's Social Service Director (SSD) dated 12-30-21 at 2:27pm revealed the SSD informed Resident #11's legal representative of an incident that had occurred that day (12-30-21) and informed the legal representative she had to come and take Resident #11 home as the facility was unable to provide the care the resident needed.

A nursing note dated 12-31-21 at 8:30am revealed Resident #11 was discharged home from the facility with family.
Resident #11's medical record revealed no physician documentation describing the specific needs that could not be managed or met at the facility and the facility efforts to meet those needs.

During a telephone interview with the facility's Social Service Director (SSD) on 1-27-22 at 11:51am, the SSD confirmed she contacted Resident #11's legal representative on 12-30-21 and informed them they needed to pick the resident up and take him home as the facility was unable to provide the care the resident needed. She explained that Resident #11 required 1:1 observation and the facility was unable to provide this due to staffing issues. The SSD discussed her conversations with Resident #11's legal representative of possible discharge since the first incident on 10-30-21 but acknowledged no formal discharge plan or written documentation that stated the reason the facility could not meet the resident's needs was presented to the representative. She stated prior to the 10-30-21 incident, she had discussed Resident #11 being too high functioning for a skilled nursing home setting with the representative but there were no other placement options available. She stated

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F 622	Continued From page 26 she did not know if the representative kept Resident #11 at home or had him placed into another facility when he was discharged on 12-31-21. The Administrator was interviewed by telephone on 1-27-22 at 12:00pm. The Administrator discussed the representative agreeing to have Resident #11 discharged into her care and that the facility had been trying to find placement for Resident #11 since the 10-30-21 incident. He stated the facility could not manage long term 1:1 observation due to staffing hours so the resident's needs could not be met but stated the representative was not forced to take Resident #11 home. The Administrator acknowledged there was no written physician statement in the medical record summarizing the specific needs that could not be met, the facility's efforts to meet those needs, or the specific services another facility could provide that would meet his needs. Several attempts were made to reach Resident #11's legal representative (1-21, 1-22 and 1-24-22) with no success.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		2/23/22

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F 623	Continued From page 27 (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,	F 623		

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F 623	Continued From page 28	F 623		

including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

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F 623	Continued From page 29 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a written notification of discharge that included the reason the resident was being discharged and a statement of the resident's appeal rights at least 30 days before the resident was discharged from the facility. This occurred for 1 of 2 residents (Resident #11) reviewed for transfer and discharge. Findings included: Resident #11 was admitted to the facility on 8-26-20. Documentation from the facility's Social Service Director (SSD) dated 12-30-21 at 2:27pm revealed the SSD informed Resident #11's legal representative of an incident that had occurred that day (12-30-21) and informed the legal representative she had to come and take Resident #11 home as the facility was unable to provide the care the resident needed. Documentation showed the representative agreed to pick Resident #11 up on 12-31-21 in the morning. Nursing documentation dated 12-31-21 at 8:30am revealed Resident #11 was discharged from the facility with his legal representative. During a telephone interview with the facility's Social Service Director (SSD) on 1-27-22 at	F 623	1.Resident #11 no longer resides in facility. 2. The facility will notify Resident requiring an involuntary transfer or discharge. The resident and/or responsible party will receive written notification at least 30 days before the planned discharge. Written transfer/ discharge notice will include reason for discharge, effective date of discharge, appeal rights and contact information for the Office of the State Long term Care Ombudsman. The Ombudsman will also receive notification of the notification/ discharge. Residents with unplanned discharge will receive Notice of transfer/ discharge. Written transfer/ discharge notice will include reason for discharge, effective date of discharge, appeal rights and contact information for the Office of the State Long term Care Ombudsman. The Ombudsman will also receive notification of the notification/ discharge. 3.Social Service educated on transfer/discharge process By Administrator 1/21/22. 4.Transfer/ Discharge notices will be reviewed by Administrator weekly x4 weeks, monthly x3.	

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F 623	Continued From page 30 11:51am, the SSD confirmed Resident #11's family had not received a 30-day notice with a written explanation for the reason of discharge and no documentation for appeal rights. The SSD discussed her conversations with Resident #11's legal representative of possible discharge since a behavioral incident occurred on 10-30-21 but acknowledged no formal discharge plan or notice was presented to the representative. The Administrator was interviewed by telephone on 1-27-22 at 12:00pm. The Administrator discussed the representative agreeing to have Resident #11 discharged into her care and that the facility had been trying to find placement for Resident #11 since the 10-30-21 incident. He stated the facility could not manage long term 1:1 observation due to staffing hours. The Administrator acknowledged there was not a 30-day notice with written explanation for the reason of discharge or documentation on appeal rights provided to Resident #11's representative. Several attempts were made to reach Resident #11's legal representative (1-21, 1-22 and 1-24-22) with no success.	F 623	5.Findings will be reported to the Quality Assurance Improvement Performance committee monthly by the Administrator and/or designee. 6.Date of compliance 2/23/22.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		2/23/22

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F 655	Continued From page 31 (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. (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, resident and staff interviews, the facility failed to develop a baseline care plan for 1 of 2 residents (Resident #153) reviewed for baseline care plans.	F 655	1.The MDS coordinator will review and update resident #153 care plan to insure it is current.	

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Continued From page 32

Findings included:

Resident #153 was admitted to the facility on 1-14-22 with multiple diagnoses that included congestive heart failure, lymphedema, and epilepsy

There was no Minimum Data Set recorded however Resident #153 was documented as alert and oriented upon admission.

Review of Resident #153's medical record revealed no care plan.

Resident #153 was interviewed on 1-19-22 at 8:40am. The resident complained of not feeling well and her face being cold. She stated staff had not discussed the plan of care for her stay at the facility. Resident discussed her previous stay at the facility in 2020 but she stated, "I don't know what is going on this time."

A telephone interview occurred with the admitting nurse (Nurse #1) on 1-19-22 at 4:20pm. Nurse #1 stated she could not develop a baseline care plan for residents when they were admitted. She explained Nurse #2 was assisting her with Resident #153's admission and would have been responsible for the baseline care plan.

Nurse #2 was interviewed on 1-19-22 at 4:40pm. Nurse #2 acknowledged she was assisting Nurse #1 with Resident #153's admission. She explained there were 2 nurses in the facility who could develop a baseline care plan for new admissions but stated it would have been her responsibility to develop Resident #153's. Nurse #2 said Resident #153's baseline care plan was

F 655

2.New admissions /readmissions will have base line care plan initiated at time of admission by licensed nursing staff. Base line care plans will be reviewed 24 hours after admission/ readmission for completion and updates in morning clinical meeting.

3.An audit of new admissions readmissions from 1/22/22 will be completed by the MDS coordinator. Audits will continue 5x/ week x4 weeks, weekly x4 weeks then monthly x3 months by Director of Health Services and/or designee.

4.Licensed nursing staff educated by DHS and/or MDS coordinator on completing baseline care plans for new admissions/readmissions. Education began 2/10/22 Base line care plan process will be incorporated in the orientation process.

5.Audit results will be reported to the Quality Assurance Performance Improvement committee monthly by the DHS (Director of Health Services) and/or designee.

6.Date of compliance 2/23/22

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F 655	Continued From page 33 missed due to her other responsibilities and the inability to complete all her tasks. The Administrator was interviewed on 1-20-22 at 4:42pm. The Administrator discussed staffing issues but stated he expected baseline care plans to be developed upon admission by the admitting nurse.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		2/23/22

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F 656	Continued From page 34 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement a comprehensive care plan for 1 of 1 resident reviewed for care plans (Resident #26). Findings included: Resident #26 was admitted to the facility on 10/18/21 with a diagnosis of major depressive disorder, anxiety disorder, and muscle weakness. The admission Minimum Data Set (MDS) dated 10/22/21 revealed Resident #26 had moderate cognitive impairment. He required supervision with bed mobility, transfers, and toilet use. He was independent with eating after set-up help was provided and was at risk for developing pressure ulcers. A review of the MDS Care Area Assessment (CAA) dated 10/22/21 for Resident #26 revealed a care plan would be developed for cognitive loss/dementia, activities of daily living function/rehabilitation potential, urinary	F 656	1.Resident #26 had a comprehensive care plan completed 2/3/2022, which includes cognitive loss/dementia, ADL function, falls, nutritional status, dehydration, and pressure ulcers. 2.Current resident care plans reviewed to ensure that all care needs are addressed. New admissions and readmissions will have comprehensive care plan reviewed once completed to ensure care needs are addressed. 3.MDS and interdisciplinary team educated on completing comprehensive care plans By DHS on 2/10/22. 4.Administrator and/or designee will monitor comprehensive care plans 5x/week during morning Interdisciplinary Team meeting. 5.Findings will be reported to the Quality Assurance Improvement Performance	

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F 656	Continued From page 35 incontinence, falls, nutritional status, dehydration/fluid maintenance and pressure ulcer. Care plans were reviewed for Resident #26 and there were no comprehensive care plans developed for cognitive loss/dementia, ADL function/rehabilitation potential, falls, nutritional status, dehydration/fluid maintenance and pressure ulcer. An interview was conducted on 1/20/22 at 4:12 PM with the MDS nurse and she stated Resident #26's comprehensive care plan should have been completed in November. She stated it was an oversight. Resident #26 was interviewed on 1/20/22 at 5:10 PM and he stated he had not met with anyone about his plan of care. An interview was conducted with the Director of Nursing on 1/20/22 at 5:20 PM, and she stated care plans should be developed and updated within the proper time frame and as needed.	F 656	committee monthly by the Administrator and/ or designee. 6.Date of compliance 2/23/22	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		2/23/22

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F 657	Continued From page 36 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update care plans for 1 of 16 residents review for updated care plans (Resident #46). FIndings included: Resident #46 was admitted to the facility on 3/5/15 with diagnoses of muscle weakness and hypertension. The quarterly Minimum Data Set (MDS) dated 12/17/21 revealed Resident #46 was severely cognitively impaired. A review of Resident #46's record revealed her last care plan was reviewed and updated on 8/3/21. On 1/20/22 at 1:05 PM the MDS nurse stated	F 657	1.Resident #46 care plan has been reviewed, updated and is current as of 2/3/22. 2.The interdisciplinary team reviewed resident care plans to ensure all are up to date and current. Comprehensive care plans will be completed within 7 days after completion of the comprehensive assessment. 3.MDS coordinator and interdisciplinary team educated on developing a comprehensive care plan timely by DHS on 2/10/22. 4.Administrator and/or designee will monitor completion of comprehensive care plans 5x/week in the IDT morning meeting.	

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F 657	Continued From page 37 care plans should be reviewed and updated every quarter. She stated Resident #46's care plan was last reviewed and updated on 8/3/21 and her care plan should have been reviewed in November. She stated it was an oversight. An interview was conducted with the Director of Nursing on 1/20/22 at 5:20 PM, and she stated care plans should be updated within the proper time frame and as needed.	F 657	5.Findings will be reported to the Quality Assurance Improvement Performance Committee 6.Date of compliance 2/23/22	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff, and physician interview, the facility failed to provide a medication to a newly admitted resident that was ordered by a hospital physician for 5 days. This occurred for 1 of 2 residents (Resident #153) reviewed for new admission. Findings included: Resident #153 was admitted to the facility on 1-14-22 with multiple diagnoses that included congestive heart failure, left leg cellulitis and edema. The New admission nursing assessment dated 1-14-22 documented that Resident #153 was alert and oriented. Review of Resident #153's discharge hospital record dated 1-14-22 revealed the resident was	F 760	1.Resident #153 medications were reviewed by MD 1/19/22 and are current. 2.New admissions/readmissions orders to be reviewed by the Director of Health Services (DHS) and/or designee 24 hours after admission. Any discrepancies MD will be notified. 3.An audit of new admissions/ readmissions will be completed for any order discrepancies by DHS and/ or designee. All discrepancies will be reported to the MD. Audits will continue daily x5 weekly by DHS and/or designee. 4.Licensed nurses educated on transcribing orders correctly by DHS and/or Nurse Manager. Education began 2/10/22. Transcription of orders will be	2/23/22

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F 760	Continued From page 38 hospitalized from 1-6-22 to 1-14-22 for congestive heart failure, left leg cellulitis and edema. The discharge medications from the hospital were; Lopressor (blood pressure medication) 100 milligrams (mg) twice a day, Demadex (diuretic) 10mg daily, Lisinopril (high blood pressure) 5mg daily, Aspirin 81mg daily, Lipitor (cholesterol) 40mg at bed time, Zyrtec (allergy) 5-10mg daily as needed, Cholecalciferol (vitamin D3 supplement) 5,000 units daily, Catapres (blood pressure medication) 0.1mg twice a day, Colace (stool softener) 100-200 mg nightly as needed, Imdur (used for heart related chest pain) 15mg every other day, Keppra (seizure medication) 500mg twice a day, Prilosec (acid reflux) 20mg daily, Lyrica (pain) 75mg twice a day, Tramadol (pain) 50mg every 6 hours as needed. The admitting physician orders dated 1-14-22 were reviewed and revealed no order for Resident #153's Demadex 10mg daily. Resident #153's Medication Administration Record (MAR) for January 2022 was reviewed and revealed Resident #153 was not receiving Demadex 10mg daily. Nurse #1 was interviewed by telephone on 1-19-22 at 4:20pm. Nurse #1 stated she admitted Resident #153. She reported she would have looked at the hospital discharge record for the resident's current medications to transcribe them to the Medication Administration Record (MAR). She explained the facility had a standing order to use the hospital discharged medications as the admitting medications for the facility. Nurse #1 further explained she had another nurse (Nurse #2) helping with the admission of Resident #153 and that nurse had entered the medications.	F 760	incorporated into the orientation process. 5.Audit results will be reported to the Quality Assurance Performance Improvement committee monthly by DHS and/or designee. 6.Date of compliance 2/23/22	

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F 760	Continued From page 39	F 760		

Continued From page 39

During an interview with Nurse #2 on 1-19-22 at 4:40pm, the nurse acknowledged she had helped Nurse #1 admit Resident #153 and had transcribed the hospital discharge medications into the computer. Nurse #2 stated she did not know why the Demadex was not ordered, and she stated, "I guess I missed that one."

Observation of Resident #153 occurred on 1-19-22 at 5:00pm with Nurse #2. Resident #153's lower extremities were noted to be slightly edematous, and the resident had a dry cough.

Nursing documentation written by Nurse #2 on 1-19-22 at 5:37pm documented +1 pitting edema to both lower extremities and diminished lung sounds at the bases. The nurse documented Resident #153 was not short of breath and her oxygen saturation was 98 percent (normal range 95-100 percent).

A telephone interview occurred with the facility Physician on 1-20-22 at 9:54am. The Physician stated he had been made aware yesterday of the Demadex being omitted from the orders but stated he did not think this was critical even though Resident #153 was presenting with +1 pitting edema and diminished lung sounds at the bases. The Physician stated he did not believe Resident #153 was in congestive heart failure. He stated he would not re-start the diuretic until he re-assessed the resident.

The Administrator was interviewed on 1-20-22 at 4:42pm. The Administrator stated he expected all medications be transcribed accurately into the computer system.

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F 803	Continued From page 40	F 803		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations, interviews with facility staff and the consulting dietitian the facility failed to provide pureed bread to 9 of 9 residents on pureed diets as specified by the planned menu for 1 of 1 meal observations. The findings included:	F 803	1.Residents on pureed diets are receiving pureed bread when the menu lists bread with meal. Began 1/18/22. 2.All residents that are ordered pureed diets will receive pureed bread on their tray when the menu lists bread with meal. Began 1/18/22	2/23/22

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F 803	Continued From page 41 A review of the menu for the fall/winter 2021-2022 Diet Guide Sheet revealed on Tuesday (Day 24) lunch the regular pureed diet was to receive 1 serving of cornbread as the bread for that meal. On 1/18/22 at 10:50 AM the Dietary Manager stated the menu was rearranged due to the resident council meal being served on 1/19/22 for dinner. She said the menu for Tuesday lunch (1/18/22) would be served on Wednesday (1/19/22) at lunch. During the observation of the tray line on 1/19/22 from 12:15 PM until 12:45 PM revealed pureed bread was not available on the tray line. On 1/19/22 at 12:45 PM the Dietary Manager said they did not usually serve pureed bread to the residents on a pureed diet. During an interview with Cook #1 on 1/19/22 at 1:30 PM she stated she did not puree any of the cornbread for the pureed diets. She said she did not add any bread product to the pureed foods she served today. Cook #1 stated she did not know why she did not provide any bread to the residents who received a pureed diet. During an interview with the Dietary Manager on 1/19/22 at 2:15 PM she said she had not noticed the pureed diets did not receive any bread. She added there were 9 residents on pureed. On 1/19/22 at 4:00 PM the Registered Dietitian stated the pureed diet should receive the same foods as the regular diet. She said the facilities had the option to purchase pureed foods or puree the foods themselves at the facility but the residents on a pureed diet should receive bread	F 803	3.Dietary manager educated by Registered Dietician on 1/18/22 providing pureed bread to all residents on pureed diet. Dietary staff educated by Dietary Manager on 1/18/22 on preparing and providing pureed bread when menu lists bread products. 4.Administrator and/or designee will monitor tray line to ensure that pureed bread is being served when menu lists read with meal 5x/week x2 weeks, weekly x4 weeks, monthly x3 months. 5.Findings will be reported to the Quality Assurance Improvement Performance committee monthly by the dietary manager. 6.Date of compliance 2/23/22	

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F 803	Continued From page 42 as specified on the diet guide sheet. The Registered Dietitian said she monitored the tray line meal service on some of her visits but had not identified the residents on a pureed diet did not receive a serving of bread at meals. She said pureed diets should receive bread as specified on the diet guide sheet.	F 803		
F 808 SS=E	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews, the facility failed to provide a therapeutic diet as ordered by the Physician for 1 of 1 resident (Resident #51) reviewed for nutrition. This practice had the potential to affect other residents on therapeutic diets. Findings included: Resident #51 was admitted to the facility on 12-23-21 with multiple diagnoses that included diabetes Review of the Physician order dated 12-23-21 read for Resident #51 to receive a liberalized diabetic	F 808	1.Resident #51 is receiving therapeutic diet as ordered by physician. Received correct diet 1/18/22 2.Residents on therapeutic diets are receiving correct meals as of 1/18/22. Tray cards and trays are checked by dietary prior to leaving kitchen by the cook and dietary aide. Nursing staff will check tray cards to ensure tray correct prior to delivering to resident. 3.Administrator and/or designee will monitor tray tickets, tray line and tray pass to ensure that correct therapeutic diet is being served 5x/week x2 weeks, weekly x4 weeks, monthly x3 months. Registered	2/23/22

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F 808 Continued From page 43

The admission Minimum Data Set (MDS) dated 12-30-21 revealed Resident #51 was cognitively intact and was coded as receiving a therapeutic diet.

Resident #51 was interviewed on 1-18-22 at 2:13pm. The resident stated he was concerned over the foods he was receiving and explained he was diabetic and receiving too many carbohydrates (sugar, starch) and sugary deserts. He stated he had discussed this with the Dietary Manager, but his meals had not changed.

Observation of Resident #51's lunch tray occurred on 1-19-22 at 1:00pm. The tray contained country fried steak, fried okra, and a brownie.

Review of the facility's diet guide sheet revealed residents on a liberalized diabetic diet were to receive baked country fried steak, boiled okra, and a cup of pears for lunch on 1-19-22.

The Dietary Manager (DM) was interviewed on 1-19-22 at 3:13pm. The DM discussed a resident on a liberalized diabetic diet would receive the same foods as a regular diet. She reviewed the facility's diet guide sheet and stated she had not realized there was a difference between a regular diet and a liberalized diabetic diet. The DM discussed the cook and herself were to be following the diet guide when preparing foods for the residents and stated she had not seen there were differences.

A telephone interview occurred with the facility's Registered Dietician (RD) on 1-19-22 at 3:56pm. The RD explained regular diets were like a liberalized diabetic diet but there were menu

F 808

Dietician will monitor tray line monthly.

4.Dietary manager educated on serving Therapeutic diets Registered Dietician on 1/18/22. Dietary staff educated by Dietary Manager 1/18/22 on preparing and serving therapeutic diets.

5.Findings will be reported to the Quality Assurance Improvement Performance committee monthly by the Administrator.

6.Date of compliance 2/23/22

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F 808	Continued From page 44 guides to show what foods the liberalized diet residents should be served. She further stated she would not have expected the liberalized diet resident to receive regular country fried steak, fried okra, and a brownie but would have expected the liberalized diet foods to be served. The Administrator was interviewed on 1-20-22 at 4:42pm. The Administrator stated he would expect the residents to receive the proper diet that had been ordered for them.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with facility staff the facility also failed to have a barrier between ready to eat foods and the bare hands of	F 812	1.Activity Director CNA (Certified Nurse Aide) #3 and CNA#4 in serviced on proper handling serving residents meals and	2/23/22

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F 812	Continued From page 45 staf ffor 3 (Activity Director, Nursing Assistants #3 & #4) of 5 staff observed assisting residents with eating. The findings included: On 1/18/22 at 12:06 PM the Activity Director was observed to assist a resident who was eating lunch in the dining room. She helped the resident with his chicken sandwich when she put mayonnaise on one side of the bun then picked up the top piece of the bun with her bare hands and place it on top of the remaining sandwich. On 1/18/21 at 2:30 PM the Activity Director stated she did touch the bun with her bare hands. She reported she understood she should not touch the resident ' s food with her bare hands. On 1/18/22 at 12:35 PM Nursing Assistant #3 was observed feeding a resident in his room. She cut his chicken sandwich into portions then picked up a portion of the sandwich with her bare hands and fed it to the resident. On 1/18/22 at 12:38 PM Nursing Assistant #3 stated she forgot she should not touch the resident ' s food with her bare fingers. On 1/18/22 at 12:45 PM Nursing Assistant #4 was observed feeding a resident a cookie from the lunch tray. She held the cookie with her bare hands as she put it into the resident's mouth. During the observation on 1/18/22 at 12:47 PM Nursing Assistant #4 stated she was not aware it was wrong to touch the food with her bare hands. During an interview with the Director of Nursing on 1/19/22 at 12:55 PM she stated foods should not be touched with bare hands. She said staff could use the residents' utensils or wear gloves if	F 812	infection control during meal service by Nurse Manager on 2/10/22. 2.Nursing staff and Activity Staff were educated on proper handling of resident meals and infection control during meal service by DHS and/or Nurse Manager. Education began 2/10/22.Proper handling of resident meals and infection control during meal service will be incorporated into the orientation process. Staff not educated by 2/12/22 will be educated prior to their next schedule shift or removed from the schedule. 3.Staff will be observed by administrative staff during meals to ensure proper handling of resident meals and infection control is maintained 5x/week for 2 weeks weekly x4 monthly x3. 4.Observation results will be reported to the Quality Assurance Performance Improvement committee monthly by the Administrator and/or designee. 5.Date of compliance 2/23/22	

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F 812	Continued From page 46 they were to hold the food items with their fingers.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		2/23/22

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F 880	Continued From page 47 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and Physician interview, the facility failed to follow Infection Control practices when (1) 2 housekeeping staff (Housekeeper #1 and Housekeeper #2) failed to don gowns when entering an enhanced droplet isolation room, (2) Housekeeper #1 failed to perform hand hygiene after exiting an enhanced droplet isolation room	F 880	1.CNA #2 and #3 and Housekeeper #1 and #2 educated by the DHS and/or Infection Preventionist on donning and doffing PPE and Hand Hygiene with return demonstration 2/8/22 and2/10/22. Viewed CDC PPE Donning and Doffing CDC significance for COVID 19 and Clean Hands Count on 2/8/22 and 2/10/22.	

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and doffed her gown and gloves in the hall after leaving an enhanced droplet room , and (3) a Nursing assistant (NA #2) entered 2 enhanced droplet rooms without donning a gown or gloves and did not perform hand hygiene between rooms. These failures occurred during the COVID 19 pandemic.

Findings included:

The facility's "Coronavirus (COVID-19) Infection Prevention and Control Practices Policy" dated 3-6-20 revealed in part; Environmental services staff wear gloves, mask, face shield/goggles and gown when entering a resident room. Staff to wear goggles/face shield, gown and gloves when entering a droplet isolation room. Hand hygiene is performed before entry and at exit from a droplet isolation room.

1a. Continuous observation of Housekeeper #1 occurred on 1-18-22 from 10:40am to 10:45am. The Housekeeper was observed entering a new admission's room who had a "Level 2" sign posted on their door. The "Level 2" sign indicated staff were to wear a N95, face shield/goggles, gloves and gown when entering the room. The Housekeeper entered the room with no gown on and began cleaning the room and touching the resident's objects in the room. When the Housekeeper exited the room, she did not remove her gloves or perform hand hygiene, touched the barrier door to the hallway twice, returned to the resident room finished her tasks then removed her gloves and washed her hands.

During an interview with Housekeeper #1 on 1-18-22 at 10:46am, the Housekeeper stated she did not pay attention to the sign on the door, so

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2.On 2/10/22 the DHS and/or Infection Preventionist began educated of all staff on donning and doffing PPE and hand hygiene with return demonstration. All staff also viewed CDC videos PPE donning and doffing CDC significance for COVID 19 and Clean Hands Count. This education has been incorporated into the orientation process of all newly hired employees. Employees not educated by 2/12/22 will be educated prior to their next scheduled shift.

3.Staff will be observed by Administrator, DHS Infection Preventionist and/or designee for proper donning and doffing of PPE and hand hygiene 5x/week x2 weeks, weekly x4, monthly x3.

4.Observation results will be reported to the Quality Assurance Performance Improvement committee monthly by the Infection Preventionist.

5.Date of compliance 2/23/22

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she was not aware she needed to wear a gown into the resident room. She further said she was not thinking when she touched the barrier door with the same gloves, she had on in the resident room but should have removed them and washed her hands prior to touching the barrier door. The Housekeeper explained she had received education on wearing PPE and handwashing but stated it was a while ago and she just forgot.

1b. A continuous observation of Housekeeper #2 occurred on 1-18-22 from 10:47am to 10:50am. The Housekeeper was observed entering a newly admitted resident room who had a "Level 2" sign posted on the door. The Housekeeper was observed not to be wearing a gown while she was in the room cleaning around the resident's bed.

Housekeeper #2 was interviewed on 1-18-22 at 10:51am. The Housekeeper stated she was aware the resident was on isolation precautions but was unaware she had to wear a gown when she entered the room. She acknowledged she saw the signage on the door but did not think it pertained to Housekeeping. The Housekeeper stated she thought she had received education on isolation and wearing PPE but stated it was a while ago and did not remember.

2a. During a continuous observation of a Nursing Assistant (NA #2) on 1-18-22 from 10:52 to 11:00am, NA #2 was observed entering one newly admitted resident room who had a "level 2" sign posted on their door without wearing a gown or gloves. She was observed touching the resident nightstand and water pitcher. She exited the room without performing hand hygiene, touched the ice scooper then the lid to the ice chest, returned to the resident room to deliver the

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ice pitcher. NA #2 exited the room again without performing hand hygiene and walked into another newly admitted resident room without performing hand hygiene with a "Level 2" sign posted on the door without donning a gown or gloves. She was observed touching the resident's nightstand and picking up the water pitcher. NA #2 exited the room without performing hand hygiene, touched the ice scoop, touched the lid to the ice chest then returned to the resident room. She replaced the water pitcher and walked out of the room without performing hand hygiene, took hold of the cart the ice chest was on and touched the barrier door.

NA #2 was interviewed on 1-18-22 at 11:01am. NA #2 acknowledged she had entered a "Level 2" room without a gown or gloves but stated she did not think she needed to wear PPE to pass snacks and fill water pitchers. She stated she could not remember if she had received education on PPE, isolation, and the spread of the COVID virus and said if she had it was a while ago.

2b. Observation of Nursing Assistant (NA #3) occurred on 1-18-22 at 1:00pm. NA #3 was observed entering a newly admitted resident room with a "Level 2" sign posted on the door without wearing a gown or gloves. She was observed touching the resident's tray table and assisting with setting up his lunch tray. NA #3 exited the room without performing hand hygiene, touching the barrier door then performing hand hygiene.

During an interview with NA #3 on 1-18-22 at 1:03pm, the NA stated she was not paying attention to the fact the resident was on isolation precautions and thought washing her hands once

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she left the area was sufficient. She explained she had received training on isolation precautions and hand washing but she was not paying attention to what she was doing.

3a. An Observation occurred on 1-19-22 at 10:04 am. The observation revealed Housekeeper #1 exiting a COVID positive resident room while still wearing her gown and gloves. She was observed to doff her gown and gloves in the hall and swirling her gown into a ball with her bare hands then walking down the hall with the dirty gown in her bare hands to throw away in the soiled utility room. Without performing hand hygiene, she touched the soiled utility room door handle and once she left the soiled utility room, she sanitized her hands.

Housekeeper #1 was interviewed on 1-19-22 at 10:10am. The Housekeeper acknowledged her actions and stated she was not thinking about taking off her PPE when she was in the room. She stated there was a receptacle in the room for her PPE but did not think about it until she got in the hall. The Housekeeper stated she had received education on doffing PPE and hand washing but just was not thinking.

A telephone interview occurred with the facility's Medical Director on 1-20-22 at 9:54am. The Medical Director discussed the need for staff to have reinforcement on wearing the proper PPE and further education on the importance of following precautions. He explained it was possible for the COVID virus to be spread with the breaches of infection control, but the Medical Director said it was unlikely because the virus was more contagious through droplet contact than air.

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F 880	Continued From page 52 During an interview with Nurse #2 on 1-20-22 at 10:55am, the nurse stated the last education was contacted in May 2021 which covered Don/Doff of PPE, wearing masks, handwashing, COVID testing and COVID symptoms. She explained there was education provided in November 2021 on standard precautions. Nurse #2 discussed the issues with staff not following infection control practices and stated she felt the staff knew better but needed further education. The Administrator was interviewed on 1-20-22 at 4:42pm. The Administrator stated he felt staff needed further education and expected staff to follow infection control practices.	F 880		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with facility staff and record review the facility failed to prevent the buildup of ice inside the walk-in freezer for 2 of 2 walk-in freezer observations. The findings included: On 1/18/22 at 10:50 AM an observation of the walk-in freezer revealed ice buildup in the freezer. There was an accumulation of ice on the interior cooling unit of the freezer which was ½ inch thick and icicles on the bottom of the interior unit which were 4-6 inches long. The ice was also observed to be covering all the boxes of food which were	F 908	1.The freezer ice buildup has been removed 1/20/22 and freezer has been repaired 2/11/22. 2.The dietary manager/ dietary employees and/or Maintenance Director will monitor freezer daily for ice buildup and remove daily as needed. 3.The dietary manager educated the dietary employees on 12/11/22 on checking freezer for ice buildup. Any dietary employee not education by 2/12/22 will be educated prior to their next	2/23/22

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F 908	Continued From page 53 under this cooling unit including a box of ice cream type supplements which could not be opened or moved due to the amount of ice buildup covering the entire exterior of the box. A hammer was also observed on the 2nd shelf where additional boxes had ice covering the exterior. The ice was observed on each of the other shelves below the interior unit and continued to the floor. The ice on the floor under the storage rack under the interior unit was 2-3 inches thick. During an interview with the Dietary Manager on 1/18/22 at 10:55 AM she stated the ice buildup in the freezer had continued for almost 2 months. She stated she and the Maintenance Director used the hammer to break up and remove the ice. She said it had to be completed at least weekly when she was expecting a food delivery. She stated she had discussed the issue of the ice buildup with the Maintenance Director weekly, but it continued. She said the ice was forming because of water leaking in from the roof. On 1/20/22 at 9:50 AM the Maintenance Director reported in September 2021 the facility sent an estimate from a refrigeration contractor to the corporate office due to ice buildup which was approved in December 2021. He stated since the roof on the facility was repaired the water now accumulated over the kitchen area then leaked down onto the freezer roof (which was not part of the roof repair) and into the freezer causing ice to form. He added the roof pitch was not correct, so the rainwater pooled on the top of the kitchen area. The Maintenance Director said the roofing company came today and pushed the accumulated water off of the roof because of the upcoming snow and ice which was predicted to	F 908	scheduled shift. 4.The Dietary Manager and the Maintenance Director will monitor freezer for ice buildup 5x per week for 2 weeks, then weekly for 4 weeks, then monthly x3 months. 5.The analysis from the freezer ice buildup data will be reported to the Quality Assurance Improvement Performance committee monthly by the Dietary Manager. 6.Date of compliance 2/23/22	

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arrive on 1/21/22.

On 1/20/22 at 3:45 PM the Administrator reported a new roof was put on the building about 1 month ago. He stated the membrane on the roof was completed so the roof was not leaking. He did say there was a low place in the center of the roof. The Administrator said the ice in the freezer was due to the freezer unit itself was old. He reported the capital expenditure for the 9/20/21 estimate was approved, and those repairs were completed but the freezer continued to have ice buildup, so they had the contracted refrigeration company return on 1/5/22 to complete additional repairs.

On 1/20/22 at 3:50 PM the exterior of the building was observed with the Administrator. The freezer compartment was not on the same roof as the rest of the building. The exterior freezer unit motor was on the facility roof with pipes leading down to the top of the exterior of the freezer. During this observation the Administrator reported the top of the freezer did not have a new membrane put on it but the freezer unit motor itself was not on top of the freezer, so he did not feel the water/ice in the freezer was coming from the roof. He said the ice buildup was due to the freezer unit needing additional parts which were on backorder.

On 1/20/22 at 4:00 PM the administrator provided a copy of the last invoice from the contracted refrigeration company which was dated 1/5/22. The description of work read in part: "Found coupling leaking. Repaired leak. Install new insulation and secure. Drain cleared. Still waiting for evaporator coil heater. Still may have freeze up issues due to this part backordered."

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