STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345318	A. BUILDING _____ B. WING _____	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUNSWICK COVE NURSING CENTER	1478 RIVER ROAD WINNABOW, NC 28479

(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 02/06/22 through 02/10/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #EHBN11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 02/06/22 through 02/10/22. Event ID# EHBN11	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social,	F 561		3/10/22

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

Electronically Signed | 03/04/2022

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F 561	Continued From page 1 religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interviews the facility failed to provide showers as scheduled for 2 of 2 residents sampled for choices. (Resident #7 and #74). Finding included: 1. Resident #7 was admitted to the facility on 05/14/2020 with diagnoses which included, in part, low back pain and weakness. A review of Resident #7's Minimum Data Set (MDS), dated 01/19/22, indicated Resident #7 was cognitively intact and required limited assistance with bed mobility, personal hygiene and dressing and extensive assistance with transfers and toileting. For bathing, the assessment was marked, "8-Activity Itself Did Not Occur." The MDS indicated Resident #7 had impairment on both sides of her lower extremities and required a wheelchair as a mobility device. A review of Resident #7's Care Plan, last updated 01/30/22, included a problem of Activities of Daily Care (ADL) self-care performance deficit related to (medical diagnosis) and interventions included, in part, (1) able to shower independently with set-up in shower room with care products, (2) required total assist from staff for transfer on and off shower chair, and (3) total assist with total lift times two staff members. A review of Resident #7's shower schedule revealed she was scheduled to have a shower on	F 561	F561 SS=D Self-Determination a. Residents #7 received her shower on 2/7/22 and #74 received her shower on 2/7/22 per each resident request. b. All residents that request showers as their preference have the potential to be affected by this deficient practice. The eHR system is being updated to assist staff with more concise documentation of bathing preferences and assistance. c. The policy for bathing and showers was reviewed and updated. All nursing staff will be re-educated on the importance of providing resident preference for showers as scheduled and to notify the nurse of any interruption in care. If the Resident preference cannot be met at that specific time, staff will offer a following shift, the following day or an alternative of their choice. All efforts will be made to provide services per Resident choice or alternate choice as quickly as possible. The Director of Nursing or designee will be responsible for monitoring and reporting this process. This will be completed by March 10, 2022. d. Audits will be conducted by the Interdisciplinary Team weekly of 25% of the current Residents to ensure compliance with providing bathing assistance per the Resident's choice.	

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F 561	Continued From page 2 the 3:00 p.m. to 11:00 p.m. shift on Tuesdays and Fridays. A review of Resident #7's Bathing Documentation from 01/01/22 through 02/08/22 revealed no documentation of having received a shower on January 4, 7, 11, 14, 18, 21, 25, 28 and February 4 and 8. During an observation and interview with Resident #7 on 02/10/22 at 12:41 p.m., Resident #7 was observed with greasy hair and when asked about her hair, she explained that while she was scheduled to get showers on Tuesdays and Fridays, she seldom got one. Resident #7 She stated she could not remember when her last shower was taken. Resident #7 explained staff usually tell her they are "short staffed" as an explanation as to why they cannot give her a shower. During a telephone interview with Nursing Assistant (NA) #3 on 02/10/22 at 11:00 a.m., NA #3 stated she had been assigned to care for Resident #7 on 01/25/22. NA #3 stated she left work early at 8:00 p.m. on that date and did not have time to give Resident #7 a shower. During a telephone interview with NA #4 on 02/10/22 at 11:13 a.m., NA #4 stated she had been assigned to care for Resident #7 on 01/04/22, 02/01/22, 02/04/22 and 02/08/22. NA #4 explained she had not given Resident #7 a shower on those dates because the resident transferred using a total lift which required two staff members. NA #4 stated on those dates, she only had access to a Personal Care Assistant (PCA) and a PCA could not use the total lift. When asked if she had asked the nurse on the	F 561	These audits will be conducted at 25% of the current census weekly to ensure 100% of the Resident's bathing assistance will be audited and reportable to the QA Committee. Audits will be submitted to the monthly QA meetings for review and recommendations monthly for the next 3 months. The next QA Committee meeting is scheduled for 3/15/2022.	

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F 561	Continued From page 3	F 561		

hall for assistance, NA #4 stated she had not.

During a telephone interview with the Director of Nursing (DON) on 02/10/22 at 10:00 a.m., the DON stated it was her expectation staff follow the residents' shower schedule and provide showers. The DON explained if a resident refused their shower or if there are any concerns about giving the shower, the NA was to discuss the concerns with their nurse or with her.

During a telephone interview with the Administrator on 02/10/22 at 1:06 p.m., the Administrator explained a PCA cannot operate a total lift, however, a PCA can be the second person "spot" during a total lift transfer if they have been trained and had the skill checked off on their check-off list. The Administrator stated it was her expectation staff provide showers to residents as per the shower schedule.

2. Resident #74 was admitted to the facility on 06/10/2020 with diagnosis including coronary artery disease (CAD), peripheral vascular disease (PVD) and heart failure. The quarterly Minimum Data Set (MDS) dated 01/11/2022 had Resident #74 coded as cognitively intact and needed total dependence on staff for activities of daily living (ADL).

The comprehensive care plan dated 02/09/2022 had focus of an ADL self-care performance deficit with interventions including dependent on mechanical lift x 2 staff members for transfers.

Review of the facilities shower schedule revealed Resident #74's shower days were Mondays and Thursdays during day shift.

An observation of Resident #74 was conducted

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F 561	Continued From page 4	F 561		

on 02/06/2022 at 2:31 PM. Resident #74 was in bed, watching television with head of bed elevated, her table was in front of her with water, books and knitting equipment. She appeared to be neat and clean.

An interview with Resident #74 was conducted on 02/06/22 at 2:31 PM. The resident stated showers were very important to her and she would like to have her 2 scheduled showers and not just the one shower a week. The staff tells her there is not enough staff to get her to the shower room on both days because she had to use a mechanical lift.

An interview with Nursing Assistant (NA) #1 was conducted on 02/08/2022 at 1:50 PM. The NA stated she was familiar with Resident #74's care and was her NA every shower day in January which were Mondays and Thursdays. Resident #74 was required to have two (2) people to transfer her using the mechanical lift, but Mondays were usually shorter in staffing, and it was very difficult to find assistance to help with transfer using a mechanical lift. The NA also stated if the resident did not get a shower on Mondays, then she would get them on Thursdays and the documentation was missed for the showers but only missed 4 out of the 9 showers. The NA also stated she had not discussed this issue with her nurse.

An interview with Nurse #1 was conducted on 02/07/2022 at 1:03 PM. The nurse stated there had been days when residents had not received their showers on their scheduled days and that was due to a shortage of staff on the 300 halls at times. The nurse also stated if the residents did not receive a shower on their shower days, then

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F 561	Continued From page 5 they received a full bed bath. An interview with the Director of Nursing (DON) was conducted on 02/08/2022 at 2:31 PM. The DON stated Resident #74's scheduled shower days were Mondays and Thursdays. She is required to have two (2) people to transfer her using the mechanical lift and the staff were supposed to ask for help to assist with transfer to showers and there has been effort to increase employees but believed there were enough staff to complete all ADL task in a timely manner and the residents shower schedule was expected to be followed.	F 561		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on	F 567		3/10/22

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resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on record review, Responsible Party and staff interviews, the facility failed to provide access to the resident personal funds after the facility banking hours for 1 of 1 resident reviewed (Resident #31).

Findings included:

Resident #31 was admitted to the facility on 07/13/21.

A review of Resident #31's quarterly Minimum Data Set, dated 12/7/21, revealed Resident #31 was severely cognitively impaired.

During an interview with Resident #31's Responsible Party (RP) on 02/07/22 at 9:44 a.m., the RP stated the resident had a personal funds account at the facility. She indicated she was able to access the resident's personal funds

F-567 SS=D

a. Resident #31 (RP) was informed that if they would like to receive money from their trust account on the weekends they may do so upon request.

b. Other residents in the facility will be notified that they can receive money on the weekends from their trust account upon request. The business office manager and the receptionist were educated that residents are able to access their funds from their trust account on the weekend upon request. Residents are encouraged to make arrangements during weekdays for larger amounts of money which may be secured with the charge nurse on weekends.

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F 567	Continued From page 7 account during normal business hours Monday through Friday, but she had not known if she could access the personal funds account on weekends or evenings (non-banking hours). During an interview with the Business Office Manager (BOM) on 02/07/22 at 12:03 p.m., the BOM confirmed Resident #31 had a personal funds account. The BOM stated residents and/or their RPs had access to personal funds Monday through Friday, from 10:00 a.m. until 3:40 p.m. The BOM stated she completed the paperwork for the transaction and the facility's secretary was the person who gave out the money. The BOM stated residents and/or the RP did not have access to personal funds on weekends or evenings (non-banking hours). During an interview with the Administrator on 02/10/22 at 1:06 p.m., the Administrator stated, in the past, if a resident and/or RP needed money from a personal funds account after the facility's "banking hours" and if the request had been made in advance, she had always made sure the money was available. The administrator stated going forward, a plan would be put in place so that residents and/or their RPs had access to personal funds on weekends and evenings per the regulation.	F 567	c. An audit will be performed by asking those residents who regularly access their trust fund accounts to see if they asked for money on the weekend and if they were able to receive it on that weekend day. This audit will be performed by the Business Office Manager or designee. This audit will be performed weekly x 4 weeks and then monthly x 3 months. d. The results of these audits will be taken to the monthly QA meeting for the next 3 months to ensure that the residents are able to access their trust funds on the weekend. The next QA Committee meeting is scheduled for 3/15/2022.	
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of	F 569		3/10/22

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F 569	Continued From page 8 the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, Responsible Party (RP) interview and staff interviews, the facility failed to notify the RP when a resident's personal funds account reached $200 less than the Social Security Income (SSI) resource limit for 1 of 1 resident reviewed for personal funds (Resident #31). Findings included: Resident #31 was admitted to the facility on 07/03/12. Resident #31's quarterly Minimum Data Set (MDS), dated 12/07/21, indicated she was severely cognitively impaired. Record review of Resident #31's Trust-Transaction History from 01/01/2021 through 12/31/21 revealed Resident #31's personal funds had reached $200 of the SSI	F 569	F-569 SS= D Notice and Conveyance of Personal Funds a. During the Facility's annual survey, the MDS record showed that Resident #31 had reached the $200 threshold for eligibility. Th RP advised that she had not been notified. b. The Business Office Manager reviewed the Resident Trust accounts for all Residents. She documented anyone else who may have met this criteria and reached out to the Resident or RP to notify. The Business Office Manager will audit all accounts on a monthly basis to ensure any other Resident meeting this criteria will be notified (or RP in cases cognitive impairment) c. This audit monthly has been	

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F 569	Continued From page 9 resource limit in January 2021. During an interview with Resident #31's RP on 02/07/22 at 9:44 a.m., the RP stated she has not received any notifications of Resident #31's personal funds account having reached $200 of the eligibility limit. During an interview with the Business Office Manager (BOM) on 02/07/22 at 12:03 p.m., the BOM stated she was aware a resident's personal fund account had a limit and that she was supposed to notify the resident and/or RP when the account reached $200 less than the SSI resource limit. The BOM reviewed her records and verified Resident #31's account balance was within $200 of the SSI resource limit in January 2021 and revealed she could find no documentation that indicated she had contacted Resident #31's RP to notify of this information. During an interview with the Administrator on 02/10/22 at 1:06 p.m., the Administrator stated it was the responsibility of the BOM to contact the residents' RPs about resident funds reaching $200 of the eligibility limit. The Administrator stated, going forward, the BOM was to complete this task and document it has been done.	F 569	implemented with no end date beginning in February 2022. d. The results of these audits will be taken to the monthly QA meeting for the next 3 months to ensure that the residents are able to access their trust funds on the weekend. The next QA Committee meeting is scheduled for 3/15/2022.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		3/10/22

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F 644	Continued From page 10 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to complete a Preadmission Screening and Resident Review (PASARR) level II screening for residents with a new mental health diagnosis for 2 of 2 residents sampled for PASARR level II. (Resident #5, #21) Finding included: 1.Resident #5 was admitted to the facility on 07/18/2017 with diagnosis including unspecified psychosis not due to a substance or known physiological condition. The quarterly Minimum Data Set (MDS) dated 01/18/2022 indicated Resident #5 was moderately cognitively impaired and had delusions. Resident #5's diagnosis included delusional disorders, psychotic disorder (other than schizophrenia), and anxiety disorder. The annual MDS dated 07/30/2021 revealed Resident #5 was not currently considered for a PASARR level II to have serious mental illness and/or intellectual disability or a related condition.	F 644	F644 SS= D Coordination of PASARR and assessments a. New level two PASARR screenings were completed for both resident #5 and #21. b. The social worker completed a PASARR audit of all current residents currently in facility to ensure that any resident who has a diagnosis of mental illness is addressed for a level II PASARR. All residents that are determined to need a new PASARR screening that screening will be completed through NC Must no later than March 10, 2022. c. The social worker will review all new psychiatry notes for anyone who may have a newly diagnosed mental illness and complete a level II screening. All new admissions and readmissions will be audited by the social worker to ensure that the appropriate PASARR screening was completed prior to admission. If the social	

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F 644	Continued From page 11 The comprehensive care plan dated 01/31/2021 included a focus of being at risk for delirium related to diagnosis of psychosis. Resident #5's diagnoses list included: unspecified psychosis not due to a substance or known physiological condition 07/18/2017, delusional disorder added 12/04/2017, anxiety disorder added 10/24/2019, and unspecified mood (affective) disorder added 08/11/2020. The January Medication Administration Record (MAR) revealed an order dated 09/23/2020 for Quetiapine Fumarate (an antipsychotic medication), give 200 mg by mouth two times a day related to delusional disorders. An interview with the Social Worker (SW) was conducted on 02/07/2022 at 11:11 AM. The SW stated he was aware of the mental health diagnosis and the PASARR level II was not completed due to oversite. An interview was conducted with the Administrator on 02/07/2022 at 2:24 PM. The Administrator stated the task is solely the responsibility of the SW but when there is a new mental health diagnosis there should be a PASARR level II screening should be completed. 2. Resident #21 was first admitted 05/13/2010 and readmitted 02/13/2021 with a diagnosis of cerebral infarction. The quarterly Minimum Data Set (MDS) dated 01/27/2022 indicated Resident #21 was coded as severely cognitively impaired and included a	F 644	worker determines that a level II screening is appropriate, the screening will be completed immediately. d. On a monthly basis during the QA meeting, the social worker will provide to the members of the committee a written summary of any PASSAR screenings that have been completed for the prior month and the outcome of the screening request. e. The audit tool will consist of a occurrence log to identify and record any Level II PASARRs that were identified. This data will be reported to the QA committee monthly for 3 months. The data will be presented in the form of a “log” similar to an incident log. The next QA Committee meeting is scheduled for 3/15/2022.	

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	345318	A. BUILDING _____ B. WING _____	02/10/2022

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F 644	Continued From page 12 diagnosis of psychotic disorder (other than schizophrenia). The comprehensive care plan dated 12/05/2021 included a focus of has a mood problem related to traumatic brain injury (TBI). Resident #21's diagnoses list included: unspecified mood affective disorder dated 12/16/2020. An interview with the Social Worker (SW) was conducted on 02/07/2022 at 11:11 AM. The SW stated he was aware when there is a new mental health diagnosis, then a new PASARR level II screening should be completed. The SW also stated the PASARR level II was not completed because he was not aware that he needed to complete an application for a PASARR level II when an established resident got a new mental health diagnosis and stated he was not always informed when an established resident gets a new psych diagnosis. An interview was conducted with the Administrator on 02/07/2022 at 2:24 PM. The Administrator stated the task is solely the responsibility of the SW but when there is a new mental health diagnosis there should be a PASARR level II screening should be completed.	F 644		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		3/10/22

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F 690	Continued From page 13 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed provide catheter care by allowing the urine collection bag and tubing to rest on the floor for 1 of 3 residents (Resident #38) reviewed for urinary catheters. Findings included:	F 690	F690 SS=D Bowel/Bladder Incontinence,Catheter,UTI a. Resident#38 catheter bag was immediately corrected and placed on bed frame on 2/6/22 and on 2/7/22 catheter tubing was immediately tucked into the cloth privacy bag on wheelchair Resident #38 continues to be non-compliant with	

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F 690	Continued From page 14 Resident #38 was admitted to the facility on 10/4/19 with diagnoses that included obstructive uropathy (a condition in which urine flow was blocked) and anxiety. A significant change Minimum Data Set (MDS) dated 12/16/21 revealed Resident #38 was cognitively intact and required extensive assistance with toileting, dressing, and hygiene. The MDS did not indicate Resident #38 refused care. A Care Plan dated 9/17/21 focused on Resident #38's catheter included a goal to be free of urinary tract infections (UTI) and catheter-related trauma through the review period. Interventions included check tubing for kinks, monitor and document urinary output, observe for signs of UTI, observe catheter site and report abnormalities, and change catheter per doctor's orders. Upon entry to the facility on 2/6/22 at 12:20 PM, an observation was made of Resident #38 sleeping in his bed with his catheter urine collection bag hooked to the side of his bed. The bed was in low position and the urine collection bag rested on the floor. An observation was made on 2/7/22 at 11:45 AM of Resident #38 in his wheelchair in the unit dining room. His catheter bag was suspended in a cloth carrying bag under the wheelchair with the tubing resting on the floor. During an interview on 2/7/22 at 12:00 PM, Nurse #3 indicated she did not know the tubing was on the floor and it should have been tucked in the carrying bag with the urine collection bag. She revealed catheter tubing on the floor was an infection control issue.	F 690	catheter tube placement and moves bag. b. All residents with foley catheters have the potential to be affected by this deficient practice. The Facility policy for catheter care was reviewed. All nursing staff will be re-educated on the importance of proper placement of foley catheter bags and prevent tubing or bag from resting on the floor. c. The policy for indwelling catheter care was reviewed and updated. All nursing staff will be re-educated on the importance of providing indwelling catheter care properly and as scheduled and to notify the Director of Nursing or Asst. Director of Nursing of any complications or delay of care. The Director of Nursing or designee will be responsible for monitoring and reporting this process. This will be completed by March 10, 2022. d. Audits will be conducted by the Interdisciplinary Team weekly of 100% of the current Residents who have indwelling catheters to ensure compliance with providing care per facility policy. These audits will be conducted at 100% of the current census of those Residents with an indwelling catheter weekly to ensure 100% of the Resident's indwelling catheter care will be audited and reportable to the QA Committee. Audits will be submitted to the monthly QA meetings for review and recommendations monthly for the next 3 months. The next QA Committee meeting	

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F 690	Continued From page 15 In an observation on 2/7/22 at 12:05 PM, Nurse #3 donned gloves and tucked Resident #38's catheter tubing into the cloth carrying case. During an interview on 2/7/22 at 1:45 PM, the Director of Nursing (DON) and Assistant DON revealed the Nurse Aide (NA) should have put the tubing in the carrying bag with the catheter bag. During an interview on 2/8/22 at 9:50 AM, NA #5 indicated staff tucked the catheter tubing into the cloth carrying bag but it falls back out. She revealed the tubing should not touch the floor. An observation was made on 2/8/22 at 12:10 PM, of Resident #38 in his wheelchair in the dining room. His catheter bag was suspended in a cloth carrying bag under his wheelchair with the tubing resting on the floor. An observation was made on 2/8/22 at 2:40 PM of Resident #38 in bed with his catheter bag hanging on the side of his bed. The bed was in lowest position with the catheter bag resting on the floor.	F 690	is scheduled for 3/15/2022.	
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 725		3/10/22

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F 725	Continued From page 16 accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide nursing staff of sufficient quantity resulting in residents not getting showers per preference. This effected 2 of 2 resident (Resident #74 and #7) reviewed for choices. The findings included: This tag is cross referenced to: F561: Based on observation, record review, resident interview, and staff interviews the facility failed to provide showers as scheduled for 2 of 2 residents sampled for choices. (Resident #74 and #7). During an interview on 2/7/22 at 1:00 PM, Nurse #1 revealed there were days when residents had not received their showers due to being short staffed.	F 725	F725 SS=D Sufficient Nursing Staff to provide Resident choices a. Adequate staff was available to provide showers to those residents who prefer showers as scheduled. There are also ancillary staff, Licensed nurses, therapists who are available to assist in transfers if needed. b. All residents who request showers have the potential be affected when there are staffing challenges. c. All residents that request showers as their preference have the potential to be affected by this deficient practice. The eHR system is being updated to assist staff with more concise documentation of bathing preferences and assistance.	

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F 725	Continued From page 17 During an interview on 2/8/22 at 1:50 PM, NA#1 revealed that Mondays were short staffed, and it was difficult for her give showers. During an interview on 2/8/22 at 2:30 PM, the Director of Nursing (DON) indicated the facility had been trying to get more employees, but she believed there was enough staff to provide care. During an interview on 2/9/22 at 3:45 PM, the Administrator revealed that they were short staffed but did have enough staff to provide showers.	F 725	d. The policy for showers was reviewed and updated. All nursing staff will be re-educated on the importance of providing resident preference for showers as scheduled and to notify the nurse of any interruption in care. Staffing schedules will be reviewed to ensure adequate levels to provide showers per resident preference. All nursing staff will educated on notifying the nurse if assistance is needed for residents to transfer so preferred shower can be provided. If the Resident preference cannot be met at that specific time, staff will offer a following shift, the following day or an alternative of their choice. All efforts will be made to provide services per Resident choice or alternate choice as quickly as possible. The Director of Nursing or designee will be responsible for monitoring and reporting this process. This will be completed by March 10, 2022. e. Audits will be conducted by the Interdisciplinary Team weekly of 25% of the current Residents to ensure compliance with providing bathing assistance per the Resident's choice. These audits will be conducted at 25% of the current census weekly to ensure 100% of the Resident's bathing assistance will be audited and reportable to the QA Committee. Audits will be submitted to the monthly QA meetings for review and recommendations monthly for the next 3 months. The next QA Committee meeting is scheduled for 3/15/2022.	

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F 755	Continued From page 18	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure 2 of 5 sampled residents (Resident #294 and Resident	F 755	F755 SS=D Pharmacy a. Medication (Phytonadione) was ordered on 2/8/22 for resident #294 and	3/10/22

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F 755	Continued From page 19 #79) observed during medication administration, received their scheduled medications. Findings included: 1. Resident #294 was admitted to the facility on 01/28/2022 with diagnoses including cirrhosis of the liver. The admission Minimum Data Set (MDS) dated 02/04/2022 had Resident #294 coded as cognitively intact and needing limited assistance with activities of daily living (ADL). A review of the medication ordering and receiving policy dated June 09, 2015, revealed in part to reorder medications 3-4 days in advance to assure adequate supply is on hand. A review of the facility medication ordering and receiving policy dated June 09, 2015, revealed in part to reorder medications 3-4 days in advance to assure adequate supply is on hand. A review of Resident #294's physician's orders revealed 01/28/2022 Lactulose (used to treat constipation) 20 gram (GM)/30 milliliters (ML), 01/29/2022 a woman's multivitamin, 02/02/2022 Spironolactone (a potassium-sparing water pill) Tablet 50 milligram (MG), 02/05/2022 Furosemide (also known as a water pill) 40 MG, and on 02/02/2022 Phytonadione (Vitamin K a medication used to prevent bleeding in people with blood clotting problems) tablet 5 MG once a day by mouth for supplement. An observation of Resident #294's medication administration on 500 hall was conducted on 02/08/2022 at 9:22 AM with Nurse #2. Nurse #2 was observed administering a woman's multivitamin, Spironolactone tablet 50 MG, Furosemide 40 MG, Lactulose 30 ML and	F 755	was administered on 2/9/22 0900 as ordered next administration. MD was notified of missing medication and ordered to hold medication until it was delivered. Resident # 79 medication (Carafate) was ordered on 2/8/22 and was administered on 2/8/22 1600 as ordered next administration. Md was notified of missing mediation and ordered to hold until medication was delivered. b. All residents have medications ordered have the potential to be affected by this deficient practice. c. Policy for medication not available was reviewed. All Licensed staff will be re-educated on the importance of ordering medications timely or calling the needed medication in to the “back-up” pharmacy if not available in the Facility e-kit to ensure timely administration of medications. The Director of Nursing or designee will be responsible for monitoring and reporting this process. This will be completed by March 10, 2022. d. Audits will be conducted by the Interdisciplinary Team weekly for medication errors or unavailable medications and the Pharmacy Consultant monthly during the scheduled audit to ensure compliance with availability of medications. These audits will be conducted at 25% of the current census weekly to ensure 100% of the Resident’s medications were available for administration. Audits will be submitted to	

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F 755	Continued From page 20 Phytonadione tablet 5 MG. The Phytonadione 5 MG tablet was not administered. An interview with Nurse #2 was conducted on 02/08/2022 at 9:31 AM. The nurse stated the Phytonadione 5 MG tablet was not in the cart. He stated it was not ordered for a refill. The nurse also stated when residents' medication gets down to 4 or 5, it should be reordered using the computer on the cart and that had not happened, and he did not know why it had not been reordered. The nurse stated he will speak to the physician for further instructions. An interview with the Director of Nursing (DON) was conducted on 02/08/2022 at 11:03 AM. The DON stated medications are to be reordered within 4 days to avoid missing medications and this medication should have been reordered sooner. The DON also stated when there is a missed medication, the physician, and pharmacy should have been called to get new instructions. The physician was called and gave an order to hold medication until it was delivered. 2. Resident #79 was admitted to the facility on 08/09/2021 with diagnosis including cerebrovascular disease. The quarterly Minimum Data Set (MDS) dated 01/14/2022 had Resident #79 coded as moderately cognitively impaired and totally dependent on staff for activities of daily living (ADL). A review of the facility medication ordering and receiving policy dated June 09, 2015, revealed in part to reorder medications 3-4 days in advance to assure adequate supply is on hand. An interview with Nurse #3 on 02/08/2022 at	F 755	the monthly QA meetings for review and recommendations monthly for the next 3 months. The next QA Committee meeting is scheduled for 3/15/2022.	

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F 755	Continued From page 21 10:08 AM. The nurse stated Resident #79's Carafate tablet had run out and was ordered the day before but had not been delivered. The nurse also called the pharmacy and called the physician to make them aware. The nurse also stated she was not the nurse on the hall when it should have been reordered, which is 4 or 5 days until the last tablet to avoid missing medications. An interview with the DON was conducted on 02/08/2022 at 11:03 AM. The DON stated medications are to be reordered within 4 days to avoid missing medications and this medication should have been reordered sooner. The DON also stated when there is a missed medication, the physician, and pharmacy should have been called to get new instructions. Nurse #3 followed those procedures, and the physician was called and gave an order to hold medication until it was delivered.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.69% for 2 of 5 sampled residents observed during medication administration. (Resident #294 and Resident #79)	F 759	F759 SS=D Free of Medication Error Rates 5 Percent or More a. Medication (Phytonadione) was ordered on 2/8/22 for resident #294 and was administered on 2/9/22 0900 as ordered next administration. MD was notified of missing medication and ordered to hold medication until it was	3/10/22

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F 759	Continued From page 22 Findings included: 1. A review of Resident #294's physician's orders revealed 01/28/2022 Lactulose (used to treat constipation) 20 gram (GM)/30 milliliters (ML), 01/29/2022 a woman's multivitamin for supplement, 02/02/2022 Spironolactone (a potassium-sparing water pill) tablet 50 milligram (MG), 02/05/2022 Furosemide (also known as a water pill) 40 MG, and 02/02/2022 Phytonadione (Vitamin K a medication used to prevent bleeding in people with blood clotting problems) tablet 5 MG once a day by mouth for supplement. An observation of Resident #294's medication administration on 500 hall was conducted on 02/08/2022 at 9:22 AM with Nurse #2. Nurse #2 was observed administering a woman's multivitamin, Spironolactone tablet 50 MG, Furosemide 40 MG, Lactulose 30 ML. The Phytonadione 5 MG tablet was not administered. An interview with Nurse #2 was conducted on 02/08/2022 at 9:31 AM. The nurse stated the Phytonadione 5 MG tablet was not in the cart. He stated it was not ordered for a refill. The nurse also stated when residents' medication gets down to 4 or 5, it should be reordered using the computer on the cart and that had not happened, and he did not know why it had not been reordered. The nurse stated he will speak to the physician for further instructions. An interview with the DON was conducted on 02/08/2022 at 11:03 AM. The DON stated medications were to be reordered within 4 days to avoid missing medications and this medication should have been reordered sooner. The DON also stated when there is a missed medication,	F 759	delivered. Resident # 79 medication (Carafate) was ordered on 2/8/22 and was administered on 2/8/22 1600 as ordered next administration. Md was notified of missing mediation and ordered to hold until medication was delivered. b. All residents have medications ordered have the potential to be affected by this deficient practice. c. Policy for medication not available was reviewed. All Licensed staff will be re-educated on the importance of ordering medications timely or calling the needed medication in to the “back-up” pharmacy if not available in the Facility e-kit to ensure timely administration of medications. The Director of Nursing or designee will be responsible for monitoring and reporting this process. This will be completed by March 10, 2022. d. Audits will be conducted by the Interdisciplinary Team weekly for medication errors or unavailable medications and the Pharmacy Consultant monthly during the scheduled audit to ensure compliance with availability of medications. These audits will be conducted at 25% of the current census weekly to ensure 100% of the Resident’s medications were available for administration. Audits will be submitted to the monthly QA meetings for review and recommendations monthly for the next 3 months. The next QA Committee meeting is scheduled for 3/15/2022.	

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the physician, and pharmacy should have been called to get new instructions.

2. A review of Resident #79's physician's order dated 08/10/2021 revealed an order for 1 gram (GM) of Carafate (for ulcer prevention) by mouth two times a day for heartburn, 08/10/2021 Pantoprazole Sodium (used to treat heart burn) 40 MG by mouth one time a day for gastrointestinal (GI) upset, 08/10/2021 Lisinopril (to decrease elevated blood pressure) 20 milligram (MG) by mouth once a day for essential (primary) hypertension, 08/10/2021 Aspirin (a pain reliever) 325 MG by mouth one time a day for unspecified cerebrovascular disease, 09/29/2021 Acetaminophen (a pain reliever) 650 MG by mouth three times a day for hemiplegia, unspecified affecting left nondominant side, , 09/30/2021 Senna-Docusate Sodium (treats constipation) 8.6-50 MG tablet by mouth two times a day for constipation, 12/21/2021 Vitamin D3 2000 international unit (IU) for vitamin D deficiency, 10/18/2021 Olopatadine (to treat itching and redness) 1 drop each eye, 12/17/2021 Hydrocortisone cream 2% (relieves skin discomfort) to left arm rash topically two times a day for dermatitis and 02/01/2022 Lidocaine patches 4% (pain patch) to left and right shoulders.

An observation of Resident #79's medication on 400 hall was conducted on 02/08/2022 at 10:05 AM with Nurse #3. Nurse #3 was observed to administer Lisinopril 20 MG, Acetaminophen 650 MG, Aspirin 325 MG, Senna-Docusate Sodium Tablet 8.6-50 MG, Protonix 40 MG, Vitamin D3 2000 IU, Olopatadine 1 drop each eye, Lidocaine patches 4%, and Hydrocortisone cream 2%. The Carafate 1 GM tablet was not administered.

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F 759	Continued From page 24 An interview with Nurse #3 on 02/08/2022 at 10:08 AM. The nurse stated Resident #79's Carafate tablet had run out and was ordered the day before but had not been delivered. The nurse called the pharmacy and called the physician to make them aware. The nurse also stated she was not the nurse on the hall when it should have been reordered, which is 4 or 5 days until the last tablet to avoid missing medications. An interview with the DON was conducted on 02/08/2022 at 11:03 AM. The DON stated medications were to be reordered within 4 days to avoid missing medications and this medication should have been reordered sooner. The DON also stated when there is a missed medication, the physician, and pharmacy should have been called to get new instructions. Nurse #3 followed those procedures, and the physician was called and gave an order to hold medication until it was delivered.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		3/10/22

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F 761	Continued From page 25 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to secure an unattended medication cart for 1 of 5 carts (500 hall cart) for medication carts reviewed for medication storage. Findings included: On 02/08/2022 at 9:22 AM, Nurse #2 was passing medications on the 500 halls. A continuous observation for 9 minutes revealed Nurse #2 picked up the medicine cup for Resident #20 from the medication cart, shut the drawers and locked computer. The nurse walked down the hall into Resident #20's room and left the medication cart unlocked. He did not have a view of the medication cart from inside the resident's room and there were staff and residents observed passing by the unlocked cart. An interview with Nurse #2 was conducted on 02/08/2022 at 9:33 AM. The nurse stated he usually locks the cart when he walks away but forgot to do it today. An interview with the Director of Nursing (DON)	F 761	F761 SS= D Label/Storage Drugs and Biologicals a. On 2/8/22 the nurse locked medication cart when approached that cart was not locked. The nurse was re educated on 2/8/22 on proper storage of medications. b. All residents who have medications ordered by MD have the potential to be affected by this deficient practice. The policy for Storage of Medications was reviewed. All Licensed staff will be re educated on the importance of securing medication carts when cart is not in sight. The Director of Nursing or designee will be responsible for monitoring and reporting this process. This will be completed by March 10, 2022. c. Supervisors and Administrative team will round daily to ensure the Nursing staff remains compliant with properly securing medication carts. Any staff found non-compliant regarding this policy will be	

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F 761	Continued From page 26 was conducted on 02/08/2022 at 11:03 AM. The DON stated it was unfortunate that the cart was left unlocked. The DON also stated there had not had any issues with unlocked carts and expected the carts to be locked before walking away.	F 761	re-educated regarding the facility policy and disciplined up to termination. d. The audit tool will consist of a disciplinary document for any nursing staff in violation of this policy. This data will be reported to the QA committee monthly for 3 months. The data will be presented in the form of a “log” similar to an incident log. The next QA Committee meeting is scheduled for 3/15/2022.	
F 812 SS=F	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 observation, record review, and staff interviews, the facility failed to have system to ensure the water temperature of the low temp	F 812	F-812 SS= F Food Procurement, Store/Prepare/Serve-Sanitary	3/10/22

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F 812	Continued From page 27 dish machine reached the minimum 120 degrees Fahrenheit for washing and sanitizing dishware as specified in the manufacturer's recommendations, failed to remove outdated food intended for use in the walk-in refrigerator, and failed to label foods in nourishment food refrigerators (100 hall, 300 hall, 400 hall). These practices had the potential to effect food served and distributed to all residents. Findings included: 1. Review of the low temp dish machine's manufacturer's specification sheet indicated a minimum required temperature of 120 degrees Fahrenheit (F). During an observation on 2/8/22 from 1:40-2:00 PM, eight cycles were run by Dietary Aid #2 of the dish machine containing lunch dishes with temperatures ranging between 100-105 degrees F for the wash and rinse cycles. A manufacturer's sticker on the dish machine indicated a minimum temperature of 120 degrees Fahrenheit required for wash and rinse cycles. The temperatures were taken by the machine's built-in thermometer and with an external thermometer. Dietary Aid #2 demonstrated testing the sanitizer using a test strip indicating 200 parts per million (ppm). A log titled "Three Compartment Sink Sanitizer Log" was used for monitoring the dish machine sanitizer levels. The log was marked "satisfactory" for each day of the month of February 2022. Temperature was not indicated on the sheet. During an interview on 2/8/22 at 2:05 PM, Dietary Aid #2 revealed he does not track the temperature of the dish machine, only the	F 812	Dish Washing Machine Temperatures (records) a. Review of the low temp dish machine's manufacturer's specification sheet indicated a minimum required temperature of 120 degrees. On 2/8/22 the dish machine was found to be 100-105 degrees F. Whaley's appliance repair was called on 2/9/22. They came out and ran diagnostics on the dish machine. It was found that a piece of plastic refuse was trapped inside the drain which was affecting proper drainage of the water between cycles which adversely affected the water temperature. This has been corrected. b. Staff has been educated by the RD and Dietary Manager regarding proper documentation on the daily audit tool for temperatures for the dish washing machine, which has been implemented since 2/9/22. As a part of this education, the process for how to wash and sanitize dishes in the event the dish machine isn't working properly. The dietary manager or designee will check the log daily to ensure temperatures continue to be done regularly and remain within the manufacturer's operation specifications. This will be completed by March 10, 2022. c. Copies of the newly implemented log are included for review. These logs are collected monthly and will be stored in the kitchen for future reference. This new log examiines wash temp, rinse temp, as well as the sanitizer concentration. The dish machine has been performing well since	

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F 812	Continued From page 28 sanitizer levels. He indicated he takes the temperature and tests the sanitizer using test strips daily and marks the log "satisfactory or unsatisfactory." He stated the sanitizer level should be 200 ppm and the temperature should be 165 degrees F. During an interview on 2/8/22 at 2:10 PM, the Dietary Manager revealed the person who runs the dish machine was responsible for monitoring the temperature and testing the sanitizer before each wash cycle. He revealed they were tracking the sanitizer levels but not the temperature of the dish machine. The Three Compartment Sink Log was used because they needed a form to track the sanitizer levels. During an interview on 2/10/22 at 12:40 PM, the administrator revealed her understanding when they purchased the dish machine was that there was no minimum temperature requirement as it was a low temperature, chemical dish machine. 2. During an observation on 2/6/22 at 11:20 AM of the kitchen walk in refrigerator, a large container of bacon grease labeled 12/17/21 was observed. During an interview on 2/6/22 at 11:30 AM, the registered dietitian (RD) revealed the bacon grease should have been thrown out after one week from the labeled date written on the container. She indicated the walk-in refrigerator was checked once a week and old food was thrown out. 3. On 2/6/22 at 3:50 PM, a tour with the RD was made of the resident nourishment rooms on all halls. The 100-hall refrigerator revealed a plastic	F 812	the repair as evidenced by the new dish machine temperature log. d. This data will be reported to the QA committee monthly for 3 months. The data will be presented in the form of a daily temperature log. The next QA Committee meeting is scheduled for 3/15/2022. Food Storage/ Labeling/ Disposal a. During an observation on 2/6/22 a large container of bacon grease was identified which should have been thrown out after 1 week. b. The Facility policy & procedure for use of leftovers was reviewed with dietary staff on 2/18/22 by the RD and Dietary Manager. c. The dietary manager is responsible for ensuring all left over food/ beverage items are checked each weekly by the Dietary Manager or designee to ensure that leftovers are either used within 7 days or thrown out. Any areas with food storage will be checked daily to ensure proper labeling and storage/ coverings are intact and within policy. d. The audit tool will consist of an “incident” log. Instances of policy violation will result in further education and/ or possible discipline. This data will be reported to the QA committee monthly for 3 months. The data will be presented in the form of a “log” similar to an incident log. The next QA Committee meeting is	

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F 812	Continued From page 29 container with sliced cheese and sausage inside with a resident's name and room number but no date, a glass container of canned peaches with no label, a grocery bag of sliced cheese with no label or date. The observation of the 300-hall refrigerator revealed three wrapped sandwiches with no label or date, two iced teas with no label or date, a large water bottle filled with red liquid with no label or date. The observation of the 400-hall refrigerator revealed one and a half wrapped sandwiches with no label or date. During an interview on 2/6/22 at 4:00 PM, the RD stated it was the nursing staff's responsibility to label and date all food items put into the nourishment room refrigerators. Food brought from outside the facility for residents should be labeled with their name and date and thrown out after 24 hours. During an interview on 2/7/22 at 2:20 PM, the Administrator indicated it was the responsibility of the food and nutrition department to ensure all foods in the nourishment room refrigerators were labeled and dated and discarded appropriately.	F 812	scheduled for 3/15/2022. Resident Nourishment Rooms a. On 2/6/22 a tour of the resident nourishment halls was taken with the RD. Numerous personal and unlabeled items were in the fridges. The 100 hall refrigerator revealed a plastic contained with sliced cheese and sausage inside with a resident's name and room number but no date. The 300 hall refrigerator revealed wrapped sandwiches with no label and date. The 400 hall refrigerator revealed one and a half wrapped sandwiches with no label or dates. b. Dining Services had been sending out sandwiches with meal trays as well as labels on the actual trays. The facility has since purchased the tray card system. This system allows for specific labels to be generated for all prescribed nourishments so nursing staff can easily identify which nourishments are for which resident. c. The dining services department also now separately labels and dates each sandwich made for the snack carts so staff can be sure any sandwiches given as snacks are fresh and run no risk of foodborne illness. Melody Kyzer, PhD, RD, LDN has been assigned the duty of monitoring the resident nourishment halls. The facility updated policy for food brought in from outside sources has been reviewed with nursing staff. See the attached policy. Weekly Dr. Kyzer or designee will inspect the nourishment	

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F 812	Continued From page 30	F 812	refrigerators to ensure any improperly dated or expired items or containers are discarded, as well as any person items belonging to staff. This will be completed by March 10, 2022. d. The audit tool will consist of an "incident" log. Instances of policy violation will result in further education and/ or possible discipline. This data will be reported to the QA committee monthly for 3 months. The data will be presented in the form of a "log" similar to an incident log. The next QA Committee meeting is scheduled for 3/15/2022.	
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners;	F 888		3/10/22

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(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;

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(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and

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F 888	Continued From page 33 secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement the facility policy for unvaccinated employees when two unvaccinated staff members were observed wearing a KN95 mask while working inside the facility (Dietary Aide #1, Nursing Assistant #2). Findings included: The facility's Covid-19 Vaccination Policy, created 01/04/22, included, "Following Mask Requirements: unvaccinated employees who have not completed their primary vaccination series to use a NIOSH-approved N95 or equivalent or higher-level respirator for source	F 888	F-888 SS=C COVID 19 Vaccination of Facility Staff a. During the survey process, two employees who did not meet the criteria of FULL vaccination were observed with improper masks. Both were re-educated to the Covid-19 infection control policy and one was terminated regarding the non-compliance. b. All staff has been educated as of March 1st (unless PRN or on leave) regarding the Facility Covid-19 infection control policy and procedure, as evident	

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	345318	A. BUILDING _____ B. WING _____	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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control, regardless of whether they are providing direct patient care to or otherwise interacting with patients."

As requested, the administrator provided a list of unvaccinated employees that included Dietary Aide #1 and Nursing Assistant (NA) #2.

An observation of Dietary Aide #1, an unvaccinated staff member, was made on 02/08/22 at 10:19 a.m. She was observed wearing a KN95 mask while working in the kitchen within 6 feet of other dietary department employees.

During an interview with Dietary Aide #1 on 02/08/22 at 10:20 a.m., Dietary Aide #1 confirmed she had not received the Covid-19 vaccination. When asked if she had to do anything different as an unvaccinated staff member, she explained she must wear an N95 mask if she leaves the kitchen to go to other parts of the facility.

A second observation of and interview with Dietary Aide #1 was made on 02/08/22 at 12:40 p.m. At this time, Dietary Aide #1 was observed to be wearing an N95 mask. Dietary Aide #1 explained she had been told by the Administrator she should be wearing an N95 mask at all times because she was unvaccinated.

An observation of Nursing Assistant (NA) #2, an unvaccinated staff member, was made on 02/08/22 at 10:30 a.m. NA #2 was observed leaving a resident's room (215A) holding a trash bag in a gloved hand and wearing a KN95 mask.

During an interview with NA #2 on 02/08/22 at 10:31 a.m., NA #2 confirmed she had not

by the signed acknowledgements of the policy. (see policy) This policy includes wearing of N-95 NIOSH (or higher level respirator) approved face masks for those staff who are not FULLY vaccinated. Those who have a medical or religious exemption are aware they are considered not FULLY vaccinated. The staff who are FULLY vaccinated may wear a KN-95 mask within the facility.

c. Supervisory staff for each department is responsible to ensure the staff in their department who are not FULLY vaccinated are wearing the appropriate masks as well as the vaccinated staff wearing their appropriate masks and other PPE. A list has been provided to the supervisory staff for reference. This list is updated upon a change in vaccination status, new hires and terminated employees. Supervisors and Administrative team will round daily to ensure the staff who are not FULLY vaccinated are wearing the appropriate mask/ PPE. Any staff found non-compliant regarding this policy will be disciplined up to termination.

d. The audit tool will consist of a disciplinary document for any staff member not wearing the appropriate mask/ PPE per facility policy and infection control guidelines. This data will be reported to the QA committee monthly for 3 months. The data will be presented in the form of a “log” similar to an incident log. The next QA Committee meeting is scheduled for 3/15/2022.

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received the Covid-19 vaccination. When asked, NA #2 explained she had provided incontinent care to the resident in room 215A in addition to getting him dressed. NA #2 explained she did not have take any additional precautions as an unvaccinated employee except getting tested for Covid-19 twice a week.

A second observation of and interview with NA #2 was made on 02/08/22 at 12:34 p.m. At this time, NA #2 was observed wearing an N95 mask. When asked why she had not been wearing an N95 mask earlier, she explained she had forgotten she had been told about having to wear an N95 mask at all times because she was unvaccinated. NA #2 further explained the Director of Nursing (DON) had come to her and told her she needed to switch out her KN95 mask to an N95 mask and reminded her she signed a paper acknowledging the new policy. NA #2 stated she vaguely remembered signing the paper about unvaccinated staff needing to wear an N95 mask. NA #2 stated N95 masks were located in the infection control nurse's office/lab, across the hall from the Station I entry where she enters the building.

During an interview with the Dietary Manager on 02/08/22 at 10:13 a.m., the Dietary Manager stated he thought unvaccinated staff were supposed to be wearing an N95 mask however he stated he was not aware that unvaccinated staff had to wear an N95 mask in all parts of the facility.

During an interview with the Infection Control Nurse (Nurse #4) and the Administrator on 02/08/22 at 1:00 p.m., they explained every person who works in the facility was provided a

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copy of the Staff Vaccination Policy. The Administrator further explained the policy was discussed with the staff and an acknowledgement statement was signed by the staff. A copy of the signed acknowledgement statements for Dietary Aide #1 (signed on 01/28/22) and NA #2 (signed on 01/26/22) was provided.

During an interview with the Administrator on 02/10/22 at 1:06 p.m., the Administrator stated unvaccinated staff were made aware of the requirement to use an N95 mask and signatures were obtained from staff indicating they had been made aware of the policy. The Administrator explained going forward, the unvaccinated staff members' supervisors will be expected to ensure their unvaccinated staff are wearing N95 masks. The Administrator stated N95 masks will now be made available to staff dietary department, therapy department and Station 1 in order for unvaccinated staff to easily access them.