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	345128	A. BUILDING _____ B. WING _____	C 02/23/2022

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ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted from 02/02/22 through 02/04/22 with additional information obtained through 02/23/22 therefore, the exit date was changed to 02/23/22. There were 39 allegations investigated and 32 of the allegations were substantiated with citation and 2 of the 39 were substantiated without citation. See Event ID #ZN7X11. Immediate Jeopardy was identified at: CFR 483.10 at citation F-580 at a scope and severity of K. Immediate Jeopardy began on 12/17/21 and was removed on 02/08/22. CFR 483.25 at citation F-686 at a scope and severity of J. Immediate Jeopardy began on 01/27/22 and was removed on 02/08/22. CFR 483.45 at citation F-757 at a scope and severity of K. Immediate Jeopardy began on 12/17/21 and was removed on 02/09/22. CFR 483.70 at citation F-835 at a scope and severity of K. Immediate Jeopardy began on 12/17/21 and was removed on 02/08/22. Citations F-550, F-677, F-686 and F-757 constituted Substandard Quality of Care. An extended survey was conducted on 02/11/22.	F 000		
F 550 SS=H	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		3/25/22

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

Electronically Signed | 03/09/2022

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

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F 550	Continued From page 2 the resident when he requested his medication (Resident #4), failed to treat residents in a dignified manner by not providing incontinence care when requested and double and triple briefing the residents (Resident 3, Resident #5, Resident #9, Resident #10, and Resident #11) for 6 of 9 residents reviewed. The residents stated that waiting on incontinence care and wearing multiple briefs made them feel bad, low and like less of a man, demeaning, embarrassed and degraded. The findings included: 1. Resident #4 was admitted to the facility on 10/26/21. Review of the admission Minimum Data Set (MDS) dated 10/28/21 revealed that Resident #4 was cognitively intact and was independent with activities of daily living. Resident #4 was interviewed on 02/02/22 at 12:19 PM. Resident #4 stated that he had been at the facility since October 2021 and "nighttime in the facility were the worst." He stated that the staff were rude and yelled and cussed him a lot. He stated that he was paralyzed in a car accident in 2004 and had very bad back spasms which were exacerbated when he did not get his medication. He explained that at home he had a very strict schedule for his medicines that allowed him to have the best coverage for his spasms but at the facility he could not get that coverage because the medications were just given whenever was convenient for the staff. He recalled an incident that occurred on 12/29/21 and stated he had cell phone video footage of the incident. He stated that Medication Aide (MA) #1	F 550	completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to treat resident in a dignified manner when requesting medication for resident #4. On 3/7/22 Administrator provided 1:1 reeducation to MA #1 on speaking to residents in a dignified manner. The facility failed to treat resident in a dignified manner by not providing incontinence are when requested and double, triple briefing resident #3, resident # 5, resident #9, resident #10 and resident #11. On 2/11/22, residents received incontinence care and single briefed. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/2022 the Director of Nursing and/or designee reviewed current incontinent residents to ensure incontinence care provided and that they	

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F 550	Continued From page 3 was so rude to him and yelled and cussed at him that night. Thankfully another nurse "came to my rescue" and helped him get his medications that night. He stated that he had reported the incident to the Administrator and her response was "I will check into it," he also stated that he had reported it to the former Director of Nursing (DON) #2, but he was only in the facility for a couple of weeks and did not have time to follow up about the incident. Resident #4 stated that the way MA #1 spoke to him was terrible and he did not appreciate it, all he wanted his medications. Review of cell phone video time stamped 12/29/21 provided by Resident #4 was reviewed. The video showed MA #1 at the medication cart and Resident #4 in his wheelchair. Resident #4 was noted to approach MA #1 and request his nighttime medication. There was a discussion about his medication and MA #1 stated to Resident #4 "you can wait on your medications just like everyone else" and walked away from the medication cart. MA #1 was heard using profanity as she walked away to another resident's room. Nurse #8 was observed to approach Resident #4 while he was waiting beside MA#1's medication cart. She asked Resident #4 what he needed, he replied he had asked for his nighttime medication. Nurse #8 was heard saying "it is 10:30 PM you have not had your medication yet" to which Resident #4 replied that he had asked for it, but MA #1 had yelled at him. Nurse #8 and Resident #4 stood by MA #1's medication cart for approximately 5-10 minutes discussing his medications and what he was supposed to have gotten. Nurse #8 was heard telling Resident #4 to follow her to her medication cart and she would pull the medications that she could and proceeded to do so. A few minutes later Nurse #8	F 550	are not double or triple briefed. No additional concerns identified. Effective 3/14/2022 the Director of Nursing and/or designee completed an observation of license nurses and medication aides during medication pass to ensure current residents are treated in a dignified manner. No additional concerns identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Director of Nursing and/or designee educated current facility and agency Certified Nursing Assistances and License Nurses on ensuring residents receive incontinence care as needed and are not double or triple briefed, and residents are spoken to in a dignified manner when requesting/receiving medications. Effective 3/24/2022 any facility or agency Certified Nursing Assistances and License Nurses that have not been educated will not be allowed to work until education received in- person or via telephone by Director of Nursing and/or designee during the orientation process. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing will complete visual	

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and Resident #4 returned to MA #1's medication cart and Nurse #8 asked MA #1 to please open the narcotic drawer for her. MA #1 asked why, and Nurse #8 replied she was going to pull Resident #4's narcotic that he requested. Nurse #8 calmy stated that he had requested his medication that were due at 9:00 PM and he had a right to have his medication. MA #1 again stated "he can wait like everyone else."

Nurse #8 was interviewed on 02/04/22 at 3:04 PM. Nurse #8 stated that she recalled the incident on 12/29/21 and stated MA #1 "was so mean to" Resident #4. She explained she was working the other medication cart and was the nurse responsible for overseeing MA #1. Nurse #8 stated she heard loud voices coming from around the corner, so she walked back there to see what was going on. She pulled Resident #4 to the side and asked what was going on and he had told her he asked MA #1 for his medications that were due at 9:00 PM and it was well past 10:00 PM and Resident #4 stated that MA #1 had yelled at him and told him he would have to wait. Nurse #8 explained to MA #1 that Resident #4 was in pain and she was making him suffer by not administering his medications that he requested, and MA #1 stated "I am not giving him anymore medication" and Nurse #8 stated she calmy told MA #1 that was fine she would medicate Resident #4 for the rest of their shift. Nurse #8 stated that she did report the incident to the former DON #1 but could not recall when and DON #1 stated she would address it.

MA #1 was interviewed on 02/04/22 at 12:26 PM. MA #1 explained that she used to work the night shift but around the first of January she had switched to day shift. She stated that she

observations for non-interviewable residents and questionnaire for interviewable residents. Monitoring as follow: 5 residents weekly x 12 weeks to ensure residents are treated in a dignified manner.

Results of these audits will be reviewed at Monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected.

Completion date: 3/25/2022

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generally worked the medication cart passing medications but always had a nurse that was responsible for overseeing her on the medication cart. MA #1 explained that a lot of residents approached her while she was on the medication cart requesting their medications and "that makes me anxious, and I make them wait until I get done" with the one I am working on, but they seem to want their medication right then. MA #1 stated that she recalled the incident on 12/29/21 she stated Resident #4 was requesting his medications. She stated that he "was upset and lashed out at me" because he wanted his medications right then. MA #1 stated that all residents have feelings and "not all days are good days" but I don't take it personal. She stated she took care of Resident #4 like she did all her residents. Residents should be treated like humans, with respect and we the staff are expected to talk nicely to the resident and should not cuss at them. MA #1 denied cussing at Resident #4 and stated she was never rude to him or any other resident that she cared for.

The former DON #1 was interviewed on 02/10/22 at 1:46 PM. She stated that she was not aware of any incident with MA #1 and Resident #4 on 12/29/21. She stated that she was on vacation from 12/22/21 through 01/02/22 and Nurse #10 was covering for her while she was out so maybe they reported the incident to her.

Nurse #10 was interviewed on 02/10/22 at 1:50 PM. Nurse #10 stated that no one reported any incident to her regarding MA #1 and Resident #4. She stated that she did know that Resident #4 had reported the incident to former DON #2 while he was in the facility but was not sure exactly what he reported only that it was reported to him.

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Former DON #2 was interviewed on 02/10/22 at 1:54 PM. The DON stated that he was only at the facility for a short time but while he was there Resident #4 had reported to him that the night shift staff were mean to him and that they hollered and cussed at him all the time and he was afraid to take medication from them. DON #2 stated that Resident #4 did not mention specific names and he did not ask Resident #4 for specific names but reported the night shift staff in general. He added he was not made aware of any specific incident including the incident on 12/29/21 just occurrences in general. DON #2 stated that he had reported to the Administrator several times what Resident #4 had reported. Resident #4 stated that he had video footage if we needed it and when the Administrator was asked, she stated no we did not need the video. The former DON #2 stated that he felt like what Resident #4 was reporting was verbal abuse, but he had reported it to the Administrator and had done all he could do.

The Administrator was interviewed on 02/11/22 at 10:38 AM. The Administrator stated she was not aware of any incident between MA #1 and Resident #4.

2. Resident #3 was readmitted to the facility on 12/07/20.

Review of the significant change Minimum Data Set (MDS) dated 12/15/21 indicated that Resident #3 was cognitively intact and required total assistance with toileting. The MDS also indicted that Resident #3 was frequently incontinent of bowel and bladder.

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A continuous observation and interview were conducted on 02/02/22 from 7:06 AM to 8:42 AM. At 7:06 AM Resident #3's call light was noted to be on. At 7:31 AM Resident #3 was heard from the hallway stating, "I need some help in here, I need to be changed." At 8:32 AM Resident #3 was observed resting in his bed, he had opened his brief and stated that he needed to be changed. Resident #3 was visibly soiled with feces and was also noted to have 2 briefs in place. Resident #3 stated, "if I have 2 briefs on then my clothes don't get wet" because it takes them so long to come in and change me sometime hours between changes. Resident #3 stated that he did not like having 2 briefs on because it makes him feel "bad" but at least it keeps me from ruining my clothes when I wet through them. At 8:42 AM Nurse Aide (NA) #7 was observed to enter Resident #3's room and Resident #3 stated "I need to be changed I have been waiting an hour and half for help." NA #7 stated that Resident #3 often had on 2 briefs and that "was a common occurrence" and proceeded to turn Resident #3 onto his side to wash his buttock and provided incontinence care.

A follow up interview was conducted with NA #7 on 02/03/22 at 10:46 AM. NA #7 indicated that she had no idea Resident #3 "was in a mess" until she carried his breakfast tray into his room. Once she knew he needed to be changed she stated she did provide care to him and then set him up to eat his breakfast. NA #7 again stated that it was common for Resident #3 to have 2 briefs on from the night shift because he reported it takes so long to get cleaned up and if he wet through his brief, he would ruin his clothes.

The Administrator and Interim Director of Nursing

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(DON) were interviewed on 02/07/22 at 3:40 PM. The DON explained that facility staff would have to increase the frequency of their incontinence checks considering the individual needs of each resident. By doing this the facility wound ensure the residents incontinence needs were met in a timelier fashion and take care of the any dignity issue at the same time. The DON stated that waiting over an hour for incontinence care was not acceptable and neither was wearing multiple briefs at one time.

3. Resident #9 was readmitted to the facility on 01/21/20.

Review of the annual Minimum Data Set (MDS) dated 01/12/22 revealed that Resident #9 was cognitively intact and was always incontinent of bowel and bladder and required extensive assistance with toileting.

A continuous observation and interview were conducted with Resident #9 on 02/02/22 from 10:23 AM to 10:45 AM. Resident #9 was observed to turn his call light on for assistance at 10:23 AM. He stated that he was wet and soiled since before breakfast but when he asked to be changed, they told him he would have to wait until after breakfast. Resident #9 stated that after the trays had been picked up around 9:00 AM he told Nurse Aide (NA) #7 that he needed to be changed and was told she would get to him as soon as she could. At 10:45 AM NA #7 entered Resident #9's room to provide incontinence care. NA #7 was observed to assist Resident #9 to a standing position and removed the soiled brief that was soiled with feces and was very wet and heavy. Resident #9 was noted to have dried feces on his buttocks which required NA #7 scrub the

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area to ensure he was clean. Resident #9's skin on his buttocks was intact and slightly red from scrubbing the dried feces off. Resident #9 stated to NA #7 that before the end of her shift at 3:00 PM he would like for her to put 2 briefs on him because it would be a while before he got changed again and did not want to ruin his clothes. Resident #9 stated that it made him feel "low" like less of man to have sit his own waste with 2 "diapers on." He added he did not like wearing multiple briefs but "what other choice do I have?"

A follow up interview was conducted with NA #7 on 02/03/22 at 10:46 AM. She stated that when she arrived at work at 7:50 AM Resident #9 requested to be changed and she told him as soon as breakfast as over, care would be provided as requested as she had been told that providing incontinence care during mealtime was "cross contamination." NA #7 stated that the first time she was able to get to Resident #9 was at 10:45 AM. She stated, "I was doing the best I could do." She added that Resident #9 frequently requested to have 2 briefs and he said it was because it would be a while before he got changed again and didn't want to ruin his clothes. NA #7 stated that if Resident #9 asked to have 2 briefs on then she put 2 on him.

The Administrator and Interim Director of Nursing (DON) were interviewed on 02/07/22 at 3:40 PM. The DON explained that facility staff would have to increase the frequency of their incontinence checks considering the individual needs of each resident. By doing this the facility wound ensure the residents incontinence needs were met in a timelier fashion and take care of the any dignity issue at the same time. The DON stated that

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waiting over an hour for incontinence care was not acceptable and neither was wearing multiple briefs at one time. The Administrator stated that when care was requested it should be provided without delay including during mealtimes.

4. Resident #10 was readmitted to the facility on 03/01/05.

Review of the quarterly Minimum Data Set (MDS) dated 01/09/22 revealed that Resident #10 was cognitively intact and required limited assistance with toileting. The MDS further revealed that Resident #10 was occasionally incontinent of bowel and bladder.

A continuous observation and interview were conducted with Resident #10 on 02/02/22 from 7:06 AM to 8:15 AM. At 7:06 AM it was noted that Resident #10's call light was on. At 7:26 AM Resident #10 stated that she needed to be changed, she stated she could not see the clock on the wall because it was too dark to know what time she turned the call light on. She stated she had been asleep and woke up and could tell that she was wet and turned the call light on. At 7:29 AM Nurse #10 entered Resident #10's room and turned the call light off and exited the room and continued down the hallway. At 7:35 AM Resident #10 again stated she needed to be changed, "I guess I better turn my light back on" and she did. At 8:15 AM Nurse #11 was observed to enter Resident #10's room and change her brief. The brief was heavily saturated with urine and when thrown into the trash can made a loud thud noise.

A follow up interview was conducted with Resident #10 on 02/02/22 at 9:24 AM. Resident #10 stated that she had turned her call light back

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on because "no one came to change me, which makes me feel bad for 2 reasons." "One reason is that I wet myself and the second is that I have to have someone change me, I am not a child."

Nurse #11 was interviewed on 02/02/22 at 8:25 AM. Nurse #11 confirmed that he had provided incontinence care to Resident #10 because her light was on but stated he had no idea how long it had been on. Nurse #11 stated that he was working as a Nurse Aide that night because they had some agency staff that did not show up and that left them in a bind. He added that during the night and into the morning they were not able to do every 2-hour incontinence checks but "we do the best we can."
Nurse #10 was interviewed on 02/02/22 at 5:45 PM. Nurse #10 confirmed that she had turned off Resident #10's call light earlier that morning but stated she had let the NA know that she needed care. Nurse #10 could not recall which NA she reported to but stated she let the direct care staff on the hall know that Resident #10 was requesting care.

The Administrator and Interim Director of Nursing (DON) were interviewed on 02/07/22 at 3:40 PM. The DON explained that facility staff would have to increase the frequency of their incontinence checks considering the individual needs of each resident. By doing this the facility wound ensure the residents incontinence needs were met in a timelier fashion and take care of the any dignity issue at the same time. The DON stated that waiting over an hour for incontinence care was not acceptable. The Administrator stated that no call light should be turned off without providing the need of the resident and that when a resident requested care it is the expectation that the care

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be provided without delay.

5. Resident #11 was admitted to the facility on 08/21/20 and recently readmitted on 01/16/22.

Review of a Medicare 5-day Minimum Data Set (MDS) dated 02/02/22 indicated that Resident #11 was cognitively intact and required extensive assistance with toileting. The MDS further revealed that Resident #11 was always incontinent of bowel and bladder.

Resident #11 was interviewed on 02/04/22 at 9:33 AM. Resident #11 stated that last night (02/03/22) she turned her call light on at 7:30 PM (time on cell phone) and then she called her family and talked to them for a while. While on the phone with her family Resident #11 stated her call light stayed on and no one from the facility came in to assist her. She stated that she was wet at 7:30 PM when she turned her call light on and while on the phone with her family at 10:30 PM her call light was still on, and she remained wet. The family member told Resident #11 that she was going to call the facility and see if she could get some help for her, and she did but got no answer. Resident #11 stated that she and her family member continued to talk for a bit longer and the family member again called the facility and again got no answer. The family member decided she was going to call the local police department for a wellness check. Resident #11 stated that she hung up with her family member a little before 11:00 PM so the family member could call the police. Resident #11 stated that shortly after 11:00 PM the staff came in and explained that they were assigned to the other side of the building and apparently the staff for the side of the building where Resident #11 resided had not

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shown up for work. They apologized that no one had been in to assist Resident #11 and stated that they were there to assist her. Resident #11 stated that when the staff changed her, she was soaking wet all the way to the pad on the bed and while the staff members were in the room assisting her the police showed up but did not stick around. Resident #11 stated that "it makes me feel so bad and it is so demeaning to me" to lay in my own waste.

NA #3 was interviewed on 02/04/22 at 11:11 AM. NA #3 confirmed that she had worked the night shift at the facility on 02/03/22. She was not sure who was assigned to take care of Resident #11 but stated that around 12:30 AM she and NA #1 were asked to go and check on the other side of the building because there was staff that had not shown up. NA #3 stated that when they went to the unit where Resident #11 resided her call light was on and so were others. She stated that Resident #11 needed to be changed and stated she had been waiting on someone to help her for several hours. She stated that Resident #11 was very wet and had a small amount of feces in her brief. NA #3 stated that while they were assisting Resident #11 the police showed up but by the time, they had completed care with Resident #11 the police were gone.

The Administrator and Interim Director of Nursing (DON) were interviewed on 02/07/22 at 3:40 PM. The DON explained that facility staff would have to increase the frequency of their incontinence checks considering the individual needs of each resident. By doing this the facility wound ensure the residents incontinence needs were met in a timelier fashion. Thus, also taking care of the any dignity issue at the same time. The DON stated

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that waiting hours for incontinence care was not acceptable and should not have occurred. The Administrator stated she was the aware that the police were called and responded to the facility. She also stated when a resident requested care it was the expectation that the care be provided without delay.

6. Resident #5 was admitted to the facility 04/14/16.

A review of Resident #5's care plan dated 08/10/21 revealed he was incontinent of bladder and bowel due to decreased sensation. The goal that he would remain free of skin breakdown related to incontinence and brief use would be attained by utilizing interventions that included place call light within reach, provide incontinent care after each episode of incontinence and as needed and apply briefs for incontinence.

The quarterly Minimum Data Set (MDS) assessment dated 10/24/21 revealed Resident #5 was cognitively intact and had no behaviors of rejection of care. The MDS also indicated the Resident required extensive one person assist with bed mobility and was incontinent of bladder and bowel.

During an interview and observation of Resident #5 on 02/04/22 at 9:30 AM the Resident explained that he was incontinent of bladder and bowel and needed to be checked and usually changed about every two hours. He stated the staff would only change him about twice a day and the last time he was changed was before third shift left that morning. The Resident continued to explain that the night shift nurse aide (unable to identify which aide) asked him if he

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wanted to wear one, two or three briefs and he told her to put three on him because the staff did not check and change him regularly and most of the time they would not answer his call light when he needed to be changed. The Resident stated that he was currently wearing three briefs (Surveyor verified he was wearing three briefs) because he felt the three briefs would prevent him from soaking his bed. The Resident stated that sometime the three briefs did not prevent him from soaking his sheets. He explained that it was embarrassing enough for a grown man to have to wear one brief but when he had to wear three briefs at a time to keep from soaking his sheets, he felt degraded.

On 02/04/22 at 12:15 PM during an interview with Resident #5 he stated he was wet and needed to be changed.

On 02/04/22 at 12:18 PM the Surveyor located Nurse Aide #9 who was assigned to Resident #5 that shift and reported the Resident's request to be changed. During the procedure the NA acknowledged that Resident #5 was wearing three briefs and the first two briefs were soiled with urine and stool. The NA applied one brief on Resident #5 after providing incontinent care.

During an interview with Nurse Aide #9 on 02/04/22 at 12:45 AM the NA explained that she did on occasion see more than one brief on the residents but she did not know why the staff would put more than one brief on a resident at a time. The NA continued to explain that she knew she was supposed to check and change the incontinent residents every two hours and as needed but it was an unrealistic expectation when she had a heavy workload to do by herself. The

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F 550	Continued From page 16 NA stated the check and change on Resident #2 was the first time she was able to provide incontinent care on the Resident during her shift and stated she worked as fast as she could but there was not enough staff to provide incontinent care on the residents every two hours and feed the residents three meals a day. The nurse aide who put the three briefs on Resident #5 was unable to be identified. During an interview with the Director of Nursing (DON) and Administrator on 02/07/22 at 3:40 PM the DON explained that Resident #5 should be checked and changed every two hours and if that was done, then he would not feel forced to wear three briefs and the Resident would not feel degraded. The Administrator explained that the facility was looking into hiring a more reliable staffing agency to improve the staffing situation. She stated that her expectation was that the residents be checked and changed if needed every two hours.	F 550		
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	F 561		3/25/22

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F 561	Continued From page 17 applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and Resident interviews, the facility failed to honor a resident's request to get out of bed at his preferred time of day for 1 of 1 resident reviewed for choices (Resident #5). The finding included: Resident #5 was admitted to the facility 04/14/16 with diagnoses that included non-traumatic intracerebral hemorrhage. The quarterly Minimum Data Set (MDS) assessment dated 10/24/21 revealed Resident #5 was cognitively intact and had no behaviors of rejection of care. The MDS also indicated the Resident was totally dependent on staff with 2 persons assist for transfers and required a wheelchair for mobility. A review of the care plan dated 01/23/22 revealed	F 561	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to honor a resident #5 request to get out of bed at preferred time of day. Resident #5 request was honored on 2/11/2022 and care plan/task list updated to reflect resident preferred time of getting in/out of bed. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/2022 the Director of Nursing and/or designee completed questionnaires with current cognitively	

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F 561	Continued From page 18 Resident #5 had a self-care performance deficit in his activities of daily living (ADL) related to limited mobility and right hemiplegia. The goal for Resident #5 to maintain his current ADL function would be met by utilizing interventions that included transfers with a mechanical lift and two persons assist and utilizing a high back reclining wheelchair with a right foot pedal. On 02/04/22 at 12:15 PM during an observation and interview with Resident #5 he explained that he liked to get out of bed before lunch and pointed to a sign which was posted on the wall at his request that stated "I choose to get up daily before lunch". The Resident continued to explain that he had not been out of the bed for over a month because the staff told him that there was not enough staff to get him up and that the facility was in the middle of a COVID outbreak so the residents had to stay in their rooms. The Resident continued to explain that he could see residents wheeling up and down the hall while wearing their masks and he would be agreeable to wearing a mask. On 02/04/22 at 12:18 PM the Surveyor located Nurse Aide (NA) #9 who was assigned to Resident #5 and reported that the Resident would like to get out of bed. The NA went into the Resident's room and the Resident reported that his personal wheelchair should be parked in the hallway. The NA explained to the Resident that there was no wheelchair parked in the hallway so she would have to look for his wheelchair and left the room. The NA came back into the Resident's room and reported that she could not find his wheelchair to get him up. An interview was conducted with Nurse Aide (NA)	F 561	intact residents and with resident representative for cognitively impaired residents to ensure preferred time for getting in/out of bed is being adhered to. Care plan/task list updated as indicated for resident preference. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Director of Nursing and/or designee educated current facility and agency Certified Nursing Assistances and License Nurses on ensuring residents choices are being honored. Effective 3/24/2022 any facility or agency Certified Nursing Assistances and License Nurses that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee as part of the orientation process. Effective 3/24/2022 newly hired facility and agency certified nursing assistances and licensed nurses will receive education during orientation and prior to working. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit (5) residents to ensure choices are being honored 3 X week X 4 weeks,	

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F 561	Continued From page 19 #9 on 02/04/22 at 12:45 PM. The NA explained that she often took care of Resident #5 and she had not gotten him up out of bed or seen him out of bed in a while. The NA continued to explained that Resident #5 required a mechanical lift and two persons transfer and most of the time the facility was so short staffed that the aides only had time to check and change the incontinent residents and feed the residents their meals. An observation of Resident #9 on 02/04/22 at 5:00 PM revealed the Resident remained in bed and was sleeping. The Resident's wheelchair was not in his room, bathroom or the hallway. During an interview with the Administrator and Director of Nursing (DON) on 02/07/22 at 3:40 PM the Administrator explained that the residents had the right to choose when they wanted to get out of bed and the facility should honor Resident #5's choice to get out of bed when he desired. The Administrator added, they would continue to look for Resident #5's wheelchair.	F 561	weekly X 4 weeks, and bi-weekly X 4 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	
F 580 SS=K	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		3/25/22

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F 580	Continued From page 20 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Nurse Practitioner (NP) and Physician (MD), the	F 580	How corrective action will be accomplished for those residents found to	

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F 580	Continued From page 21 facility failed to notify the Provider of 19 Prothrombin Time Test/ International Normalized Ratio (PT/INR) laboratory (lab) tests that were not completed as ordered. The facility also failed to notify the Provider of 6 PT/INR laboratory results that were outside of the Resident's set parameters of 2.0 to 3.0. Resident #1 was hospitalized on 1/26/22 for a ruptured abdominal hematoma with visible oozing of blood and was found to have a supratherapeutic (elevated) PT/INR of 4.57 upon arrival. This was for 1 of 1 resident reviewed for Coumadin (anticoagulant-oral blood thinner) therapy (Resident #1). The facility also failed to notify the Provider when they were unable to provide ordered medications when Nurse # 16 failed to administer medications because she did not know the residents resided on her unit for 2 of 2 residents (Resident #14 and Resident #15) and failed to provide a nightly snack for 1 of 2 residents reviewed for neglect (Resident #15). The immediate jeopardy began on 12/17/21 when the facility failed to notify the provider of PT/INR labs that were not completed as ordered. The immediate jeopardy was removed on 2/8/22 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The facility was cited at F-580 for example #2 and 3 at a scope and severity of of level E. Findings included:	F 580	have been affected by the deficient practice; The facility failed to notify the provider when a physician's order for obtaining scheduled PT/INR labs was unable to be drawn and failed to notify the medical provider of PT/INR levels outside the given parameters of 2.0- 3.0 for Resident #1. On 2/3/22, the licensed charge nurse notified the nurse practitioner of Resident #1 missed PT/INR labs between 12/17/21 and 1/24/22 and discussed On 2/7/22, the MDS nurse updated Resident #1 anticoagulant therapy care plan to include monitoring for adverse side effects: discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, SOB or nose bleeds. Care plan also includes notification to physician/nurse practitioner of all PT/INR results and of any adverse side effects to anticoagulant drug use. How the facility will identify other residents having the potential to be affected by the same deficient practice; Residents with scheduled PT/INR lab orders are at risk of the Physician/Nurse Practitioner not being notified of labs results that are not obtained as ordered and lab levels not within their therapeutic levels. Therefore, effective 2/7/22, the	

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F 580	Continued From page 22 Resident #1 was admitted to the facility on 10/21/21 and most recently readmitted on 12/16/21 with diagnoses of atrial fibrillation and acute embolism and thrombosis of deep vein of the lower extremity. According to the hospital discharge summary dated 12/16/21, Resident #1 was to maintain a PT/INR therapeutic range of 2.0 to 3.0 while on Coumadin therapy. A Physician's order dated 12/17/21 indicated daily PT/INRs were to be obtained due to anticoagulant usage. A review of the daily PT/INR laboratory results for Resident #1 from 12/17/21 through 1/13/22 revealed the following: - There were no PT/INR laboratory results for 15 of the 27 dates that PT/INRs were ordered (12/17/21, 12/19/21, 12/22/21, 12/23/21, 12/28/21, 12/30/21, 1/1/22 through 1/6/22, and 1/9/22 through 1/11/22) in the medical record. There was no documentation to indicate the Provider was contacted and made aware these labs were not obtained. - There were 6 PT/INR results that were outside of the therapeutic range of 2.0 to 3.0 (12/24/21 - 6.32, 12/25/21 - 3.29, 12/26/21 - 3.31, 12/31/21 - 4.47, 1/7/22 - 5.24, and 1/8/22 - 4.59). There was no documentation to indicate the Provider was notified of these PT/INR results which fell outside the provided parameters for Resident #1. On 1/13/22 the Nurse Practitioner wrote an order for PT/INRs to be changed from being required daily to every Monday and Friday.	F 580	Interim Director of Nursing and licensed charge nurse reviewed current facility residents with orders for PT/INR labs to ensure labs are being obtained as ordered and that failure to obtain labs as ordered and PT/INR levels outside the given parameters are reported to the Physician/Nurse Practitioner. One additional resident identified with PT/INR results outside given levels not being documented as reported to the medical provider as ordered. The licensed charge nurse notified Nurse Practitioner on 2/7/22. PT/INR flow record initiated, anticoagulant care plan and medication administration record (MAR) updated by the licensed nurse to include monitoring for adverse side effects and reporting to physician/nurse practitioner. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 2/7/22, the Director of Regulatory and Risk Management provided education to the Administrator, Interim Director of Nursing, SDC (Staff Development Coordinator) and Licensed Charge Nurses on the lab process for residents on coumadin therapy to include; obtaining PT/INR labs as ordered, the corresponding lab results, sub/supratherapeutic levels, signs of coumadin toxicity, treatment for toxicity, drawing blood samples for PT/INRs, requisitions to contracted lab provider and reporting to nurse supervisor for alternate	

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F 580	Continued From page 23 An interview was conducted with the Nurse Practitioner (NP) on 02/03/22 at 3:40 PM. She reported that on admission the PT/INR set parameters for Resident #1 were 2.0 to 3.0. She explained that generally speaking variances of levels between 2.0 to 3.5 was not abnormal for residents on Coumadin therapy, but she expected to be notified of any results that were outside of the set parameters of 2.0 to 3.0. She explained that these parameters were used to regulate Coumadin dosing. The NP revealed facility staff did not consistently notify the providers when they were not able to obtain ordered PT/INRs or for results that were outside of the set parameters. The NP reported she reviewed Resident #1's PT/INR results in the medical record and noticed multiple results that were not in the record. She explained that she searched the laboratory system herself in an effort to find these missing PT/INR results and identified multiple PT/INR labs that were not obtained as ordered. The NP revealed she was not notified of the elevated PT/INR results on 1/7/22 (5.24). On 1/8/22, the NP reviewed the medical record and questioned staff about why the PT/INRs were not obtained daily as ordered and she placed the Coumadin on hold on 1/8/22, and 1/9/22. She elaborated to say on 1/13/22 after extensive communication with Resident #1's Hematologist, the orders for PT/INR's were changed to twice a week in an effort to ensure the labs were routinely obtained and to effectively manage and regulate Resident #1's Coumadin dosage. The NP could not recall specifics in regard to notifications of abnormal PT/INR results on 12/24/21, 12/25/21, 12/26/21, or 12/31/21; however, stated when a supratherapeutic PT/INR level resulted, she would make alterations to the current Coumadin therapy. She reported that Coumadin therapy was	F 580	options to obtain the sample as ordered and reporting all lab results and labs that are unable to be obtained as ordered to the Physician/Nurse Practitioner. Effective 3/24/22, the Director of Nursing and Licensed Charge Nurses provided education to current facility and agency licensed nurses on lab process for residents on coumadin therapy. Newly hired agency and facility licensed nurses will not work until education received during the orientation process. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator or Director of Nursing will monitor residents with PT/INR orders to ensure compliance with obtaining, monitoring and notification to the Physician/Nurse Practitioner is completed for labs unable to be obtained and for PT/INR levels not within given parameters. Audits will be completed three times weekly x 12 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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held on 12/25/21 secondary to an abnormal PT/INR she discovered herself for a lab that was obtained on 12/24/21 and anticoagulant therapy was restarted on 12/26/21, but there were no other alterations made to the Coumadin therapy that corresponded to these abnormal PT/INRs for Resident #1.

A review of PT/INR laboratory results ordered for Mondays and Fridays for Resident #1 from 1/13/22 through 1/26/22 revealed the following:
- There were no PT/INR laboratory results for 4 of the 4 dates that PT/INRs were ordered (1/14/22, 1/17/22, 1/21/22, and 1/24/22) in the medical record. There was no documentation to indicate the provider was contacted and made aware these labs were not obtained.

An interview on 2/3/22 at 1:00 PM with Nurse #2 revealed he was an out of state agency nurse where they did not allow licensed practical nurses to perform venipunctures and had not been trained on how to do so by facility staff. He further indicated he worked with Resident #1 on 1/2/22 and noticed the order, but he did not notify a shift Supervisor or the Provider of his inability to obtain the ordered PT/INR lab but reported the inability to obtain the lab to the oncoming shift.

An interview on 2/3/22 at 2:53 PM with Medication Aide (MA #1) revealed she worked the medication cart on 1/1/22. She indicated she noticed the order for Resident #1 to have a PT/INR drawn on her shift, but she knew she was not qualified to perform the task and felt like the Nursing Supervisor would have known the lab was to be drawn and therefore she did not notify anyone it needed to be drawn.

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An interview on 02/08/22 at 11:40 AM with Nurse #3 revealed she had times when the facility did not have supplies to draw ordered labs and there had been times when the outside contracted lab provider had not shown up to draw labs, but staff were not made aware the lab was not drawn. Nurse #3 stated she worked with Resident #1 on 1/3/22 and 1/14/22 and she did not notify the MD/NP when she was unable to obtain the scheduled PT/INR or of any abnormal lab PT/INRs for Resident #1 but was unable to recall specifics for each date.

An interview on 2/9/22 at 7:23 PM with Nurse #20 revealed she had worked as an agency nurse at the facility with Resident #1 on 12/22/21 and 12/23/21 and stated she was not able to draw labs in the facility on 12/23 due to the lack of supplies such as tourniquets and lab tubes. Nurse #20 verbalized there were also times (12/22/21) when the outside contracted lab company would not show up on the designated days when they were scheduled, and staff did not always know they had not shown up and therefore didn't know to draw labs on these days. Nurse #20 stated she did not notify the MD/NP when she was unable to obtain the scheduled PT/INR or of any abnormal PT/INRs for Resident #1.

An interview on 02/10/22 at 1:45 PM with Nurse #1 revealed she was an agency nurse and stated she had been unable to obtain labs at times due to lack of butterfly needles and blue lab tubes. Nurse #20 indicated Nursing Supervisors had been made aware, but the problem seemed to be ongoing. Nurse #20 stated she did not notify the MD/NP when she was unable to obtain the scheduled PT/INR or of any abnormal PT/INRs

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for Resident #1. Nurse #1 acknowledged she was assigned to Resident #1 on 12/17/21, 12/30/21, and 1/9/22 when she nor the outside contracted lab provider obtained Resident #1's ordered PT/INR's as well as on 1/7/22 and 1/8/22 when Resident #1 had supratherapeutic PT/INRs which she did not report the abnormalities to the Provider.

A hospital discharge summary dated 1/28/22 revealed Resident #1 arrived at the Emergency Room (ER) around 11:00 PM on 1/26/22 for a ruptured abdominal hematoma with visible oozing of blood. He was found to have a supratherapeutic PT/INR of 4.57 upon arrival. The area on the right abdomen was sutured but began to bleed with significant decrease in blood pressure during initial attempts at imaging at which time the ER physician felt this to be a potential of a life- threatening emergency, given Vitamin K, and admitted Resident #1 to the hospital's intensive care unit. Resident #1 was stabilized and discharged to the facility on 1/28/22.

A hospital discharge summary dated 02/03/22 revealed Resident #1 was transferred back to the ER via EMS but shortly after readmission to the facility on 1/28/22. Secondary to shortly after his readmission, he was transferring from chair to the toilet at the facility and he felt a warm and wet sensation in his abdomen and found himself to be bleeding from the same site. Upon arrival of EMS, he was felt to have lost approximately 300 cc of blood. Given these findings and the inability to stop the bleeding from direct pressure, Resident #1 was admitted to the hospital intensive care unit. Surgical services were consulted on 1/29/22 and Resident #1 underwent

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abdominal wall exploratory surgery.

During an interview with the Nurse Practitioner (NP) on 02/03/22 at 3:40 PM she indicated that because of these orders not being followed, Resident #1 had multiple elevated PT/INR levels which resulted in hospitalization with exploratory abdominal surgery. The NP indicated if she had been notified; she could have potentially adjusted his Coumadin dosage to prevent his rehospitalization.

An interview on 02/09/22 at 5:30 PM with the MD revealed she expected nursing staff to obtain labs as ordered and if the outside contracted lab provider did not obtain the lab as scheduled, she expected facility staff to obtain the lab and send it to the local contracted hospital lab for results. The MD indicated a Medical Provider was on-call 24/7 which should be made aware of abnormal lab results or the inability to obtain a scheduled lab to seek further direction in the event the Coumadin dosage or frequency needed to be adjusted. The MD stated she has had trouble contacting nursing staff in the evening to check on lab results and believed it was the facility's responsibility to contact the Provider instead of the Provider being required to manually look up lab values. The MD explained copies of all labs were to be placed in the Physician's contact binder, but all abnormal labs should be called immediately. The MD elaborated for the safety of Resident #1 and others on Coumadin therapy, all residents receiving anticoagulant therapy should be closely monitored for adverse reactions and side effects of the medication usage.

An interview on 02/08/22at 12:20 PM with the Administrator and Interim Director of Nursing

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(Corporate Nurse) revealed they each expected staff to monitor all residents on anticoagulant therapy to include: follow orders for lab, notify the provider when labs are unable to be obtained or any lab results in an abnormal value outside the resident's set parameters.

The Administrator was notified of the Immediate Jeopardy on 2/06/22 at 10:25 AM.

The facility provided the following IJ removal plan.

F580: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to notify the provider when a physician's order for obtaining scheduled PT/INR labs was unable to be drawn and failed to notify the medical provider of PT/INR levels outside the given parameters of 2.0- 3.0 for Resident #1.

Resident #1 was admitted to the facility on 10/21/21 with diagnosis of atrial fibrillation (AFib) and acute embolism and thrombosis of unspecified deep vein (DVT) of the lower extremity. Physician orders included anticoagulation therapy (Coumadin) which requires lab monitoring to ensure therapeutic ranges of 2.0 -3.0. Between the dates of 12/17/2021 - 1/24/2022, Resident #1 had physician orders for PT/INRs to be obtained. The facility failed to obtain PT/INRs labs for Resident #1 based upon physician orders with missing lab results for 6 days between the dates of 12/17/21 - 12/31/21 and 13 days of missing lab results between the dates of 1/1/22 - 1/24/22. Additionally, Resident #1 had supratherapeutic INR levels between the dates of 12/24/21 -

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1/10/2022 with no notification to physician or nurse practitioner. Subsequently, Resident #1 had a change in condition (bleeding) which required transfer to the hospital for treatment on 1/26/22. Hospital records revealed Resident #1 had a ruptured abdominal hematoma with visible oozing of blood. He was found to have a supratherapeutic PT/INR of 4.57 upon arrival to the hospital. The resident continued to bleed from his abdomen which required stabilization in the intensive care unit. Resident #1 was stabilized and discharged back to the facility on 1/28/22 around 6PM with a subtherapeutic PT/INR of 1.28. Resident #1 required transfer back to the hospital on 1/28/2022 due to bleeding from abdominal area which in turn required a surgical procedure to evacuate a large hematoma from Resident #1 abdomen.

On 2/3/22, the licensed charge nurse notified the nurse practitioner of Resident #1 missed PT/INR labs between 12/17/21 and 1/24/22 and discussed the PT/INR levels outside of the given parameters of 2.0-3.0 for Resident #1.

On 2/7/22, the MDS nurse updated Resident #1 anticoagulant therapy care plan to include monitoring for adverse side effects: discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, SOB or nose bleeds. Care plan also includes notification to physician/nurse practitioner of all PT/INR results and of any adverse side effects to anticoagulant drug use.

Residents with scheduled PT/INR lab orders are at risk of the Physician/Nurse Practitioner not

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being notified of labs results that are not obtained as ordered and lab levels not within their therapeutic levels. Therefore, effective 2/7/22, the Interim Director of Nursing and licensed charge nurse reviewed current facility residents with orders for PT/INR labs to ensure labs are being obtained as ordered and that failure to obtain labs as ordered and PT/INR levels outside the given parameters are reported to the Physician/Nurse Practitioner. One additional resident identified with PT/INR results outside given levels not being documented as reported to the medical provider as ordered. The licensed charge nurse notified Nurse Practitioner on 2/7/22. PT/INR flow record initiated, anticoagulant care plan and medication administration record (MAR) updated by the licensed nurse to include monitoring for adverse side effects and reporting to physician/nurse practitioner.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 2/7/2022, the Administrator, Interim Director of Nursing, Regional Director of Operations, Director of Regulatory and Risk Management and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to discuss root cause analysis of the facilities failure to ensure that the Physician/Nurse Practitioner was notified of scheduled PT/INR labs not being drawn as ordered and PT/INR levels outside the given parameters of 2.0- 3.0 for Resident #1 and to formulate plan of correction to address this issue. Facility corrective action plan formulated to include education, lab process update,

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monitoring/audits, and follow-up reviews by QAPI Committee. It is determined based upon root cause analysis that 1) the facility management failed to ensure that the lab policy was implemented, followed, and monitored related to notification of PT/INR results outside of parameters and 2) licenses nurses failed to implement PT/INR procedure of notifying the medical provider when PT/INR blood samples were unable to be obtained as ordered and when PT/INR levels were outside the given parameters for Resident #1. After interviewing licensed nurses to determine reason for not following lab process, the facility concludes; a) while Licensed Nurses could verbalize process of notifying the Charge Nurse when unable to obtain a PT/INR as ordered, they could not provide a reason for not following the process and b) while Licensed Nurses could verbalize the process of notifying the medical provider when PT/INR levels were outside the given parameters, they could not provide a reason for not following the process.

On 2/7/22, the Director of Regulatory and Risk Management provided education to the Administrator, Interim Director of Nursing, SDC (Staff Development Coordinator) and Licensed Charge Nurses on the lab process for residents on coumadin therapy to include; obtaining PT/INR labs as ordered, the corresponding lab results, sub/supratherapeutic levels, signs of coumadin toxicity, treatment for toxicity, drawing blood samples for PT/INRs, requisitions to contracted lab provider and reporting to nurse supervisor for alternate options to obtain the sample as ordered and reporting all lab results and labs that are unable to be obtained as ordered to the Physician/Nurse Practitioner. Education also included 1) responsibility of the licensed nurse to

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ensure blood samples are collected as ordered including when not drawn by contracted lab provider and that 2) the licensed nurse communicates inability to obtain lab as ordered to the Charge Nurse for alternate interventions to obtain blood sample and 3) reporting to medical provider if unable to obtain and 4) notifying the Physician/Nurse Practitioner of PT/INR levels not within given parameters and 5) education on the use of the PT/INR flow records for documenting lab results, next lab draw date and current and/or changing coumadin orders to maintain each resident therapeutic INR range and reporting all results and missed lab draws to the Physician/Nurse Practitioner. Newly hired Administrators, Directors of Nursing, SDCs and Licensed Charge Nurses receive education during orientation.

On 2/7/22, the Interim Director of Nursing and Licensed Charge Nurses provided education to current facility and agency licensed nurses on lab process for residents on coumadin therapy to include; obtaining PT/INR labs as ordered, the corresponding lab results, sub/supratherapeutic levels, signs of coumadin toxicity, treatment for toxicity, drawing blood samples for PT/INRs, requisitions to contracted lab provider and reporting to nurse supervisor for alternate options to obtain the sample as ordered and reporting all lab results to the Physician/Nurse Practitioner. Education also included 1) responsibility of the licensed nurse to ensure blood samples are collected as ordered including when not drawn by contracted lab provider and that 2) the licensed nurse communicates inability to obtain lab as ordered to the Charge Nurse for alternate interventions to obtain blood sample and 3) reporting to medical provider if unable to obtain

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and 4) notifying the Physician/Nurse Practitioner of PT/INR levels not within given parameters and 5) education on the use of the PT/INR flow records for current PT/INR parameters, documenting lab results, next lab draw date and current and/or changing coumadin orders to maintain each resident therapeutic INR range and reporting results outside of parameters to the Physician/Nurse Practitioner. Licensed facility and agency licensed nurses not receiving education on 2/7/22 will not work until education completed. The Director of Nursing will utilize a master employee list to track completion of education. This responsibility was communicated to the Director of Nursing by the Director of Regulatory and Risk on 2/7/22. Staff will not be allowed to work until education is completed. Education will also be included during orientation for newly hired staff.

Effective 2/7/22, the licensed nurse assigned the day resident lab is ordered to be drawn will ensure PT/INR labs are obtained as ordered, documented on the MAR and on the individual PT/INR flow record and all results reported to the physician/nurse practitioner. The licensed nurse will complete a lab requisition, place requisition in the lab binder on the nursing unit and document on the lab log all orders for PT/INRs. The lab order will be transcribed into the resident electronic medical record which will display new order on the Medication Administration Record (MAR). Licensed Nurses will refer to electronic medical record for all new PT/INR physician orders. If PT/INR orders are to be drawn on Mondays, Wednesdays or Fridays, the contracted lab provider will obtain blood samples. The licensed nurse is responsible for obtaining on alternate dates or in the absence of the

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contracted lab provider. If the licensed nurse or nurse supervisor is unable to obtain lab draw as ordered, the Physician/Nurse Practitioner will be notified, interventions and/or new orders implemented and documented in the medical record. The licensed nurse receiving PT/INR lab results will report all PT/INR results including levels not within given parameters to physician/nurse practitioner and implement new orders as indicated. The individual resident PT/INR flow record will be updated by the licensed nurse and maintained in the lab binder on the nursing unit. Flow records will be reviewed by nursing management in clinical morning meeting to monitor ongoing compliance. Education was initiated on 2/7/22 by the Interim Director of Nursing for all Licensed Nurses (including agency Licensed Nurses) concerning this systemic change in PT/INR lab process. Licensed facility and agency licensed nurses not receiving education on 2/7/22 will not work until education completed. The Director of Nursing will utilize a master employee list to track completion of education. This responsibility was communicated to the Director of Nursing by the Director of Regulatory and Risk on 2/7/22. Staff will not be allowed to work until education is completed. Education will also be included during orientation for newly hired staff.

On 2/7/22, the Regional Director of Clinical Services provided education to the Administrator, DON (Director of Nursing) and day shift charge nurse(s) on monitoring PT/INR flow records during morning clinical meeting to validate labs are obtained as ordered and PT/INR levels not within given parameter and any failure to obtain lab draws are reported to the Physician/Nurse Practitioner. Newly hired Administrators, Director

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of Nurses and day shift charge nurse(s) will receive education during orientation.

Effective 2/7/22, the Administrator or Director of Nursing will monitor residents with PT/INR orders to ensure compliance with obtaining, monitoring and notification to the Physician/Nurse Practitioner is completed for labs unable to be obtained and for PT/INR levels not within given parameters. Audits will be completed five times weekly.

Effective 2/7/2022, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.
Alleged Date of IJ Removal: 2/8/22

A credible allegation validation was conducted in the facility on 02/11/22. Record review included Resident #1's MAR, nurse charting, laboratory results, care plan, and PT/INR logs. The in-service training records reflected all staff to include nursing staff were in-serviced on the importance of following the orders for laboratory testing and notification of a provider for labs not completed as ordered and any abnormalities and changes in a resident's condition to include a lab result outside the set parameters set for each individual resident. The facility's IJ removal date of 2/8/22 was validated.

2. Resident #14 was admitted to the facility on 12/21/20 with diagnoses that included schizophrenia (mental disorder that impairs a person's ability to think feel and behave clearly) and dementia with hallucinations (memory impairment with a perception of having seen, heard, touched, tasted, or smelled something that

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wasn't there).

A review of the Medication Administration Record (MAR) for January 2022 revealed on 1/5/22 on 7P-7A shift, Resident #14 did not receive any medications and was initialed to indicate a #9 which is associated with a linked nurses note. The following ordered medications were not administered during the shift: Depakote 125 milligram (mg) daily for dementia with hallucinations, Melatonin 3 mg daily for insomnia, Ativan 0.5 mg twice daily for anxiety, and Seroquel 25 mg twice daily for Schizophrenia.

A nurses note written by Nurse #16 and dated 1/6/21 effective 7:57 AM read in part: "Resident #14 didn't receive any medications on shift due to she was on the unit for 2 days and shift report was not given to this nurse and medication was not sent over nor was this nurse told the resident was transferred to unit with no medications there is no phone on unit when this nurse uses her personal phone to call no one answers resident is stable report given to oncoming nurse."

An interview on 02/04/22 at 8:00 AM with Nurse #16 revealed she was familiar with Resident #14 and cared for her during night shift on 1/5/22. Nurse #16 stated she was assigned to work the COVID-19 isolation unit on that night and elaborated to say staff were unable to leave the unit when assigned to care for residents in that area because of isolation precautions. She explained she did not receive report when she came on shift to make her aware Resident was placed on the unit and later in the shift discovered Resident #14 had been transferred there without her ordered medications. Nurse #16 indicated she did not medicate Resident #14 because she

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did not have access to her ordered medications and there is no way to access the main portion of the facility to obtain medications from the backup stocked supply. She did not notify the provider that the medications were not provided.

An interview on 02/08/22 at 12:20 PM with the Interim Director of Nursing (DON) and the Administrator revealed staff to follow physician's orders and administer medications as indicated, but in the event medications were unable to be provided, she expected the provider to be contacted..

An interview on 02/9/22 at 5:30 PM with the Physician (MD) revealed she was not made aware Resident #14 had not received her schedule medications on the night of 1/5/22 at the time. The MD explained she expected all residents to receive medications as ordered and be notified if they were unable to provide medications. The MD also stated Resident #14 missing these medications could have caused increase behaviors such as hallucinations secondary to her schizophrenia and was important she receive her medications as ordered.

3. Resident #15 was readmitted to the facility on 10/19/19 with diagnoses that included hemiplegia following a cerebral infarction (paralysis of an extremity following a stroke), insomnia, and diabetes.

A review of the Medication Administration Record (MAR) for January 2022 revealed on 1/5/22 on 7P-7A shift, Resident #15 did not receive any medications and was initialed to indicate a #9 which is associated with a linked nurses note.

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The following ordered medications were not administered during the shift: Ambien 5mg daily for insomnia, Lorvastatin 40mg daily for stroke prevention, Melatonin 10mg daily for insomnia, a bedtime snack for weight loss and diabetes, and Keppra 500mg BID for seizures disorder.

A nurses note written by Nurse #16 and dated 1/6/21 effective 7:56 AM read in part: "Resident #15 didn't receive any medications on shift because he was on the unit and shift report was not given to this nurse and medication was not sent over nor was this nurse told the resident was transferred to unit with no medications. She explained there was no phone on unit and when Resident #16 used her personal phone to call no one answers resident is stable report given to oncoming nurse. "

An interview on 02/04/22 at 8:00 AM with Nurse #16 revealed she was familiar with Resident #15 and cared for him during night shift on 1/5/22. Nurse #16 stated she was assigned to work the COVID-19 isolation unit on that night and elaborated to say staff were unable to leave the unit when assigned to care for residents in that area because of isolation precautions. She explained she did not receive report when she came on shift to make her aware Resident #15 was placed on the unit and later in the shift discovered Resident #15 had been transferred there without her ordered medications. Nurse #16 indicated she did not medicate Resident #15 because she did not have access to his ordered medications and there was no way to access the main portion of the facility to obtain medications from the backup stocked supply. She did not notify the provider that the medications were not provided.

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F 580	Continued From page 39 An interview on 02/08/22 at 12:20 PM with the Interim Director of Nursing (DON) and the Administrator revealed staff to follow physician's orders and administer medications as indicated and in the event medications were unable to be administered, the provider was to be contacted. The Administrator acknowledged staff assigned to the COVID unit were not supposed to come off that unit and there was not a backup medication stock for that unit. The Interim DON stated the nurse should have come to the main portion of the facility to obtain any needed medications for administration. An interview on 02/9/22 at 5:30 PM with the Physician revealed she was not made aware Resident #15 had not received his schedule medications on the night of 1/5/22 at the time. The MD explained she expected all residents to receive medications as ordered and be notified if medications were unable to be provided. The MD also stated Resident #15 was placed at an increased risk of seizures and low blood sugar secondary to him missing his medication for epilepsy and his nighttime snack.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but	F 583		3/25/22

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F 583	Continued From page 40 this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interview the facility failed to protect the privacy of a resident who sustained a fall in the facility for 1 of 3 resident reviewed for accidents (Resident #3) when Resident #4, Resident #19, and Resident #20 reported the details of the incident as overheard by staff members. The findings included: Resident #3 was readmitted to the facility on 12/07/20.	F 583	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to protect the privacy of resident #3 who sustained a fall in the facility. Staff will continue to respect resident privacy by discussing resident incidents/care issues in designated nursing room away from other residents. How the facility will identify other residents	

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F 583	Continued From page 41 The significant change Minimum Data Set (MDS) dated 12/15/21 indicated that Resident #3 was cognitively intact and required total assistance with transfers. An observation and interview with Resident #3 were conducted on 02/02/22 at 8:32 AM. Resident #3 was resting in bed and was alert. He stated that he recalled falling from the bed on 12/22/21 and recalled that he had laid in the floor for 2 hours before anyone came to help. Resident #3 stated that he had to "use his reacher to turn on the call light so staff could come in and help" him. He denied any injury from the fall and stated that when the staff finally came in to help, they used the lift to get him off the floor and up to my wheelchair. Resident #3 denied being sprayed with any type of cleaner or disinfectant. a. Resident #19 was readmitted to the facility on 10/14/21. Review of the quarterly Minimum Data Set (MDS) dated 01/10/22 indicated that Resident #19 was cognitively intact. Resident #19 was interviewed on 02/02/22 at 9:24 AM. During the interview Resident #19 stated that in December right before Christmas she heard several nursing staff members at the nurse's station talking about Resident #3 falling and lying in the floor for several hours before staff assisted him. Resident #19 stated that she had heard the staff talking about Resident #3 being COVID-19 positive and no one wanted to care for him, so they sprayed him with bleach or some type of disinfectant. b. Resident #4 was admitted to the facility on	F 583	having the potential to be affected by the same deficient practice; Effective 3/14/2022 the Director of Nursing and/or designee will ensure staff utilizes the room behind the nurse's station to prevent other residents from being affected by this practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Director of Nursing and/or designee educated current facility and agency Certified Nursing Assistances, Medication Aides and License Nurses on ensuring residents information is discussed in a private area, such as the designated room behind the nurses station. Effective 3/24/2022 all Certified Nursing Assistances, Medication Aides and License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on "ensuring residents information is discussed in a private area." Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will make observational rounds of the nurse's station weekly x 12 weeks to ensure residents information is	

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F 583	Continued From page 42 10/26/21. Review of the admission Minimum Data Set (MDS) dated 10/28/21 indicated that Resident #4 was cognitively intact. Resident #4 was interviewed on 02/02/22 at 12:19 PM. During the interview Resident #4 stated that a couple of months ago he had overheard the nursing staff on the back hall talking about Resident #3. They stated that Resident #3 had fallen out of bed because no one would put him in his chair, and he had urinated on himself. Then when the staff responded they poured bleach and a disinfectant on him, and he laid in floor for a couple of hours before anyone helped him. c. Resident #20 was readmitted to the facility on 09/02/17. Review of the annual Minimum Data Set (MDS) dated 01/09/22 indicated that Resident #20 was cognitively intact. Resident #20 was interviewed on 02/02/22 at 3:12 PM. During the interview Resident #20 stated in December 2021 she had overheard staff and other resident all over the building talking about Resident #3 who had fallen out of bed. She heard that no one wanted to touch him because he had urinated on himself and so the staff sprayed him with bleach but then the staff stated that it was a disinfectant not bleach. Resident #20 also overheard that Resident #3 had laid in the floor for a couple of hours before assisted him. She added she could not recall which staff members she had heard talking about the incident but indicated they worked in the	F 583	discussed privately. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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housekeeping department.

The former Director of Nursing (DON) #1 was interviewed on 02/03/22 at 11:20 AM. DON #1 confirmed that she was made aware of Resident #3's fall that occurred in December 2021. She stated later after the event she was made aware by the housekeeping staff that Resident #3 had been sprayed with a bleach or some type of cleaner and they inquired if he was ok. DON #1 stated she reported that to the Administrator who did an investigation, but she stated she left for vacation and did not know what came of the investigation.

Nurse #10 was interviewed on 02/07/22 at 1:01 PM. Nurse #10 confirmed that she was a Unit Manager in the facility. She stated that in December when Resident #3 fell there were rumors going around that Resident #3 had been sprayed with bleach or some type of cleaner. She stated that former DON #1 or the Administrator had an in-service with the staff to clear up the rumors that were circulating around the facility. Nurse #10 stated that she knew some of the residents would go out to the smoking area and "gossip" she stated that maybe Resident #4, Resident #19, and Resident #20 heard about the fall in the smoking area. Nurse #10 stated she had not specifically heard any staff talking about the fall but again stated that the residents talked a lot amongst themselves.

The Administrator was interviewed on 02/07/22 at 3:40 PM. The Administrator stated that she was aware that Resident #3 had a fall in December 2021 and then heard that he had been sprayed with bleach or some type of cleaner. She stated that she spoke to Resident #3, and he denied

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F 583	Continued From page 44 being sprayed with any cleaner or bleach. The Administrator stated "maybe the residents overheard a conversation" but stated the staff have a room behind the nurse's station that could be used for report and the staff should be using it to ensure the residents information was not overheard.	F 583		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including 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);	F 584		3/25/22

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F 584	Continued From page 45 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to repair cabinetry in 1 of 2 resident dining areas, failed to paint and/or repair dry wall in resident rooms (Room #134, Room #234, and Room #229), failed to clean up a soiled brief in the floor (Room #116), failed to remove a large bag of soiled linen (Room #130), and failed to clean a spill of feeding tube formula from the floor (Room #102) for 2 of 4 hallways. The facility also failed to repair a bedside table that had a missing drawer facing for 1 of 1 resident reviewed (Resident #2). The findings included: 1a. An observation of the main dining room of the facility was conducted on 02/03/22 at 3:56 PM. The left wall of the dining room had a long row of cabinets that hung on the wall and a lower set of cabinets that ran the same length of the cabinets that hung on the wall. The lower cabinets were noted to be missing the door facing of the lower cabinets. There had been plywood nailed to cover part of the missing cabinets but part of the inside of the cabinets remained visible and exposed.	F 584	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to repair cabinetry in 1 of 2 resident dining areas. Cabinetry will be repaired by 3/24/22. The facility failed to paint and/or repair dry wall in resident rooms #134, #234 and #229. Dry wall in rooms 134, 234 and 229 were repaired and painted to match the wall color by 3/25/22. The facility failed to clean up a soiled brief on the floor in room #116. Brief discarded on 2/4/22. The facility failed to remove a large bag of soiled linen in room #130. Soiled linen sent to laundry on 2/4/22 and floor cleaned by housekeeping. The facility failed to clean a spill of feeding tube formula from the floor in room #102.	

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	345128	A. BUILDING _____ B. WING _____	C 02/23/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 46 An observation of the main dining room of the facility was conducted on 02/04/22 at 9:03 AM. The left wall of the dining room had a long row of cabinets that hung on the wall and a lower set of cabinets that ran the same length of the cabinets that hung on the wall. The lower cabinets were noted to be missing the door facing of the lower cabinets. There had been plywood nailed to cover part of the missing cabinets but part of the inside of the cabinets remained visible and exposed. 1b. An observation of Room #134 was made on 02/03/22 at 4:21 PM. On the long wall to the entrance of the room was 2 large areas of white that had been patched with dry wall puddy but had not been painted the same color as the rest of the room. An observation of Room #134 was made on 02/04/22 at 9:23 AM. On the long wall to the entrance of the room was 2 large areas of white that had been patched with dry wall puddy but had not been painted the same color as the rest of the room. 1c. An observation of Room #234 was made on 02/03/22 at 4:25 PM. On the long wall to the entrance of the room were several areas of white that had been patched with dry wall puddy but had not been painted the same color as the rest of the room. An observation of Room #234 was made on 02/04/22 at 9:26 AM. On the long wall to the entrance of the room were several areas of white that had been patched with dry wall puddy but had not been painted the same color as the rest of the room.	F 584	Floor stripped and waxed on 2/3/22. The facility failed to repair a bedside table that had a missing drawer face in room #228B. Drawer face repaired on 2/4/22. How the facility will identify other residents having the potential to be affected by the same deficient practice; On 3/14/22, the Maintenance Director completed an observational inspection of resident rooms, dining areas, halls and resident common areas to identify cabinetry/furnishings, dry wall and wall paint/coverings to identify any additional needed repairs. Repairs and additional painting will occur on a schedule until all rooms have been painted and/or dry wall. On 3/14/22, the Housekeeping Supervisor completed observational rounds to ensure floors in resident rooms and resident common areas were clean and free of spills and soiled linens or briefs. No additional concerns observed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/22 all staff received education by Administrator/Maintenance Director on reporting repairs into TELS that will automatically alert Maintenance Director of a work order generated. Newly hired facility and agency staff will receive education during orientation.	

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F 584	Continued From page 47 1d. An observation of Room #239 was made on 02/03/22 at 4:33 PM. There were several large areas of white that had been patched with dry wall puddy but had not been painted the same color as the rest of the rom on both long walls of the resident room. An observation of Room #239 was made on 02/04/22 at 9:29 AM. There were several large areas of white that had been patched with dry wall puddy but had not been painted the same color as the rest of the room on both long walls of the resident room. 1e. On observation of Room #116 was made on 02/04/22 at 9:13 AM. In the bathroom there was a soiled brief hanging from the handrail that was so heavily soiled it hung and rested on the floor. On observation of Room #116 was made on 02/04/22 at 11:05 AM. In the bathroom there was a soiled brief hanging form the handrail that was so heavily soiled it hung and rested on the floor. An interview was conducted with Housekeeper #2 on 02/04/22 at 2:50 PM. Housekeeper #2 was observed coming out of Room #116 and getting ready to enter the next room on the hall. Housekeeper #2 was asked if she had cleaned up a soiled brief that was handing on the handrail in the bathroom. She replied, "I don't recall" and proceeded to walk away into the next room on the hallway. The Housekeeping Supervisor was unavailable for interview on 02/04/22 at 3:30 PM. 1f. An observation of Room #130 was made on 02/04/22 at 9:16 AM. There was an extra-large	F 584	Effective 3/24/22 resident rooms will be inspected during department head rounds to ensure floors are clean and free of spills; soiled briefs and linens are not on the floor and wall coverings and furnishings are in good repair. Any concerns identified will be reported to maintenance or housekeeping accordingly and documented in TELS with areas addressed to maintain a safe, clean, sanitary, and homelike environment. Monitoring for completion will also be discussed during morning department head meetings. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator or designee will observe 5 resident rooms, hallways, dining rooms and resident common areas 2x weekly, weekly x 2 months, and monthly x 2 months to ensure floors are clean and free of spills, soiled briefs and linens and wall coverings and cabinetry/furnishings are in good condition and repair. Any areas discovered will be addressed immediately. Results of these audits will be reviewed at Monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/22	

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clear trash bag lying in the bathroom floor that was full of soiled linen that included towels, sheets, wash clothes, and bed pads.

An observation of Room #130 was made on 02/04/22 at 12:28 PM. There was an extra-large clear trash bag lying in the bathroom floor that was full of soiled linen that included towels, sheets, wash clothes, and bed pads.

An interview was conducted with Housekeeper #2 on 02/04/22 at 2:50 PM. Housekeeper #2 confirmed she was responsible for cleaning Room #130 and indicated she had already cleaned that room. She stated she could "not recall" if there was a large bag of soiled linen in bathroom when she cleaned or not. She added that the nursing staff "should pick that stuff up."

The Housekeeping Supervisor was unavailable for interview on 02/04/22 at 3:30 PM.

1g. An observation of Room #102 was made on 02/03/22 at 4:01 PM. There was a feeding tube pole that had bottle of tube feeding formula hanging from the pole. The base of the feeding tube pole and the floor surrounding the pole was noted to have dried brown liquid that appeared the same color as the feeding tube formula that was hanging from the pole.

An observation of Room #102 was made on 02/04/22 at 9:06 AM. There was feeding tube pole that had bottle of tube feeding formula hanging from the pole. The base of the feeding tube pole and the floor surrounding the pole was noted to have dried brown liquid that appeared the same color as the feeding tube formula that was hanging from the pole.

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The Maintenance Supervisor (MS) was interviewed on 02/04/22 at 2:43 PM. The MS stated that he has been working at the facility since October 2021 and had been working on painting and repairing rooms but when the facility had a COVID outbreak they stopped. He added that the 300 and 400 hall have been repainted and repairs done but 100 and 200 halls had not been done yet. The MS stated that he had done approximately 4-5 room that were empty since October 2021 but added that the rooms that have the dry wall mud on them have been that way since before he got to the facility, and we are working on getting them repaired and painted. The MS stated that he had asked previously to have the cabinets in the dining room replaced and was told no because it was too expensive so he was doing the best he could with the supplies he had.

The Administrator was interviewed on 02/07/22 at 3:40 PM. The Administrator stated that each resident room was to be cleaned each day including weekends by a member of the housekeeping staff. The soiled brief should have been disposed of by the nursing staff. The Administrator stated that she planned to have the MS start painting and repairing rooms on the 2 units that had not been done soon. She stated with the COVID outbreak they had that started around Christmas time that caused them to halt the progress but added she expected the rooms to be painted and repaired and to be comfortable for each resident.

h. Resident #2 was admitted to the facility on 02/02/21.

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The recent quarterly Minimum Data Set assessment dated 11/24/21 indicated Resident #2's was cognitively intact.

During an interview with Resident #2 on 02/02/22 at 3:10 PM an observation was made of the middle front panel from the drawer of his bedside table which was laying on top of the bedside table. The Resident explained that the panel had been laying on his bedside table for about two months and the previous Activities Director had filled out a repair order to have it fixed.

On 02/04/22 at 10:00 AM an observation of the drawer panel remained on the top of Resident #2's bedside table.

During an interview with the Maintenance Supervisor (MS) on 02/04/22 at 12:45 PM he reported that he did not have a work order to repair the drawer panel on Resident #2's bedside table but he would immediately address the situation. The MS explained that the staff were educated on using the TEL system, which was a system for which they could request a work repair on items, but the staff did not utilize the system appropriately or not at all.

An interview was conducted with the Administrator and acting Director of Nursing on 02/07/22 at 3:40 PM. The Administrator explained that in October 2021 the facility educated all staff on the process of reporting needed repairs on the TELs system as a part of the facility's plan of correction after their last recertification survey. The Administrator continued to explain that to make reporting easier on the staff, the facility posted directions for the system at the nursing stations and the staff could also utilize an app on

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F 584	Continued From page 51 their cell phones. Regardless, the Administrator indicated the drawer should have been repaired within a reasonable amount of time.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 585		3/25/22

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grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance,

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F 585	Continued From page 53 the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff and resident interviews, the facility failed to address filed grievances for 1 of 1 resident reviewed for grievances (Resident #4). The Findings Included: Resident #4 was admitted to the facility on 10/26/21. A review of Resident #4's Admission Minimum Data Set Assessment dated 10/28/21 revealed Resident #4 to be cognitively intact with no psychosis, behaviors, or rejection of care. A review of facility provided grievance logs revealed no documented grievances by Resident #4 since his admission.	F 585	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 3/9/22, the Administrator (Grievance Coordinator) met with Resident #4 to identify any unresolved grievances. Grievance form completed and concerns resolved. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/22, the Social Worker and Administrator interviewed and reeducated current cognitively intact residents on	

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F 585	Continued From page 54 During an interview with Resident #4 on 02/02/22 at 12:21 PM, he reported he had filled out 8-10 grievances since his admission to the facility in October regarding a variety of issues including lack of care, poor staff attitudes, and staff 'playing tag with Lysol in the hallways". He stated each time he filed a grievance out, he slid it under the Director of Nursing's office door. He reported he never received any follow-up from facility staff and after 2-3 weeks, he went to the Administrator to ask about the follow up. He reported when he questioned the Administrator about the lack of follow up to his grievances, she reported she did not know anything about them. During an interview with the Director of Nursing #1 on 02/03/22 at 11:52 AM she reported she was not the facility's grievance official while she was at the facility and that the Administrator would be the one who received grievance reports. She stated she had, at times received grievances under her door but stated she did not remember receiving one from Resident #4. She also stated she remembered Resident #4 and reported she was unaware of any filed grievances he alleged to have filed. She stated if the grievances would have been slid under her door, she would have addressed them or passed them on to the Administrator. She reported she only dealt with grievances related to "medical issues". During an interview with the Administrator on 02/09/22 at 1:03 PM, she reported she was unaware of any grievances filed by Resident #4 and that if Resident #4 had filed grievances and placed them under the Director of Nursing's door, she would have provided the grievances at the morning meetings they have. The Administrator	F 585	process of reporting grievances to the Administrator (Grievance Coordinator) or placing grievance in mailbox located at Administrators door to ensure receipt of concerns for resolution. Effective 3/14/22, the Administrator reviewed grievance log from 2/14/22 -3/14/22 to ensure timely resolution of all filed grievances. Effective 3/14/22, residents that are cognitively impaired/Responsible party will continue to be informed of the grievance process upon admission. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/22 education provided by Administrator to department heads on communicating all reported resident/family grievances to the Grievance Coordinator (Administrator) and completing a grievance form and turning in immediately to Administrator to ensure appropriate follow-up and resolution of concerns. The Administrator is the designated Grievance Coordinator and will receive and ensure resolution of resident/family grievances. Newly Hired department heads will receive education upon hire. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

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F 585	Continued From page 55 reported she did not remember him speaking to her about the missing grievances and that she expected all grievances to be addressed and resolved promptly.	F 585	The Administrator or designee will audit via questionnaire 3 cognitively intact residents and the grievance log to ensure grievances are received and resolved timely. Monitoring will occur 2 x/wk x 4 weeks them 1x/wk x 12 weeks. Results of monitoring, with tracking and trending, will be reported by Administrator to the Quality Assurance Performance Improvement committee monthly and changes will be made to the plan as necessary to maintain compliance. Completion date: 3/25/22	
F 600 SS=E	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; This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner (NP), and Physician (MD) interviews, the facility neglected to provide ordered medications for 2 residents when Nurse #16 failed to administer	F 600	How corrective action will be accomplished for those residents found to have been affected by the deficient practice;	3/25/22

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F 600	Continued From page 56 medications because she did not know the residents resided on her unit (Resident #14 and Resident #15) and also failed to provide a nightly snack for Resident #15 for 2 of 2 residents reviewed for neglect. Findings included: 1. Resident #14 was admitted to the facility on 12/21/20 with diagnoses that included schizophrenia (mental disorder that impairs a person's ability to think feel and behave clearly) and dementia with hallucinations (memory impairment with a perception of having seen, heard, touched, tasted, or smelled something that wasn't there). A review of the Medication Administration Record (MAR) for January 2022 revealed on 1/5/22 on 7P-7A shift, Resident #14 did not receive any medications and is initialed to indicate a #9 which was associated with a linked nurses note. The following ordered medications were not administered during the shift: Depakote 125 milligram (mg) daily for dementia with hallucinations, Melatonin 3 mg daily for insomnia, Ativan 0.5 mg twice daily for anxiety, and Seroquel 25 mg twice daily for Schizophrenia. A nurses note written by Nurse #16 and dated 1/6/21 effective 7:57 AM read in part: "Resident #14 didn't receive any medications on shift due to she was on the unit for 2 days and shift report was not given to this nurse and medication was not sent over nor was this nurse told the resident was transferred to unit with no medications there is no phone on unit when this nurse uses her personal phone to call no one answers resident is stable report given to oncoming nurse."	F 600	Resident #14 and resident #15 did not suffer any adverse side effects as a result of medications not being administered timely on 1/5/22 and resident #15 also not receiving bedtime snack. Resident #14 transferred off covid unit to well unit on 1/13/22 and Resident #15 transferred to well unit on 1/11/22 and medications continue to be available and administered as ordered. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/2022 the Director of Nursing and/or designee reviewed residents with rooms changes from 2/14/22 – 3/14/22 to ensure medications were transferred with resident and available for administration and bedtime snack was provided if ordered by the physician. Resident medications were available and administered as ordered, including bedtime snacks. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Director of Nursing and/or designee educated current facility and agency Licensed Nurses and Medication Aides (MA) on ensuring medications is transferred immediately to appropriate medication cart when residents have a room change and verbal shift to shift report provided by ongoing	

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	345128	A. BUILDING _____ B. WING _____	C 02/23/2022

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F 600	Continued From page 57 An interview on 02/04/22 at 8:00 AM with Nurse #16 revealed she was familiar with Resident #14 and cared for her during night shift on 1/5/22. Nurse #16 stated she was assigned to work the COVID-19 isolation unit on that night and elaborated to say staff were unable to leave the unit when assigned to care for residents in that area because of isolation precautions. She explained she did not receive report when she came on shift to make her aware Resident was placed on the unit and later in the shift discovered Resident #14 had been transferred there without her ordered medications. Nurse #16 indicated she did not medicate Resident #14 because she did not have access to her ordered medications and there is no way to access the main portion of the facility to obtain medications from the backup stocked supply. 2. Resident #15 was readmitted to the facility on 10/19/19 with diagnoses that included hemiplegia following a cerebral infarction (paralysis of an extremity following a stroke), insomnia, and diabetes. A review of the Medication Administration Record (MAR) for January 2022 revealed on 1/5/22 on 7P-7A shift, Resident #15 did not receive any medications and is initialed to indicate a #9 which was associated with a linked nurses note. The following ordered medications were not administered during the shift: Ambien 5mg daily for insomnia, Lorvastatin 40mg daily for stroke prevention, Melatonin 10mg daily for insomnia, a bedtime snack for weight loss and diabetes, and Keppra 500mg BID for seizures disorder. A nurses note written by Nurse #16 and dated	F 600	and off going nurses. Education included rounding on residents on your assigned unit regularly including at start of shift. The licensed nurse and/or MA is responsible for transferring medications to appropriate medication cart when resident room changes occur and continuing to administer medications and bedtime snacks timely as ordered by the physician. Newly hired facility and agency licensed nurses and MAs will receive education during orientation and prior to first shift worked. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit residents with rooms changes to ensure medications were transferred with resident and available for administration and bedtime snack was provided if ordered by the physician. Monitoring will be completed weekly X 12 weeks. Results of these audits will be reviewed at Quality Assurance Meeting monthly for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 600	Continued From page 58	F 600		

1/6/21 effective 7:56 AM read in part: "Resident #15 didn't receive any medications on shift because he was on the unit and shift report was not given to this nurse and medication was not sent over nor was this nurse told the resident was transferred to unit with no medications. She explained there was no phone on unit and when Resident #16 used her personal phone to call no one answers resident is stable report given to oncoming nurse."

An interview on 02/04/22 at 8:00 AM with Nurse #16 revealed she was familiar with Resident #15 and cared for him during night shift on 1/5/22. Nurse #16 stated she was assigned to work the COVID-19 isolation unit on that night and elaborated to say staff were unable to leave the unit when assigned to care for residents in that area because of isolation precautions. She explained she did not receive report when she came on shift to make her aware Resident #15 was placed on the unit and later in the shift discovered Resident #15 had been transferred there without her ordered medications. Nurse #16 indicated she did not medicate Resident #15 because she did not have access to his ordered medications and there was no way to access the main portion of the facility to obtain medications from the backup stocked supply.

An interview on 02/08/22 at 12:20 PM with the Interim Director of Nursing (DON) and the Administrator revealed staff to follow Physician's orders and administer medications as indicated. The Administrator acknowledged staff assigned to the COVID unit were not supposed to come off that unit and there was not a backup medication stock for that unit. The Interim DON stated the nurse should have come to the main portion of

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F 600	Continued From page 59 the facility to obtain any needed medications for administration. An interview on 02/9/22 at 5:30 PM with the Physician revealed she was not made aware Resident #14 or Resident #15 had not received their schedule medications on the night of 1/5/22 at the time. The MD explained she expected all residents to receive medications as ordered. The MD also stated Resident #14 missing these medications could have caused increase behaviors such as hallucinations secondary to her schizophrenia and was important she receive her medications as ordered. The interview further revealed Resident #15 was placed at an increased risk of seizures and low blood sugar secondary to him missing his medication for epilepsy and his nighttime snack.	F 600		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.	F 636		3/25/22

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F 636	Continued From page 60 (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization	F 636		

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F 636	Continued From page 61 or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed complete comprehensive Minimum Data Set assessments with the subsequent care area assessments within the required time frame for 3 of 3 resident reviewed (Resident #3, Resident #6, and Resident #7). The findings included: 1. Resident #3 was readmitted to the facility on 12/07/21. Review of the significant change Minimum Data Set (MDS) dated 12/15/21 revealed that it was completed on 02/01/22 which is after the 14-day time frame for completion requirement. MDS Nurse #1 was interviewed on 02/04/22 at 12:19 PM who stated that the former MDS nurse suddenly left and there was no one at the facility to train her on how to fully complete the MDS and care area assessments. MDS Nurse #1 added that the former MDS nurse had completed Resident #3's MDS but was not aware that the former MDS nurse had not completed the care area assessments which made the entire assessment late. MDS Nurse #1 indicated that someone from their corporation had shown her how to complete the care area assessments on 02/03/22 and she began working on them but stated "they are already late." The Administrator was interviewed on 02/07/22 at 3:40 PM. The Administrator stated she was not aware that the facility had late MDS assessment	F 636	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to complete a Comprehensive Minimum Data Set assessment for resident #3, resident #6 and resident #7, within 14 days. Resident #3 was transmitted and accepted on 2/2/22. Resident # 6 was transmitted and accepted on 2/7/22. Resident #7 Comprehensive assessment on 1/10/22 transmitted and accepted 2/7/22. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/2022 current residents were reviewed by MDS Nurses to ensure Comprehensive Assessments are completed within the required timeframe. All Comprehensive MDS Assessments are current. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 636	Continued From page 62 until MDS Nurse #1 recently told her. She also stated that she was not aware that MDS Nurse #1 was not properly trained to complete the entire assessment but added "we need to get her the proper training" so the MDS assessment can be completed timely. 2. Resident #6 was admitted to the facility on 01/05/22. Review of the Admission Minimum Data Set (MDS) dated 01/13/22 revealed that it was completed on 02/02/22 which is after the 14-day time frame for completion requirement. MDS Nurse #1 was interviewed on 02/04/22 at 12:19 PM who stated that the former MDS nurse suddenly left and there was no one at the facility to train her on how to fully complete the MDS and care area assessments. MDS Nurse #1 added that she had completed Resident #6's MDS but was not aware how to complete the care area assessments which made the entire assessment late. MDS Nurse #1 indicated that someone from their corporation had shown her how to complete the care area assessments on 02/03/22 and she began working on them but stated "they are already late." The Administrator was interviewed on 02/07/22 at 3:40 PM. The Administrator stated she was not aware that the facility had late MDS assessment until MDS Nurse #1 recently told her. She also stated that she was not aware that MDS Nurse #1 was not properly trained to complete the entire assessment but added "we need to get her the proper training" so the MDS assessment can be completed timely.	F 636	Effective 3/24/2022 Regional MDS Consultant educated MDS nurses on completing the comprehensive MDS within the required timeframe. The Newly hired MDS staff will be educated during orientation. The Regional MDS Consultant will provide back-up support to facility to ensure timely submission of all resident Comprehensive MDS Assessments. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will audit 5 residents comprehensive assessments weekly for 12 weeks to ensure comprehensive assessments are completed within the required timeframe. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 636	Continued From page 63 3. Resident #7 was admitted to the facility on 07/28/17. A review of Resident #7's electronic medical record revealed an annual Minimum Data Set (MDS) assessment with an ARD (Assessment Reference Date) of 01/10/22. The MDS was not completed within the 14 day timeframe and had not been transmitted to the state agency. During an interview with the Minimum Data Set Nurse #1 on 02/04/22 at 12:20 PM the Nurse explained that the previous MDS Nurse suddenly left and there was no one at the facility to train her on how to fully complete the MDS and care area assessments. The MDS Nurse indicated that corporate staff had shown her how to complete the care area assessments on 02/03/22 and she began working on the late assessments. On 02/07/22 at 3:40 PM during an interview with the Administrator and Director of Nursing the Administrator explained that she was not aware that the facility had late MDS assessments and she did not know that the MDS Nurse was not properly trained to the MDS process until the MDS Nurse recently informed her. The Administrator indicated that the facility would provide the proper training to the MDS Nurse so the MDS process could be completed timely.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		3/25/22

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F 641	Continued From page 64 by: Based on record review, and facility staff and resident interviews, the facility failed to accurately code an admission minimum data set assessment for height and discharge planning for 1 of 3 residents reviewed (Resident #4). The Findings Included: 1.a. Resident #4 was admitted to the facility on 10/26/21 with diagnoses that osteomyelitis, paraplegia, partial traumatic amputation of right lower leg, and complete traumatic amputation of left lower leg. A review of Resident #4's admission Minimum Data Set Assessment dated 10/28/21 revealed Resident #4 to be cognitively intact with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #4 was coded as being 67 inches tall and 144 pounds (lbs). During an interview with MDS Nurse #2 on 02/04/22 at 10:09 AM, she verified she was the MDS Nurse that completed Resident #4's admission Minimum Data Set Assessment. She reported she did not know what to say and that she filled out the assessment to the best of her ability. During an interview with the facility's previous Director of Nursing on 02/07/22 at 3:04 PM, she reported a height of 67 inches did "not seem accurate". She reported with a resident with bilateral amputations, the facility would have taken a wingspan but that it should not have been recorded as his height. She stated she could not say what Resident #4's height was but was certain it was not 67 inches. The Director of	F 641	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to accurately code an Admission Minimum Data Set for resident #4. The facility modified resident #4 to reflect discharge as “planned” on discharge assessment on 10/28/2021 and retransmitted on 3/4/2022. The facility modified resident #4 to reflect “height” on admission on 10/28/2021 and retransmitted on 3/4/2022. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/2022 Minimum Data Set Nurses reviewed 30 days of discharge residents to ensure accuracy of coding planned and/or unplanned. No additional concerns identified. Effective 3/14/2022 Minimum Data Set Nurses reviewed current resident height to ensure accuracy of coding. No additional concerns identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 641	Continued From page 65 Nursing indicated that Minimum Data Set Assessments should be accurate. b. A review of Resident #4's admission Minimum Data Set Assessment dated 10/28/21 revealed Resident #4 to be cognitively intact with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #4 was coded as expecting to be discharged to the community. However, he was coded as not wanting to "talk to someone about the possibility of leaving the facility and returning to live and receive services in the community." Resident #4 was also coded as not wanting to be asked about returning to the community on all future assessments. During an interview with Resident #4 on 02/02/22 at 12:17 PM, Resident #4 reported he had not expected to be admitted the facility for as long as he had. He reported when he was admitted he made it clear he had wanted to eventually discharge and live on his own. He reported he did not remember being asked by anyone in the facility if he wanted to speak to someone about his discharge plans and living in the community, or if he wanted to be asked on future assessments about his discharge plans. He stated, "why would I tell them I wanted to discharge to the community and then tell them I did not want to speak to anyone about discharging or be asked about discharging in the future?" During an interview with MDS Nurse #2 on 02/04/22 at 10:09 AM, she reported she remembered very little about the completion of Resident #4's admission Minimum Data Set Assessment. She reported the discharge planning part of the assessment was something	F 641	Effective 3/24/2022 Regional MDS Consultant educated MDS nurses on coding MDS assessment accurately per RAI guidelines. Newly hired MDS staff will be educated during orientation by Regional MDS Consultant or designee on coding MDS assessment accurately. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will audit 5 discharge assessments weekly to ensure discharge assessments are coded accurately. Administrator will audit 5 admission assessments weekly to ensure assessment for height are coded accurately. Results of these audits will be reviewed monthly in Quality Assurance Meeting for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 641	Continued From page 66 she typically did not complete but had to for Resident #4 because the facility did not have a social worker at the time the assessment was completed. When asked why Resident #4 would report wanting to discharge to the community but then state he did not want to speak to anyone about discharge plans or be asked about discharging in the future, she reported "I don't know what to tell you, I completed [the assessment] to the best of my ability and the answers he gave me". When asked why she coded Resident #4 as expecting to discharge to the community but not wanting to speak to anyone about discharging to the community she again stated she had completed the assessment to the best of her ability. During an interview with Director of Nursing #1 on 02/07/22 at 2:47 PM, she reported she did not know why Resident #4's admission Minimum Data Set Assessment was coded with him planning on discharging to the community and then as not wanting to speak to anyone about discharging or be asked about discharge on future assessments. The Director of Nursing indicated that Minimum Data Set Assessments should be accurate.	F 641		
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.	F 655		3/25/22

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F 655	Continued From page 67 The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a baseline care within 48 hours of admission that addressed surgical	F 655	How corrective action will be accomplished for those residents found to have been affected by the deficient	

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ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

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F 655	Continued From page 68 wound care or smoking status of the resident for 1 of 3 residents reviewed for smoking (Resident #6). The findings included: Resident #6 was admitted to the facility on 01/05/22 with diagnoses that included multiple fractures to left lower extremity. Review of an admission assessment dated 01/05/22 and completed by Nurse #4 indicated that Resident #6 had multiple surgical incisions. The admission assessment did not address Resident #6's tobacco use. The admission Minimum Data Set (MD) dated 01/13/22 revealed that Resident #6 was cognitively intact and required limited assistance with activities of daily living. The MDS also revealed that Resident #6 used tobacco and required surgical wound care. Review of Resident #6's medical record on 02/02/22 revealed no baseline care plan had been developed upon admission. MDS Nurse #1 was interviewed on 02/04/22 at 12:19 PM. MDS Nurse #1 stated that she did not do anything with the baseline care plans. She stated that the admitting nurse was responsible for initiating the baseline care plan as well as going over the care plan with the resident/family on admission then the Director of Nursing (DON) or other management would sign off on the baseline care plan. Nurse #10 was interviewed on 02/07/22 at 1:01 PM. Nurse #10 confirmed that she was the Unit	F 655	practice; The facility failed to develop a baseline care plan in the area of smoking and surgical wound care within 48 hours of admission for resident #6. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/2022, the Director of Nursing reviewed current residents admitted from 2/7/22 – 3/2/22 to ensure baseline care plan was completed within 48 hours to address smoking status and wound care. All baseline care plans were completed timely and accurately to reflect smoking status and wound care needs. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Director of Nursing and/or designee educated current facility and agency licensed nurses on completing baseline care plans upon admission to accurately reflect resident smoking status and wound care needs within 48 hours of admission. The admission nurse will be responsible for initiating the baseline care plan upon admission. Newly hired facility and agency licensed nurses will receive education during orientation and prior to first shift worked.	

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F 655	Continued From page 69 Manager (UM) for Resident #6. She stated she was able to complete the baseline plans if she had the time, but the responsibility was really the admitting nurse and then the MDS Nurse would come in and do their part. Nurse #10 stated that recently she has been working a medication cart and doing other things and had not had time to review the recent admissions but stated she did not recall being a part of Resident #6's admission. The Administrator and interim DON were interviewed on 02/07/22 at 3:40 PM. The interim DON stated that baseline care plans were the responsibility of the nurses involved in the admission. She explained that at times the facility got admissions late in the day and if the baseline care plans were not able to be initiated at that time it should be reported to the oncoming nurse to be completed. The interim DON also stated that as a second check, the UMs reviewed each admission to ensure all pieces of the admission were complete and they were able to initiate the baseline care plan if the admission nurse had not done so. The Administrator added that all agency staff were educated in the last 4-5 months on the baseline care plan process and were aware of the process of completing them and she expected the baseline care plan to be initiated within 48 hours of admission. Nurse #4 was interviewed on 02/10/22 11:50 AM. Nurse #4 confirmed that she had admitted Resident #6 to the facility on 01/05/22. She stated she had completed the admission assessment, the skin assessment and made a progress note about his admission. Nurse #4 stated that she was not responsible for completing the baseline care plan that was the MDS nurse's responsibility.	F 655	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit admissions to ensure resident smoking status and wound care needs are reflected on the baseline care plan within 48 hours of admission. Audits will be completed 2x/wk X 12 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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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. (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 interview, the facility failed to revise comprehensive care plans in the areas of anticoagulation for 1 of 1 resident reviewed for Coumadin therapy (Resident #1) and 1 of 1 resident reviewed for pressure ulcer (Resident #2). The findings included:	F 657	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #1 comprehensive care plan revised on 2/7/2022 by the licensed nurse for use of anticoagulant medication.	3/25/22

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F 657	Continued From page 71 1. Resident #1 was admitted to the facility on 10/21/21 with a readmission dated 12/16/21 with diagnoses that included atrial fibrillation (A Fib) and acute embolism and thrombosis of unspecified deep vein (DVT) of the lower extremity. A care plan initiated on 11/22/21 included the use of Lovenox and Coumadin although Lovenox was discontinued on 12/9/21 with interventions dated 11/22/21 that included monitor for anticoagulant side effects every shift. A physicin's order dated 12/9/21 indicated Lovenox was discontinued. A quarterly Minimum Data Set (MDS) dated 12/25/21 revealed Resident #1 intact and received 6 of 7 days of anticoagulants. An interview with the MDS Nurse Coordinator on 2/7/22 at 11:07 AM indicated she only started developing care plans approximately a month ago. She stated the care plan should include have been updated when the Lovenox was discontinued, and interventions should have been added to include monitoring for adverse effects from Coumadin therapy. An interview with the Interim Director of Nursing (DON) and the Administrator on 2/8/22 at 12:21 PM expects all care plans to be followed and modified as needed for individualization to each resident. For a resident on anticoagulant therapy, The DON and Administrator expects anticoagulant care plans to include monitoring for adverse effects such as bleeding or bruising, all labs to be obtained as ordered, and the medical	F 657	Resident #2 comprehensive care plan revised on 2/7/2022 by the licensed nurse for care of pressure ulcer. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/18/2022 Minimum Data Set (MDS) and/or licensed nurse designee reviewed current residents comprehensive care plans for residents with anticoagulants and pressure wounds to ensure accuracy. All revisions made during audit. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Regional MDS Consultant educated the MDS nurse on updating comprehensive care plans for residents with anticoagulants and pressure wounds to reflect changes and care needs. Newly hired MDS nurses will receive education during orientation. The MDS nurse will review new physician orders daily and make revisions to resident care plans to reflect anticoagulant use and/or pressure wounds. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

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F 657	Continued From page 72 provider to be made aware of all results promptly. 2. Resident #2 was admitted to the facility on 02/02/21. A review of Resident #2's care plan dated 05/26/21 revealed he had a potential for pressure ulcer development with an actual pressure ulcer to the left gluteal fold related to decreased mobility and incontinence. The interventions included utilizing the facility's pressure ulcer prevention and treatment protocols, conducting a weekly skin assessment and providing incontinence care after each incontinence episode. Resident #2's care plan did not address his current stage 4 pressure ulcer identified on 01/27/22. A review of Resident #2's medical record revealed a Wound Care Physician's progress note dated 06/17/21 that indicated a stage 2 pressure ulcer to the left gluteal fold had resolved. The quarterly Minimum Data Set (MDS) assessment dated 11/24/21 revealed Resident #2 was cognitively intact and was at risk for pressure ulcers but had no pressure ulcers at the time of the MDS assessment. A review of a change in condition progress note dated 01/27/22 revealed Nurse #12 found a black crusty area with irregular edges over the Resident's right upper buttock that measured approximately 10 x 4 centimeters (cm). A review of the Wound Care Physician's progress note dated 02/03/22 revealed Resident #2 had a stage 4 pressure ulcer on his right buttock that	F 657	Administrator will audit 5 residents weekly x 12 weeks to ensure comprehensive care plans are revised for pressure wounds and anticoagulant use. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 657	Continued From page 73 measured 8.5 x 10.5 x 1.4 cm with heavy serous drainage and 100% necrosis. An interview was conducted with MDS Nurse #1 on 02/08/22 at 11:50 AM. The MDS Nurse explained that she became aware of Resident #2's stage 4 pressure ulcer when she read the Physician's orders for the pressure ulcer. The MDS Nurse continued to explain that she should have updated Resident #2's care plan on that day but she was overwhelmed with her duties due to the MDS Coordinator had recently quit and she has been trying to do all the MDS process by herself. On 02/07/22 at 3:40 PM during an interview with the Administrator and Director of Nursing they acknowledged the last MDS Coordinator had recently left the company and the MDS process was too overwhelming for one MDS person. The Administrator indicated that she would request corporate support for the MDS Nurse, and the facility would get caught up with the backlog of the MDS's and care plans.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each	F 660		3/25/22

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F 660	Continued From page 74	F 660		

resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or

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F 660	Continued From page 75 LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff and resident interviews, the facility failed to have a discharge planning process in place for a resident wishing to discharge to the community (Resident #4) for 1 of 1 resident reviewed for discharge planning. The Findings Included: Resident #4 was admitted to the facility on 10/26/21. A review of Resident #4's Admission Minimum Data Set Assessment dated 10/28/21 revealed Resident #4 was cognitively intact. Resident #4	F 660	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to have a discharge planning process in place for resident #4. On 3/9/22, the Social Worker completed a discharge planning assessment for Resident #4 to ensure discharge plan in place. How the facility will identify other residents having the potential to be affected by the	

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F 660	Continued From page 76 was coded as independent with bed mobility, transfer, locomotion on and off the unit, dressing, toilet use, and bathing. Resident #4 required supervision with eating and personal hygiene. Resident #4 was coded as expecting to be discharged to the community. A review of Resident #4's care plan dated 11/16/21 revealed no care plan area for discharge or discharge planning. A review of Resident #4's electronic progress notes, scanned documents, and completed assessments revealed no documentation from any staff member regarding Resident #4's discharge planning or his plan to remain in the facility long term. During an interview with Resident #4 on 02/02/22 at 12:17 PM, he reported he was admitted to the facility from the hospital for treatment of wounds to his body. He reported it was his understanding that he would only be in the facility long enough to finish antibiotic treatment and ensure his wounds continued to heal. He reported he told the facility, unable to recall who he spoke with, he would like to return to the community upon completion of his antibiotics but had not had any meaningful conversations with anyone regarding his discharge planning process. During a follow-up interview with Resident #4 on 02/03/22 at 12:15 PM, he stated he had spoken to the Admissions Coordinator about wanting to be discharged to the community around the end of December 2021. He stated the Admissions Coordinator told him she could assist him with a transfer to another facility which he declined as he reported he wanted to be at home in the	F 660	same deficient practice; Effective 3/18/2022 the Social Worker reviewed current residents to ensure a discharge plan is in place. Residents without a documented plan had a discharge planning assessment completed in the electronic medical record. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Administrator provided education to the Social Worker on completing discharge planning for short term and long-term residents and documenting in the electronic medical record. Newly hired MDS staff will be educated during orientation. The Social Worker will complete a discharge planning assessment upon admission for residents to ensure proper planning for return to community. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will audit admissions to ensure discharge plans are in place weekly x 12 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed.	

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F 660	Continued From page 77 community and not in a nursing facility. He stated he spoke to the Admissions Coordinator about his discharge planning because there was not a social worker employed at the facility during his admission. During an interview with the Social Worker (SW) on 02/03/22 at 9:15 AM, she reported she had just started the previous Wednesday, 01/26/22. She stated she was not familiar with Resident #4 or his discharge plan. She reported she had worked on 5-6 discharges since she started, and she did not see any discharge planning in place or in process for Resident #4. An interview with the Admissions Coordinator on 02/04/22 at 11:55 AM revealed Resident #4 had come to her "teary eyed" on 12/31/21 stating he wanted to discharge home. She reportedly told him the facility had a new social worker starting soon and he would have to speak with her about his discharge planning. She reported she inquired if he would be interested in transferring to an assisted living facility which he declined. The Admissions Coordinator stated she was not sure what the current discharge plan was for Resident #4. She indicated when the new SW started work (1/26/22), she had not informed her that Resident #4 needed to discuss discharge planning. During an interview with the Administrator on 02/09/22 at 1:03 PM, she reported she "kinda figured he [Resident #4] would want to be discharged to the community." The Administrator stated when a resident was admitted to the facility a care plan meeting should be scheduled for soon after the admission and discharge planning would be discussed with a discharge care plan	F 660	Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 660	Continued From page 78 drawn up for residents who wish to discharge home. The Administrator reported she did not know if there had been any discharge planning in place for Resident #4 but reported if there were not any discharge plans in place, she would make sure the facility got started on discharge planning for Resident #4. She explained that the facility had been without a full time SW for around 3 months up until 1/26/22 and that during that time the SW duties, including discharge planning, were divided up among the administrative team. She reported she did not know the time frame Resident #4 was expected to be admitted to the facility and that she would expect a discharge plan to be in place for residents who stated upon admission they had intentions of discharging home.	F 660		
F 677 SS=H	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and family member interview the facility failed to provide incontinence care when requested by the resident (Resident #3, Resident #5, Resident #9, Resident #10, Resident #11) and failed to provide shower activities (Resident #2, Resident #7, and Resident #12) for 8 of 8 resident reviewed for activities of daily living. The findings included: 1. Resident #3 was readmitted to the facility on	F 677	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #2, resident #7 resident #12 task list updated for bathing type and frequency preference and residents continue to receive showers per plan of care Incontinence care for resident #3, resident	3/25/22

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F 677	Continued From page 79 12/07/20 with diagnoses that included diabetes, hypertension, bilateral lower limb amputations, and others. Review of a care plan revised on 07/01/21 read in part; Resident #3 has an activity of daily living self-care deficit related to a history of dementia and bilateral lower extremity amputations. The goal read; Resident #3 will maintain/improve current level of activities of daily living through the review date. The interventions included: Resident #3 required extensive assistance of 2 staff members with toileting. Review of the significant change Minimum Data Set (MDS) dated 12/15/21 indicated that Resident #3 was cognitively intact and required total assistance with toileting. The MDS also indicted that Resident #3 was frequently incontinent of bowel and bladder and exhibited no behaviors or rejection of care during the assessment reference period. A continuous observation and interview were conducted on 02/02/22 at 7:06 AM to 8:42 AM. At 7:06 AM Resident #3's call light was noted to be on. At 7:31 AM Resident #3 was heard from the hallway stating, "I need some help in here, I need to be changed." Various staff members were up and down the hallway during the continuous observation. At 7:35 AM Nurse #10 was observed to enter Resident #3's room and turn off his call light. At 8:24 AM no other staff had entered Resident #3's room and he was continued to be heard from the hallway requesting to be changed. At 8:24 AM Resident #3 again turned his call light on. At 8:32 AM Resident #3 was observed resting in his bed, he had opened his brief and stated that he needed to be changed. Resident #3 was	F 677	#5, resident #9, resident #10 and resident #11 will continue to be provided to maintain incontinence care needs. How the facility will identify other residents having the potential to be affected by the same deficient practice: Effective 3/14/2022, Director of Nursing and/or designee completed and audit via questionnaire with cognitively intact incontinent residents to ensure incontinence care needs are being met. Cognitively impaired incontinent residents were monitored by rounding observation to ensure briefs are being changed timely and not being left soiled. No additional concerns identified. Bathing report reviewed in Electronic Medical Record (EMR) and updates made to resident care plan, task list and Master Shower schedule to reflect resident preference for bath type and frequency. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 the Director of Nursing and/or designee will educate the current facility and agency Certified Nursing Assistants (CNA) Licensed Nurses providing showers/baths and incontinence care for dependent residents per preference and plan of care. Education included the licensed nurse updating Master Shower schedule and bathing task list upon admission and with	

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F 677	Continued From page 80 visibly soiled with feces and was also noted to have 2 briefs in place. Resident #3 stated, "if I have 2 briefs on then my clothes don't get wet" because it takes them so long to come in and change me sometime hours between changes. At 8:42 AM Nurse Aide (NA) #7 was observed to enter Resident #3's room carrying his breakfast tray. When NA #7 entered the room and Resident #3 stated "I need to be changed I have been waiting an hour and half for help." NA #7 took the tray to a cart outside his room and proceeded back into Resident #3's room to clean him up. NA #7 stated that Resident #3 often had on 2 briefs and that "was a common occurrence" and proceed to turn Resident #3 onto his side to wash his buttock. Resident #3 was noted to have dried feces on his buttock which required NA #7 to scrub the area to remove the dried feces. The skin on his buttocks was intact and slightly red due to NA #7 having to scrub the area to get Resident #3 cleaned up. Once Resident #3 was cleaned up NA #7 placed one new brief on him dressed him and placed Resident #3 in his wheelchair. After removing her gloves and washing her hands she brought Resident #3 his breakfast tray so he could eat his meal. Nurse #10 was interviewed on 02/02/22 at 5:45 PM. Nurse #10 confirmed that she had turned off Resident #3 call light earlier that morning but stated she had let the NA know that he needed care. Nurse #10 could not recall which NA she reported too but stated she let the direct care staff on the hall know that Resident #3 was requesting care. A follow up interview was conducted with NA #7 on 02/03/22 at 10:46 AM. NA #7 stated that on 02/02/22 she was late to work and did not report	F 677	changes and the CNA providing care as scheduled and notifying licensed nurse for refusals and providing incontinence care by rounding every two hours and as needed for incontinent residents. The licensed nurse will be responsible for maintaining shower schedules and updates and the CNA will provide care and report refusals to the licensed nurse responsible for resident care for follow-up. Resident showers will be monitored for completion by the DON and/or Unit Coordinator daily for compliance. The licensed nurse will monitor incontinence care compliance by routine rounding observations throughout shift. Newly hired facility and agency licensed nurses, CNAs and Unit Coordinators will receive education during orientation and prior to working. Effective 3/24/2022 the Director of Nursing and/or designee will educate current facility and agency Certified Nursing Assistants, licensed nurses on providing incontinence care when identified or requested prior to taking meal tray into the room. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON and/or designee will monitor 5 dependent residents to ensure residents are receiving showers and incontinence care to meet needs. Monitoring will be completed via observational rounds and review of shower records in the EMR 3x	

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F 677	Continued From page 81 to duty until 7:50 AM and was never told by Nurse #10 that Resident #3 needed to be changed. NA #7 indicated that she had no idea Resident #3 "was in a mess" until she carried his breakfast tray into his room. Once she knew he needed to be changed she stated she did provide care to him and then set him up to eat his breakfast. NA #7 stated that she was the only NA on the front 200 unit on 02/02/22 and all of her residents only received incontinent care twice during her 8-hour shift "because that was all she could do." The Administrator and Interim Director of Nursing (DON) were interviewed on 02/07/22 at 3:40 PM. The DON stated that the facility had to increase their checks of the resident and look at the individual needs and establish what their needs were then we can ensure that their incontinence needs are met in a timelier fashion. The Administrator stated that no call light should be turned off without providing the need of the resident and that when a resident requested care it is the expectation that the care be provided as soon as possible. 2. Resident #9 was readmitted to the facility on 01/21/20 with diagnoses that included a cerebral vascular accident. Review of a care plan revised on 09/15/21 read in part; Resident #9 has an activity of daily living self-care deficit related to left side hemiplegia. The goal read; Resident #9 will improve current level of function in activities of daily living through the review period. The interventions included: requires extensive assistance of one staff member with toileting. Review of the annual Minimum Data Set (MDS)	F 677	weekly then weekly for 8 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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dated 01/12/22 revealed that Resident #9 was cognitively intact and had no behaviors or rejection of care during the assessment reference period. The MDS also indicated that Resident #9 was always incontinent of bowel and bladder and required extensive assistance with toileting.

A continuous observation and interview were conducted with Resident #9 on 02/02/22 from 10:23 AM to 10:45 AM. Resident #9 was observed to turn his call light on for assistance. He stated that he was wet and soiled since before breakfast but when he asked to be changed, they told him he would have to wait until after breakfast. Resident #9 stated that after the trays had been picked up around 9:00 AM he told Nurse Aide (NA) #7 that he needed to be changed and was told she would get to him as soon as she could. At 10:35 AM Nurse #16 entered Resident #9's room and was told that he needed incontinence care. At 10:45 AM NA #7 entered Resident #9's room to provide incontinence care. NA #7 was observed to assist Resident #9 to a standing position and removed the soiled brief that was soiled with feces and was very wet and heavy. Resident #9 was noted to have dried feces on his buttocks which required NA #7 scrub the area to ensure he was clean. Resident #9 stated to NA #7 that before the end of her shift at 3:00 PM he would like for her to put 2 briefs on him because it would be a while before he got changed again and did not want to ruin his clothes.

A follow up interview was conducted with NA #7 on 02/03/22 at 10:46 AM. NA #7 stated that on 02/02/22 she was late to work and did not report to duty until 7:50 AM. She stated that when she arrived at work Resident #9 requested to be

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changed and was told as soon as breakfast as over, care would be provided as requested. NA #7 stated that she was the only NA on the front 200 unit on 02/02/22 and had to pick up the breakfast trays and then began providing care to the residents and the first time she was able to get to Resident #9 was at 10:45 AM. She stated, "I was doing the best I could do." She added that Resident #9 frequently requested to have 2 briefs and he said it was because it would be a while before he got changed again and doesn't want to ruin his clothes. NA #7 stated that if Resident #9 asked to have 2 briefs on then she put 2 on him.

The Administrator and Interim Director of Nursing (DON) were interviewed on 02/07/22 at 3:40 PM. The DON stated that the facility had to increase their checks of the resident and look at the individual needs and establish what their needs were then we could ensure that their incontinence needs were met in a timelier fashion. The Administrator stated that when a resident requested care it is the expectation that the care be provided as soon as possible.

3. Resident #10 was readmitted to the facility on 03/01/05 with diagnoses that included sequelae of cerebrovascular accident, dementia, and others.

Review of a care plan revised on 08/01/21 read in part, Resident #10 had bowel and bladder incontinence related to dementia and impaired mobility. The goal read; Resident #10 will remain free from skin breakdown due to incontinence and brief use through the review date. The interventions included: check frequently and as required for incontinence. Wash, rinse, and dry perineum. Change clothing as needed after

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incontinence episodes.

Review of the quarterly Minimum Data Set (MDS) dated 01/09/22 revealed that Resident #10 was cognitively intact and required limited assistance with toileting. The MDS further revealed that Resident #10 was occasionally incontinent of bowel and bladder and had no behaviors or rejection of care during the assessment reference period.

A continuous observation and interview were conducted with Resident #10 on 02/02/22 at 7:06 AM to 8:15 AM. At 7:06 AM it was noted that Resident #10's call light was on. Nurse #11 was observed going in and out of room just past Resident #10's room. At 7:26 AM Resident #10 stated that she needed to be changed, she stated she could not see the clock on the wall because it was dark to know what time she turned the call light on. She stated she had been asleep and woke up and could tell that she was wet and turned the call light on. At 7:29 AM Nurse #10 entered Resident #10's room and turned the call light off and exited the room and continued down the hallway. At 7:35 AM Resident #10 again stated she needed to be changed, "I guess I better turn my light back on" and she did. At 8:15 AM Nurse #11 was observed to enter Resident #10's room and change her brief. The brief was heavily soiled with urine and when thrown into the trash can made a loud thud noise.

Nurse #11 was interviewed on 02/02/22 at 8:25 AM. Nurse #11 confirmed that he had provided incontinent care to Resident #10 because her light was on but stated he had no idea how long it had been on. Nurse #11 stated that he was working as a Nurse Aide that night because they

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had some agency staff that did not show up and that left them in a bind. He added that during the night and into the morning they were not able to do every 2-hour incontinence checks but "we do the best we can."

Nurse #10 was interviewed on 02/02/22 at 5:45 PM. Nurse #10 confirmed that she had turned off Resident #10's call light earlier that morning but stated she had let the NA know that she needed care. Nurse #10 could not recall which NA she reported too but stated she let the direct care staff on the hall know that Resident #10 was requesting care.

The Administrator and Interim Director of Nursing (DON) were interviewed on 02/07/22 at 3:40 PM. The DON stated that the facility had to increase their checks of the resident and look at the individual needs and establish what their needs were then we can ensure that their incontinence needs are met in a timelier fashion. The Administrator stated that no call light should be turned off without providing the need of the resident and that when a resident requested care it is the expectation that the care be provided as soon as possible.

4. Resident #11 was admitted to the facility on 08/21/20 and recently readmitted on 01/16/22 with diagnoses that included acute/chronic respiratory failure, anemia, chronic pain syndrome and others.

Review of a care plan revised on 06/29/21 read in part; Resident #11 has an activity of daily living self-care deficit related to chronic obstructive pulmonary disease and others. The goal read; Resident #11 will maintain current level of

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function in activities of daily living through the review date. The interventions included: Resident #11 requires extensive assistance of 2 staff members for toilet use.

Review of a Medicare 5-day Minimum Data Set (MDS) dated 02/02/22 indicated that Resident #11 was cognitively intact and required extensive assistance with toileting. The MDS further revealed that Resident #11 was always incontinent of bowel and bladder and no behaviors or rejection of care was noted during the assessment reference period.

Review of a nurses note dated 02/04/22 at 5:06 AM read in part, resident is alert and in bed sleeping. Police were called this shift due to resident stating that she was waiting extended hours to be changed. Reassured resident that she would find her Nurse Aide (NA) so she could get changed. The note was signed by Nurse #18.

Resident #11 was interviewed on 02/04/22 at 9:33 AM. Resident #11 stated that last night (02/03/22) she turned her call light on at 7:30 PM (time on cell phone) and then she called her family and talked to them for a while. While on the phone with her family Resident #11 stated her call light stayed on and no one from the facility came in to assist her. She stated that she was wet at 7:30 PM when she turned her call light on and while on the phone with her family at 10:30 PM her call light was still on, and she remained wet. The family member told Resident #11 that she was going to call the facility and see if she could get some help for her, and she did but got no answer. Resident #11 stated that she and her family member continued to talk for a bit longer and the family member again called the facility and again

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got no answer. The family member decided she was going to call the local police department for a wellness check. Resident #11 stated that she hung up with her family member a little before 11:00 PM so the family member could call the police. Resident #11 stated that shortly after 11:00 PM the staff came in and explained that they were assigned to the other side of the building and apparently the staff for the side of the building where Resident #11 resided had not shown up for work. They apologized that no one had been in to assist Resident #11 and stated that they were there to assist her. Resident #11 stated that when the staff changed her, she was soaking wet all the way to the pad on the bed and while the staff members were in the room assisting her the police showed up but did not stick around.

Nurse #8 was interviewed on 02/04/22 at 10:34 AM. Nurse #8 stated that she had worked the night shift on 02/03/22. She stated she was working at the facility when the police showed up to check on Resident #11. Nurse #8 stated that Nurse #18 was assigned to Resident #11 and indicated that her family had called the police because Resident #11 had been trying to get some help for 3.5 hours.

Attempts to speak to Nurse #18 were unsuccessful.

NA #3 was interviewed on 02/04/22 at 11:11 AM. NA #3 confirmed that she had worked the night shift at the facility on 02/03/22. She was not sure who was assigned to take care of Resident #11 but stated that around 12:30 AM she and NA #1 were asked to go and check on the other side of the building because there was staff that had not

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shown up. NA #3 stated that when they went to the unit where Resident #11 resided her call light was on and so were others that "had probably been on awhile." She stated that Resident #11 needed to be changed and stated she had been waiting on someone to help her for several hours. NA #3 stated that Resident #11 did at times exaggerated things but stated she honestly had no idea how long Resident #11 had been waiting on assistance. She stated that Resident #11 was very wet and had a small amount of feces in her brief. NA #3 confirmed that her brief was very wet and heavy and as was her pad. NA #3 stated that while they were assisting Resident #11 the police showed up but by the time, they had completed care with Resident #11 the police were gone, and she went on to answer the other lights that were on and assist those residents before returning to her assigned locations.

Attempts to speak to NA #1 were made on 02/04/22 were unsuccessful.

Resident #11's family member was interviewed on 02/04/22 at 12:00 PM. The family stated that the previous night she had been on the phone with Resident #11 and was told that she had turned her call light on around 7:30 PM and at 11:00 PM no one from the facility had been in to assist her. After being on the phone for an hour the family stated they called the facility twice and got no answer, so the family member hung up with Resident #11 and called the police for a wellness check. The family member stated that the police offer called her back and asked for Resident #11's room number but stated she had not heard anything else from them.

Nurse #19 was interviewed on 02/04/22 at 3:15

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PM. Nurse #19 confirmed that she worked the night shift on 02/03/22 and they thought they had 5 NAs but in fact they did not. Nurse #19 explained around 10:00 PM we discovered that a couple of the staff members that were on the schedule had not shown up for their shift so those assignments had gone uncovered since the shift change at 7:00 PM. Nurse #19 stated when they discovered that the staff had not shown up for work they attempted to call the management staff and got no response so they did the best they could.

The Administrator and Interim Director of Nursing (DON) were interviewed on 02/07/22 at 3:40 PM. The DON stated that the facility had to increase their checks of the resident and look at the individual needs and establish what their needs were then we could ensure that their incontinence needs were met in a timelier fashion. The Administrator stated that when a resident requested care it is the expectation that the care be provided as soon as possible.

5. Resident #2 was admitted to the facility on 02/02/21 with diagnoses that included diabetes mellitus.

A review of Resident #2's care plan dated 03/30/21 revealed the Resident had a self-care deficit performance related to paraplegia. The goal for Resident #2 to improve in his current level of function activities of daily living would be attained by providing sponge bath when full bath or shower cannot be tolerated.

A review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated 11/24/21 revealed

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he was cognitively intact and required extensive assistance of one person for personal hygiene and bathing. The MDS also indicated the Resident was incontinent of bowel and had no behaviors of rejection of care.

A review of Resident #2's (activities of daily living) ADL record for January 1 through February 2, 2022 revealed the Resident was scheduled to receive showers on Monday and Thursday evenings. There were no showers documented for Resident #2 on his assigned shower days or any day during that timeframe.

An observation and interview were conducted with Resident #2 on 02/02/22 at 3:10 PM. The Resident explained that he was supposed to get his showers on Monday and Thursday evenings, but he had not had a shower since October 2021. The Resident continued to explain that when he would inquire about his shower, he was told that there was not enough help to give him his showers and the best they could do was to sponge him off. The Resident stated he could wash himself off at the sink, but it was not like having a complete shower. The Resident's hair was noted to be dry and stiff.

On 02/05/22 at 1:00 PM an interview was conducted with Nurse Aide (NA) #12 who worked with Resident #2 on Thursday 01/13/22, Monday 01/17/22, Thursday 01/20/22 and Monday 01/24/22. The NA explained that before the vaccine mandates the facility was short staffed and now, they are even shorter. The NA stated that he has never given the Resident a shower.

On 02/08/22 at 8:00 AM an interview was conducted with Nurse Aide (NA) #3 who worked

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with Resident #2 on Monday 01/10/22 evening shift. The NA explained that she could not remember the last time she gave Resident #2 a shower. She continued to explain that they were not always able to complete all the showers scheduled for the evening shift because they do not have enough help to complete the tasks.

On 02/08/22 at 9:55 AM Nurse Aide (NA) #13 acknowledged that she worked with Resident #2 on Thursday 01/27/22. The NA stated she has never given Resident #2 a shower.

On 02/08/22 at 10:20 AM Nurse Aide (NA) #14 confirmed she worked with Resident #2 on Monday 01/31/22 and explained that the facility was short staffed, and she had to do the she could do because of being short staffed. The NA stated she could not remember the last time she showered Resident #2 but that it had been a while.

Nurse Aide #11 worked with Resident #2 on Monday 01/03/22 evening shift but no longer worked at the facility and unable to be interviewed.

The Surveyor was unable to identify which nurse aide worked with Resident #2 on Thursday 01/06/22 evening shift.

During an interview with the Administrator and Interim Director of Nursing (DON) on 02/07/22 at 3:40 PM they both remarked that they were not aware that the residents' scheduled showers were not being given. The DON explained that the facility would reevaluate the staffing needs and adjust the amount of staff needed to provide the needs of the residents. The Administrator and

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DON stated it was unacceptable for a resident to go months without a shower.

6. Resident #5 was admitted to the facility on 04/14/16 with diagnoses that included hypertension.

A review of Resident #5's care plan dated 06/30/21 revealed he had a self care performance deficit related to hemiplegia and limited mobility. The goal that he would maintain current level of care would be attained by utilizing interventions of extensive assistance of one for bed mobility and extensive assist of two persons for toileting and personal hygiene. A care plan dated 08/10/21 revealed he was incontinent of bladder and bowel due to decreased sensation. The goal that he would remain free of skin breakdown related to incontinence and brief use would be attained by utilizing interventions that included place call light within reach, provide incontinent care after each episode of incontinence and as needed and apply briefs for incontinence.

The recent quarterly Minimum Data Set (MDS) assessment dated 10/24/21 revealed Resident #5 was cognitively intact and required extensive assistance of one person for bed mobility and extensive assist of two persons for toileting and personal hygiene. The MDS also indicated the Resident was incontinent of bladder and bowel and had no behaviors of rejection of care.

During an interview and observation with Resident #5 on 02/03/22 at 12:15 PM the Resident explained that he was soiled with bowel movement and urine and needed to be changed. The Resident continued to explain that he was

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supposed to be checked and changed every two hours and the last time he was changed was early morning before third shift left for the day. The Resident had an odor of urine incontinence.

On 02/04/22 at 12:18 PM the Surveyor located Nurse Aide #9 who was assigned to Resident #5 that shift and reported the Resident's request to be changed. The NA changed the Resident's briefs which were soiled with bowel movement and urine and provided incontinent care.

During an interview with Nurse Aide #9 on 02/04/22 at 12:45 AM the NA confirmed that she was assigned to Resident #5 that day and that the Resident needed to be checked and changed every two hours because he was incontinent of bladder and bowel. The NA verified that she had not checked or changed Resident #5 that shift and explained that it was an unrealistic expectation for the aides to check and change the incontinent residents every two hours and provide the other daily tasks because there was not enough staff to provide the care. The NA stated she was working as fast as she could to provide the amount of care the residents needed.

7. Resident #7 was admitted to the facility on 07/28/17 with diagnoses that included diabetes mellitus and heart failure.

The care plan dated 03/31/21 revealed Resident #7 had a self care performance deficit related to his diagnoses and decreased range of motion. The goal to maintain current activities of living function would be attained by requiring extensive assistance of one staff for bathing/showering twice a week and as needed.

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The annual Minimum Data Set (MDS) assessment dated 01/09/22 revealed Resident #7 was cognitively intact and had no behaviors of rejection of care. The MDS indicated he required limited assistance to transfer for bathing and was occasionally incontinent of bladder and bowel.

A review of Resident #7's ADL record revealed the Resident was scheduled to receive his showers on Monday and Thursday evenings. The ADL record for January 2022 revealed there were no showers documented for Resident #7 on his scheduled shower days or any day in January 2022.

During an observation and interview with Resident #7 on 02/03/22 at 2:50 PM the Resident explained that he had not received a shower since November 2021. The Resident continued to explain that he was supposed to get his showers on Monday and Thursday evenings but when he asked about his showers the staff would respond with "they forgot". The Resident had an odor about his body.

An interview was conducted on 02/05/22 at 10:40 AM with Nurse Aide (NA) #15 who was scheduled to work with Resident #7 on Thursday 01/20/22. The NA stated she has never worked with Resident #7 therefore she has never given him a shower.

An interview was conducted with Nurse Aide (NA) #16 on 02/05/22 at 12:20 PM. The NA was informed that she was scheduled to work with Resident #7 on Monday 01/24/22 second shift. The NA explained that she had never given Resident #7 a shower but that a shower team would be scheduled to give showers when there

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was enough staff to schedule for showers.

An interview was conducted with Nurse Aide (NA) #12 on 02/05/22 at 1:00 PM. The NA confirmed he worked with Resident #7 on Monday 01/03/22, Thursday 01/13/22 and Thursday 01/27/22 second shift and explained that he has never given Resident #7 a shower and did not know if the Resident was even scheduled for a shower on second shift.

An interview was conducted with Nurse Aide (NA) #4 on 02/07/22 at 3:25 PM. The NA confirmed that he worked with Resident #7 on Thursday 01/06/22 second shift and explained that she has never given Resident #7 a shower because they usually have people scheduled to give showers. The NA continued to explain that when there was not enough staff scheduled to give showers then they do not give them showers because it was all they could do to provide the routine care for the residents.

An interview was conducted with Nurse Aide (NA) #3 on 02/08/22 at 8:15 AM the NA confirmed she was scheduled to work with Resident #7 on Monday 01/10/22 and explained that they do not give showers on second shift unless they have enough staff scheduled to give showers.

On 02/08/22 at 10:20 AM an interview was conducted with Nurse Aide (NA) #14 who was scheduled to work with Resident #7 on Monday 01/31/22 second shift. The NA explained that she could only remember giving the Resident a shower one time and could not recall when it was.

The Surveyor was unable to identify the nurse aide who worked with Resident #7 on 01/17/22.

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During an interview with the Administrator and Interim Director of Nursing (DON) on 02/07/22 at 3:40 PM they both remarked that they were not aware that the residents' scheduled showers were not being given. The DON explained that the facility would reevaluate the staffing needs and adjust the amount of staff needed to provide the needs of the residents. The Administrator and DON stated it was unacceptable for a resident to go months without a shower.

8. Resident #12 was admitted to the facility on 09/12/21 with diagnoses that included diabetes mellitus and chronic obstructive pulmonary disease.

The quarterly Minimum Data Set (MDS) assessment dated revealed he was cognitively intact and had no behaviors of rejection of care. The MDS also indicated he required physical help in part of bathing activity and occasionally incontinent of urine and frequently incontinent of bowel.

A review of Resident #12's ADL record revealed the Resident was scheduled to receive a shower on Thursday and Saturday first shift. Review of Resident #12's ADL record for January 20222 revealed there were no showers documented for Resident #12.

During an observation and interview with Resident #12 on 02/03/22 at 11:00 AM the Resident explained that his showers were scheduled for day shift on Thursday and Saturday and he had not received a shower in over a month. The Resident's hair was stiff and dry.

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An interview was conducted on 02/03/22 at 11:20 AM with Nurse Aide (NA) #9 who was scheduled to work with Resident #12 on Thursday 01/27/22 first shift. The NA explained that when they have enough staff scheduled for the shift, they will assign someone to give the showers. The NA continued to explain that if they did not have anyone scheduled to give showers that it was impossible for the hall staff to provide care to the residents and give showers as well and for that reason the scheduled showers could not be given.

On 02/07/22 at 12:10 PM an interview was conducted with Nurse Aide (NA) #17 who confirmed that he worked with Resident #12 on Saturday 01/08/22. The NA explained that he has never showered Resident #12 and that there was usually a shower team scheduled to give the showers.

The Surveyor was unable to identify the nurse aide who worked with Resident #12 on Saturday 01/01/22, Thursday 01/06/22, Saturday 01/15/22 and Saturday 01/29/22 first shift.

Attempts were made to interview Nurse Aide #7 who was scheduled to give showers on Thursday 01/13/22 and Thursday 01/20/22 and Nurse Aide #18 who was scheduled to give showers on Saturday 01/22/22 first shift but the attempts were unsuccessful.

During an interview with the Administrator and Interim Director of Nursing (DON) on 02/07/22 at 3:40 PM they both remarked that they were not aware that the residents' scheduled showers were not being given. The DON explained that the facility would reevaluate the staffing needs

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F 677	Continued From page 98 and adjust the amount of staff needed to provide the needs of the residents. The Administrator and DON stated it was unacceptable for a resident to go months without a shower.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to follow physician orders for treatment to a venous stasis ulcer (Resident #7), failed to follow physician order for treatment to a diabetic foot ulcer (Resident #18), and failed to follow physician order for treatment of surgical wounds (Resident #6) for 3 of 5 residents reviewed. 1. Resident #7 was admitted to the facility on 07/28/17 with diagnoses that included heart failure. The recent quarterly Minimum Data Set (MDS) assessment dated 10/10/21 revealed Resident #7 was cognitively intact and had no behaviors of rejection of care. The MDS also indicated Resident #7 had no venous ulcers. A review of Resident #7's Physician orders	F 684	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Treatment for resident #7 venous statis ulcer was provided on 3/3/2022 and will continue to be provided as ordered by the physician. Treatment for resident #18 diabetic foot ulcer was provided on 3/5/2022 and will continue to be provided as ordered by the physician. The facility failed to follow physician order for treatment of surgical wounds for resident #6. Resident discharged on 2/8/2022.	3/25/22

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F 684	Continued From page 99 revealed an order dated 01/11/22 to cleanse the right lower leg venous ulcer with wound cleanser, apply Xeroform gauze, wrap with Kerlix then cover with coban once a day on the day shift. A review of Resident #7's Treatment Administration Record (TAR) for February 2022 revealed the treatment had not been signed out for on 02/02/22 and 02/03/22. A review of the staffing assignment for 02/02/22 day shift revealed Medication Aide #2 was assigned to Resident #7. An observation and interview were conducted with Resident #7 on 02/03/22 at 2:55 PM. The Resident explained that he was supposed to have the dressing changed on his right lower leg every day and the last time the dressing was changed was Tuesday (02/01/22). An observation of the dressing on the Resident's right lower leg revealed the dressing was intact with a coban wrap and was undated. During an interview with Medication Aide (MA) #2 on 02/03/22 at 4:05 PM the MA explained that she could not do any of the residents' treatments so the treatment nurse would have been responsible for doing the treatments if they had a treatment nurse scheduled that day. The MA continued to explain that if there was not a treatment nurse scheduled then the nurse working the hall next to her which was Nurse #20 would have been responsible for doing the treatments. On 02/04/22 at 10:20 AM an interview was conducted with Nurse #20 who explained that she did not do the dressing change for Resident #7	F 684	How the facility will identify other residents having the potential to be affected by the same deficient practice: Effective 3/14/2022, Director of Nursing and/or designee reviewed current residents receiving treatments to ensure treatments are done according to physicians' orders. No additional concerns were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 the Director of Nursing and/or designee will educate the current facility and agency Licensed Nurses on following physicians orders for residents with wound treatments and documenting completion on the Treatment Administration Record (TAR) as ordered. The licensed nurse will be responsible for completing wound treatments as ordered and documenting on the TAR. Licensed nurses that oversee Medication Aide will be alerted on the TAR. The facility will monitor for wound treatment completion per the TAR compliance report during morning clinical meetings. Newly hired facility and agency licensed nurses will receive education during orientation and prior to working. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON and/or designee will monitor	

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F 684	Continued From page 100 on 02/02/22 because she had informed the management team before that day that she would not accept the responsibility for doing a medication aide's treatments. The Nurse stated she did not remind management of that nor did she report it to the oncoming shift that the treatments were not done. An interview and observation were conducted with Resident #7 on 02/04/22 at 1:30 PM. The undated coban dressing on the Resident's right lower leg was intact. The Resident explained that the dressing had not been changed since Tuesday (02/01/22) and the dressing should be changed every day. A review of the staffing assignment for 02/03/22 revealed Nurse #2 was assigned to Resident #7. An interview was conducted with Nurse #2 on 02/04/22 at 2:40 PM who admitted that he did not perform the dressing change on Resident #7 on 02/03/22 because things were chaotic on the hall and he was busy doing other things and time got away from him. The Nurse stated he should have passed along in report to the night shift to do the treatment, but he forgot to. During an interview with the Administrator and Interim Director of Nursing (DON) on 02/07/22 at 3:40 PM they explained that they were aware that the Wound Management system in the facility needed some attention and the facility currently did not have a designated Wound Care Nurse (WCN) but that it was a priority on their list to hire a full time WCN that will be responsible for the Wound Management process. 2. Resident #18 was admitted to the facility on	F 684	residents with treatment orders to ensure treatments completed and documented as ordered 3 x weekly x 4 weeks, then weekly for 8 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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09/22/21 with diagnoses that included diabetes mellitus.

The recent quarterly Minimum Data Set (MDS) assessment dated 12/22/21 revealed Resident #18 was cognitively intact and had no behaviors of rejection of care. The MDS also indicated Resident #18 had a diabetic foot ulcer.

A review of Resident #18's Physician orders dated 01/23/22 revealed an order to cleanse the left heel with wound cleanser, gently pat dry and apply betadine and double silver alginate then cover with ABD pad and wrap with kerlix daily on every day shift.

A review of Resident #18's Treatment Administration Record (TAR) for February 2022 revealed the treatment had not been signed out for on 02/02/22.

A review of the staffing assignment for 02/02/22 day shift revealed Medication Aide #2 was assigned to Resident #18.

During an interview and observation made of Resident #18 on 02/03/22 at 2:30 PM the Resident explained that some days the dressing did not get changed on his left heel as it was ordered to be changed which was every day. The Resident continued to explain that the Wound Physician assessed his wound that morning and the dressing was applied after the assessment.

During an interview with Medication Aide (MA) #2 on 02/03/22 at 4:05 PM the MA explained that she could not do any of the residents' treatments so the treatment nurse would have been responsible for doing the treatments if they had a

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treatment nurse scheduled that day. The MA continued to explain that if there was not a treatment nurse scheduled then the nurse working the hall next to her which was Nurse #20 would have been responsible for doing the treatments.

On 02/04/22 at 10:20 AM an interview was conducted with Nurse #20 who explained that she did not do the dressing change for Resident #18 on 02/02/22 because she had informed the management team before that day that she would not accept the responsibility for doing a medication aide's treatments. The Nurse stated she did not remind management of that nor did she report it to the oncoming shift that the treatments were not done.

During an interview with the Administrator and Interim Director of Nursing (DON) on 02/07/22 at 3:40 PM they explained that they were aware that the Wound Management system in the facility needed some attention and the facility currently did not have a designated Wound Care Nurse (WCN) but that it was a priority on their list to hire a full time WCN that will be responsible for the Wound Management process.

3. Resident #6 was admitted to the facility on 01/05/22 with diagnoses that included fracture of shaft of tibia and fibula, fracture of left acetabulum, non-displaced fracture of second metatarsal bone, and others.

Review of the admission Minimum Data Set (MDS) dated 01/13/22 revealed that Resident #6 was cognitively intact and required limited assistance with activities of daily living. The MDS further revealed that Resident #6 had a surgical

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wound.

Review of a physician order dated 01/22/22 revealed the following:

Cleanse surgical site left lateral calf with wound cleaner, apply skin prep and cover with dry dressing daily.

Cleanse surgical wound to left knee with wound cleaner, apply skin prep and cover with dry dressing daily.

Cleanse surgical wound to right knee with wound cleaner, apply skin prep and cover with dry dressing daily.

Cleanse surgical wound to left calf with wound cleaner, apply skin prep and cover with dry dressing daily.

Cleanse surgical wound to left hip with wound cleaner and apply skin prep and cover with dry dressing daily.

Review of the treatment record dated 01/01/22 through 01/31/22 revealed no treatment orders for surgical wound care.

Review of the treatment record dated 02/01/22 through 02/28/22 revealed no treatment order for surgical wound care.

An observation and interview were conducted with Resident #6 on 02/02/22 at 11:49 AM. Resident #6 stated that he was hit by a motor vehicle while riding his scooter and had multiple fractures and surgical sites from his stay in the hospital. He stated that his doctor had prescribed

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daily dressing to all of his surgical incisions and the staff did not complete them. He stated he had dressings on them when he came to the facility but had not had any in place since then. He stated he would wash the sutures and incision when he bathed but no dressings had been applied as ordered by his doctor. The incisions were observed to be dry and scaly some had sutures, some had staples. The staples to the left lower leg were dry and scabbed and the skin had begun to grow over the staples. None of the surgical incisions had dressing on them and none of the incisions had any redness or signs of infection.

Review of a orthopedic follow up note dated 02/04/22 indicated that Resident #6 had been evaluated following surgery and the plan of care was discussed and shared with Resident #6.

Resident #6 was discharged home on 02/08/22.

Nurse #17 was interviewed on 02/02/22 at 2:22 PM. Nurse #17 stated she cared for Resident #6 frequently and stated he had no daily wound care. Nurse #17 was noted to pull up the electronic treatment record and again confirm that Resident #6 had no surgical wound care orders.

Nurse #10 was interviewed on 02/07/22 at 1:01 PM. Nurse #10 confirmed that she was one of the Unit Managers in the building. She stated that she was familiar with Resident #6 and of his multiple incisions with sutures and/or staples in place. Nurse #10 stated that he was not able to get those incisions wet but she was not aware of any orders to the surgical incisions. She added he had followed up with doctor but was not able to recall any additional orders received.

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F 684	Continued From page 105 The interim Director of Nursing (DON) was interviewed on 02/07/22 at 3:40 PM. The DON stated that each hall nurse was responsible for wound care because the facility did not have a wound nurse. She explained that the facility had not had wound care nurse for a couple of months, and they continued to try and hire a full-time wound care nurse. She explained that if Resident #6's orders were entered into the electronic medical record they should have gone to the treatment record for completion by the hall nurse. She was unable to explain how the order was entered but did not appear on the treatment record. The DON stated that she expected all wound care to be completed as ordered.	F 684		
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff, Resident, Wound Physician and Physician interviews the facility failed to provide the	F 686	How corrective action will be accomplished for those residents found to have been affected by the deficient	3/25/22

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necessary goods and services to maintain skin integrity for a resident with a history of skin breakdown. Resident #2 called for staff assistance after smelling a foul odor and was observed with a stage IV pressure ulcer (the pressure ulcer will become very deep and as the ulcer deepens, muscle or bone may be visible, making infection a strong possibility if not cared for) on his right buttock. The facility also failed to provide pressure ulcer treatments for 2 of 3 residents (Resident #2 and Resident # 18) reviewed for pressure ulcers.

Immediate Jeopardy began on 01/27/22 when the facility identified a stage IV pressure ulcer on Resident #2. The immediate jeopardy was removed on 02/08/22 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) due to examples 1.b. and 2 and to ensure monitoring systems put into place are effective related to pressure ulcers.

The finding included:

1a. Resident #2 was admitted to the facility on 02/02/21 with diagnoses that included diabetes mellitus, acute transverse myelitis in demyelinating disease of the central nervous system and paraplegia. The Resident had a history of a pressure ulcer on the left gluteal fold that was healed 06/17/21.

A review of Resident #2's Braden Assessment dated 11/23/21 revealed a score of 15.0. The score indicated Resident #2 was at a high risk of

practice;

The facility failed to prevent and identify a pressure ulcer Resident #2 who was at risk for pressure ulcers.

On 2/3/22, the Wound Physician evaluated Resident #2 right buttock pressure ulcer. Wound staged as a Stage 4 wound with heavy serous exudate and 100% necrotic. Scalpel debridement was completed on the wound and new orders implemented. Resident #2 will continue to receive wound care to heal and prevent further skin breakdown. Care plan updated by MDS Coordinator.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Because all residents are at risk for pressure ulcers when skin changes are not reported and interventions implemented to prevent breakdown, the following plan has been devised:

Effective 2/7/22, the licensed nurses and charge nurses completed head-to-toe skin assessments on 100% current facility residents to identify residents with skin breakdown. Residents identified with changes in skin condition were reported to the physician and/or nurse practitioner by the licensed nurse and follow-up orders obtained as appropriate. The Minimum Data Set (MDS) nurse updated resident care plans to reflect skin changes for actual or potential pressure wounds and

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F 686	Continued From page 107 pressure ulcer development. The quarterly Minimum Data Set (MDS) assessment dated 11/24/21 revealed Resident #2 was cognitively intact and had no behaviors of rejection of care. The MDS indicated the Resident required supervision for bed mobility and one assist for transfers. The Resident had a suprapubic catheter and was always incontinent of bowel. The MDS also indicated that Resident #2 did not have a pressure ulcer. A review of Resident #2's medical record revealed his weekly skin assessments were scheduled for Saturdays. A review of Resident #2's weekly skin assessment dated 01/15/22 and conducted by Nurse #13 revealed no skin breakdown noted on the assessment. Several attempts were made to interview Nurse #13 who performed the skin assessment on Resident #2 on 01/15/22 but the attempts were unsuccessful. A review of Resident #2's weekly skin assessment dated 01/22/22 and conducted by Nurse #4 revealed no skin breakdown noted on the assessment. An interview was conducted with Nurse #4 on 02/10/22 at 12:00 PM. The Nurse explained she remembered doing the weekly skin assessment on 01/22/22 and knew that the Resident did not have any skin breakdown when she did the assessment. An interview was conducted with Nurse Aide (NA)	F 686	preventative interventions in place. All residents will continue to have skin assessed by the licensed nurse upon admission, weekly and with changes in skin condition and changes reported to physician with new wound treatments provided as ordered. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/24/22, the Director of Nurses and Charge Nurses educated facility and agency Licensed Nurses and Nurse Aides on the facility wound management policies. The licensed nurse will assess resident skin condition upon admission, weekly and with changes to identify changes in skin condition. The nurse aide will report skin concerns to the licensed nurse as identified during showers and routine activities of daily living care. Skin concerns will be reported by the licensed nurse for follow up assessment and reported to the physician upon finding and treatment orders will be completed with care plan updated accordingly. Newly hired facility and agency Licensed nurses and Nurse Aide staff will be educated during orientation and prior to working Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 3/24/22, 5 residents will be audits for appropriate care and treatment	

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F 686	Continued From page 108 #5 on 02/08/22 at 11:15 AM. The NA was assigned to work with Resident #2 on 01/24/22 third shift. The NA explained that Resident #2 was alert and oriented and could voice his needs. The NA stated the Resident was incontinent of bowel but because of the decreased sensation in his lower body that he did not always know when he had a bowel movement, so the Resident had to be checked and changed routinely. The NA explained that she was not sure when she worked with Resident #2 prior to the pressure ulcer being discovered but that if she checked and changed his brief she would have looked at his skin and reported the pressure ulcer if it was there. An interview was conducted with Nurse Aide (NA) #12 on 02/05/22 at 1:00 PM. The NA was assigned to work with Resident #2 on 01/24/22 second shift and third shift and on 01/26/22 third shift. NA #12 explained that Resident #2 was alert and oriented and could voice his needs. He continued to explain that the Resident was incontinent of bowel and when he had a bowel movement, he could let the staff know. The NA stated he did not notice any skin breakdown on Resident #2 when he changed him and would have reported it to the nurse if he had. An interview was conducted with Nurse Aide (NA) #19 on 02/07/22 at 11:50 AM. The NA was assigned to work with Resident #2 on 01/25/22 first shift. The NA explained that she noticed the pressure ulcer on Resident #2 during a brief change and reported it the nurse but could not remember who the nurse was that she notified. During an interview with Nurse #2 on 02/07/22 at 9:50 AM the Nurse confirmed that he worked on	F 686	of skin. Scheduled licensed nurses skin assessments and nurse aide shower sheets will be monitored to ensure accuracy and completeness and to ensure that the physician is notified and treatment is provided as ordered. Monitoring will be completed by the DON or Charge Nurse three times weekly x 4 weeks then, weekly for 8 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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01/25/22 first shift prior to when the pressure ulcer was discovered on Resident #2 on 01/27/22. The Nurse explained that he was not made aware of a pressure ulcer on Resident #2's right buttock.

An interview was conducted with Nurse Aide (NA) #16 on 02/05/22 at 12:20 PM. The NA was assigned to work with Resident #2 on 01/25/22 second shift. The NA explained that Resident #2 was alert and oriented and could voice his needs and would let you know when he had a bowel movement. The NA continued to explain that she did not remember the last time she changed his brief but if she had noticed any skin breakdown, she would have reported it to the nurse.

An interview was conducted with Nurse Aide (NA) #17 on 02/07/22 at 12:10 PM. The NA was assigned to work with Resident #2 on 01/26/22 first shift. The NA explained that Resident #2 was alert and oriented and could voice his needs. The NA continued to explain that the Resident was incontinent of bowel and you had to check and change him every two hours if needed. The NA stated Resident #2 did not have a pressure ulcer the last time he worked with him because if he had the NA would have reported it to the nurse.

An interview was conducted with Nurse Aide (NA) #15 on 02/05/22 at 10:40 AM. The NA was assigned to work with Resident #2 on 01/26/22 second shift. The NA explained that when she discovered skin issues with the residents, she reported the issues to the nurse on duty at the time.

During an observation and interview with Resident #2 on 02/02/22 at 3:10 PM the Resident

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was lying in bed wearing shorts and a brief. The Resident explained that he has had a pressure ulcer on his buttocks on and off for several years because he was paraplegic and did not have the normal sensation from his hips down. The Resident continued to explain that last Thursday (01/27/22) he was sitting in his wheelchair and started to smell a foul odor and when the Resident got back into bed, he realized it was a pressure ulcer that was draining. The Resident stated that Nurse Aide (NA) #9 helped him get cleaned up then got Nurse #12 to assess the pressure ulcer. Resident #2 explained that he was incontinent of bowel and did not have the normal sensation of a bowel movement which required him to be checked and or changed every two hours but the staff did not check on him every two hours unless he rang his call light and then it could take several hours for the staff to answer his call light. The Resident stated he has not had a shower since October 2021 and the staff did not give him a bed bath. The Resident also stated that the nurses did not perform a weekly skin assessment on him.

An interview was conducted with Nurse Aide (NA) #9 on 02/04/22 at 3:20 PM. The NA confirmed she worked with Resident #2 on 01/27/22 day shift and noticed the pressure ulcer on the Resident when she changed his brief and reported the pressure ulcer to Nurse #12. The NA continued to explain that Resident #2 did not have the normal sensation below his hips, so he needed to be checked and changed for bowel incontinence every two hours because he did not always know when he had a bowel movement. The NA stated that if she had noticed a pressure ulcer the last time she cared for Resident #2, she would have reported it to the Nurse.

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An interview was conducted with Nurse #12 on 02/04/22 at 12:50 PM. The Nurse confirmed he worked with Resident #2 on 01/27/22 and explained that the Resident called him into his room and told him that something was leaking on his backside and asked if the Nurse could look at it. The Nurse continued to explain that he could smell the pressure ulcer before he saw it and knew that after he assessed the stage IV pressure ulcer on his right buttock that the pressure ulcer should have been discovered and reported before the pressure ulcer developed to a stage IV. The Nurse explained that he cleansed the pressure ulcer and applied a gauze dressing and reported it to Nurse #20 who had made rounds with the Wound Physician that day.

A review of a Change in Condition assessment dated 01/27/22 at 4:42 PM and completed by Nurse #12 revealed changes in the area of Skin Status. The assessment indicated Resident #2 asked Nurse #12 to access his buttock due drainage coming from his right buttock. Nurse #12 observed a black patch with crusty irregular edges over the right upper buttock that measured approximately 10 x 4 centimeters (cm). The Nurse cleansed the wound with wound cleanser and applied a dry dressing then reported the pressure ulcer to the acting treatment nurse, Nurse #20, and notified the Resident's Responsible Party and the Provider.

An interview was conducted with Nurse #20 on 02/03/22 at 10:20 AM. The Nurse confirmed that she was notified of and observed the stage IV pressure ulcer on Resident #2's right buttock on 01/27/22 when Nurse #12 brought it to her attention. The Nurse explained that she had

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rounded with the Wound Physician (WP) that day but the WP had already left the facility when she was notified by Nurse #12 of Resident #2's pressure ulcer, so she notified the WP and obtained a treatment order for the pressure ulcer until the WP could consult with Resident #2 on 02/03/22.

A review of a Nursing Progress Note dated 01/27/22 6:54 PM and written by Nurse #20 revealed, Resident #2 reported a wound on his right buttocks. The Wound Physician was made aware and ordered Santyl ointment and Calcium Alginate dressing. Resident #2 tolerated the dressing change with no complaint of discomfort.

On 02/05/22 at 7:00 PM during an interview with Nurse #20 she explained that the reason why the treatment for Resident #2's pressure ulcer was not on the Treatment Administration Record for January 2022 was because she was still learning the system and it was possible that she did not input the order correctly.

The Surveyor was unable to interview Nurse #17 who was responsible for Resident #'2 pressure ulcer treatment on 01/29/22 to determine whether or not the treatment was performed on 01/29/22.

An interview was conducted with the Staff Development Coordinator (SDC) on 02/10/22 at 11:30 AM. The SDC explained that on 01/30/22 she was assigned to perform the treatments on the residents and when she got to Resident #2, she realized that there was not a treatment order in place for his stage IV pressure ulcer on his right buttock. The SDC continued to explain that she knew that there had already been communication with the Wound Physician (WP)

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and reviewed the Resident'2 progress notes and found on 01/27/22 there was an order given by the WP for Santyl, Calcium Alginate and an absorptive dressing so she initiated the treatment on the January 2022 Treatment Administration Record. The SDC stated there was a dressing in place on 01/30/22 when she initiated the treatment, but she could not remember if the dressing had a date on it.

A review of Resident #2's Physician orders revealed an order dated 01/30/22 to cleanse right buttock with wound cleanser, gently pat dry then apply Santyl ointment and Calcium Alginate dressing and cover with absorptive dressing every day shift and as needed.

A review of the Wound Physician consult dated 02/03/22 revealed Resident #2 presented with a stage IV pressure ulcer to the right buttock that measured 8.5 x 10.5 x 1.4 and heavy serous drainage and 100% necrotic. The pressure ulcer was debrided with a scalpel which the Resident tolerated well. The treatment plan was to cleanse right buttock pressure ulcer with wound cleanser, apply Santyl ointment and Dakin's wet to dry dressing and cover with foam dressing every day shift and as needed.

During an interview with the Wound Physician (WP) on 02/04/22 at 2:40 PM the WP explained that she had previously consulted with Resident #2 for a stage II pressure ulcer on the left gluteal fold which was resolved in June 2021. The WP continued to explain that Resident #2 had endured COVID and currently had an infection (UTI) which all those issues could cause a rapid decline in a resident's physical health that could cause a rapid onset of a stage IV pressure ulcer.

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But the WP continued to explain that after the consult with Resident #2 on 02/03/22 she did not feel like the Resident was going through a rapid medical decline. The WP explained that the facility called her on 01/27/22 and informed her of Resident #2's pressure ulcer and she made a note to make sure she consulted when she visited the facility on 02/03/22 and gave orders for the pressure ulcer based on the description given to her. The WP stated that given the decreased sensation that Resident #2 had below his hips that it was possible that a pressure ulcer could develop in a five to six day window but a pressure ulcer of that magnitude should have been noticed before it was on 01/27/22. The WP stated she changed the treatment order for the pressure ulcer and would continue to consult weekly with Resident #2.

A second interview was conducted with the Wound Physician (WP) on 02/07/22 at 9:15 AM. The WP explained that if the facility had been routinely checking and changing Resident #2 for incontinence, they would have noticed the pressure ulcer before it developed to a stage IV.

An interview was conducted with Resident #2's Physician on 02/05/22 at 8:00 PM. The Physician explained Resident #2 was at risk for pressure ulcer development due to several comorbidities including paraplegia and a history of a pressure ulcer of the buttocks and for that reason alone the facility should have been more vigilant to reoccurring pressure ulcers. The Physician stated that pressure ulcers can progress rapidly in a resident whose health was in a rapid state of medical decline but Resident #2's health was not in a rapid state of decline. The Physician continued to explain that when she was notified of

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Resident #2's stage IV pressure ulcer she notified the facility administration for an air mattress and the Registered Dietician to conduct a nutritional assessment to ensure the Resident received sufficient nutritional intake for wound healing. The Physician stated it was unfortunate that Resident #2 developed a pressure ulcer because when she saw the Resident's stage IV pressure ulcer she was extremely disappointed because she remembered when the Resident was admitted to the facility, they had a discussion about how susceptible he was for pressure ulcers and how they would try to prevent them. The Physician stated that in her opinion the pressure ulcer should have been identified through routine care and skin checks before the pressure ulcer developed to a stage IV. The Physician explained that worse case scenario was Resident #2 would set up infection, sepsis and death and osteomyelitis was still a possibility because of the severity of the pressure ulcer. The Physician stated unfortunately, the facility has not had the leadership of a Director of Nursing and no consistent oversight in the wound management department for months.

A second interview was conducted with Resident #2's Physician on 02/07/22 at 9:10 AM. The Physician stated the stage IV pressure ulcer found on the Resident's right buttock on 01/27/22 was avoidable.

On 02/04/22 at 11:30 AM an observation was made of Nurse #2 performing a pressure ulcer dressing change on Resident #2's right buttock. After positioning the Resident on his left side, the Nurse removed the old dressing and changed his gloves after washing his hands. Nurse #2 used a would cleanser to clean the Resident's pressure

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ulcer of bloody, foul odor then changed his gloves after washing his hands before he applied Santyl ointment and a Calcium Alginate dressing and covered the dressing with a large foam border dressing. The Resident stated the dressing change was not painful.

During an interview with the Administrator and Interim Director of Nursing (DON) on 02/07/22 at 3:40 PM they explained that they were aware that the Wound Management system in the facility needed some attention and the facility currently did not have a designated Wound Care Nurse (WCN) but that it was a priority on their list to hire a full time WCN that will be responsible for the Wound Management process.

On 02/07/22 at 11:00 AM the Administrator was notified of immediate jeopardy.

The facility provided an acceptable credible allegation of immediate jeopardy removal on 02/08/22.
Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to prevent and identify a pressure ulcer Resident #2 who was at risk for pressure ulcers.
Resident #2 admitted to the facility on 02/02/21 with acute transverse myelitis in demyelinating disease of the central nervous system (paraplegic), diabetes mellitus and Hx of pressure ulcer left gluteal fold resolved 06/2021. Resident #2 has weekly skin assessments scheduled on Saturdays. A skin assessment completed by Licensed Nurse on 1/15/22 and 1/22/22 revealed no skin issues. On 01/27/22, a necrotic

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unstageable 10 x 4 cm pressure ulcer on right buttock was discovered. The Wound Nurse assessed the right buttock wound for Resident #2 on 1/27/22 and called Wound Physician for orders. Treatment was initiated on 1/27/22. On 2/3/22, the Wound Physician evaluated Resident #2 right buttock pressure ulcer. Wound staged as a Stage 4 wound with heavy serous exudate and 100% necrotic. Scalpel debridement was completed on the wound.

Because all residents are at risk for pressure ulcers when skin changes are not reported and interventions implemented to prevent breakdown, the following plan has been devised:

Effective 2/7/22, the Licensed Nurses and Charge Nurses completed head-to-toe skin assessments on 100% current facility residents to identify residents with skin breakdown. Residents identified with changes in skin condition were reported to the Physician and/or Nurse Practitioner by the Licensed Nurse and follow-up orders obtained as appropriate. The Minimum Data Set (MDS) Nurse updated resident care plans to reflect skin changes for actual or potential pressure wounds and preventative interventions in place.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 2/7/2022, the Administrator, Interim Director of Nursing (DON), Regional Director of Operations, Director of Regulatory and Risk Management and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance

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Improvement) meeting to discuss root cause analysis. The QAPI committee reviewed the facility wound management policy for needed modifications. No revisions were needed. A root cause analysis was completed. Root cause analysis determined that facility failed to implement the facility wound management program to include completion of skin assessments to identify and address resident skin impairments 1) facility management did not provide necessary oversight related to the facility wound management program to identify non-compliance of wound care strategies (completion of skin assessments to identify, address resident skin impairments and implement wound prevention strategies) by the licensed nurses and nurse aides. A plan was formulated by the QAPI committee to address the identified issue to include a review of education, audit/monitoring needs, and QAPI committee responsibilities in reviewing for compliance.

On 2/7/22, the Director of Nurses and Charge Nurses completed education to current facility and agency Licensed Nurses and Nurse Aides on the facility wound management policies. Education included the following: a) the facility's wound care protocol and the expectation of each Licensed Nurse and Nurse Aide, b) the facility's protocol on skin assessments and role of Licensed Nurse, c) the facility's protocol on Nurse Aides inspecting skin during activities of daily living (ADL) care such as when performing incontinence care and bathing to identify and report any changes in resident skin condition to the Licensed Nurse Supervisor, d) interventions to reduce the risk of a pressure ulcer (turning/reposition, hydration, routine incontinence care, showers, and bed baths).

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Effective 2/7/22, the Licensed Nurse will review resident skin condition upon admission, weekly and with changes in condition. Nurse Aides will complete body audits during ADL care and will report skin concerns to the Licensed Nurse verbally, written and/or via an electronic point of care clinical alert. New skin concerns will be reported to the Physician and/or Nurse Practitioner upon findings by the Licensed Nurse for follow-up treatment. These expectations were communicated to Licensed Nurses and Nurses on 2/7/22. Licensed Nurses and Nurse Aides not receiving education on 2/7/22 will not be allowed to work until completed. The Director of Nursing will utilize a master employee list to track completion of education. This responsibility was communicated to the Director of Nursing by the Director of Regulatory and Risk on 2/7/22. Education will also be included during orientation for newly hired staff.

Effective 2/7/22, all scheduled Licensed Nurses skin assessments and Nurse Aide shower sheets will be audited to ensure accuracy and completeness and to ensure that preventative care and treatment is in place as ordered by the Physician. Monitoring will be completed by the DON or Charge Nurse five times weekly.

Effective 2/7/22, the Director of Nurses or Charge Nurses will complete follow-up skin assessments to confirm accuracy of the skin assessment completed by the Licensed Nurse for the week. These follow-up assessments will be completed on (5) five residents weekly.

Effective 2/7/22, the Administrator, Director of Nurses and Charge Nurses will complete incontinence care rounds to validate incontinence

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care has been completed routinely. These rounds will be completed three (3) times weekly (across all shifts including weekends).

Effective 2/7/2022, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged Date of IJ Removal: 2/8/22

The facility Administrator was the person responsible for the credible allegation implementation.

On 02/11/22 the facility's credible allegation was validated through record reviews, staff and resident interviews as well as sign in sheets for all nursing staff. The facility provided educational information regarding pressure ulcer prevention, identification, weekly skin assessments, reporting and treatment implementation of pressure ulcers for the Licensed Nurses and assessment of residents skin condition and changes during incontinent care, turning and repositioning, showers, bed baths and how to document the skin changes in the electronic health record and well as verbally reporting the changes to the nurse in charge for the Nurse Aides. The facility educated the Licensed Nurses to perform skin assessments on admission and weekly on skin assessment days and to report the findings to the Physician and/or Nurse Practitioner. The newly hired Director of Nursing and or designee will perform follow up skin assessments to confirm accuracy of the skin assessments performed by the Licensed Nurses and will conduct incontinent care rounds to ensure incontinent care rounds have been completed routinely. During a meeting

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with the Administrator and Director of Nursing on 02/11/22 at 4:38 PM they validated the credible allegation was implemented as written and ensured that ongoing auditing for compliance would be maintained.

The credible allegation for the removal of immediate jeopardy with a removal date of 02/08/22 was validated on 02/11/22.

1. b. A review of Resident #2's Physician orders dated 01/31/22 revealed cleanse the right buttock stage IV pressure ulcer with wound cleanser and gently pat dry, apply Santyl and Calcium Alginate dressing and cover with absorptive dressing every day shift, and as needed.

A review of Resident #2's Treatment Administration Record (TAR) for February 2022 revealed the treatment for his stage IV pressure ulcer was not signed off as being done on 02/02/22.

A review of the staffing assignment for 02/02/22 day shift revealed Medication Aide #2 was assigned to Resident #2.
During an interview with Resident #2 on 02/03/22 at 10:00 AM the Resident stated that the dressing on his pressure ulcer was not changed on 02/02/22.

During an interview with Medication Aide (MA) #2 on 02/03/22 at 4:05 PM the MA explained that she could not do any of the residents' treatments so the treatment nurse would have been responsible for doing he treatments if they had a treatment nurse scheduled that day. The MA continued to explain that if there was not a treatment nurse scheduled then the nurse

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working the hall next to her which was Nurse #20 would have been responsible for doing the treatments.

On 02/04/22 at 10:20 AM an interview was conducted with Nurse #20 who explained that she did not do the dressing change for Resident #2 on 02/02/22 because she had informed the management team before that day that she would not accept the responsibility for doing a medication aide's treatments. The Nurse stated she did not remind the management of that nor did she report it to the oncoming shift that the treatments were not done.

2. Resident #18 was admitted to the facility on 04/05/21 with diagnoses that included diabetes mellitus.

A review of Resident #18's care plan dated 05/22/21 revealed the Resident had a stage IV pressure ulcer on his sacrum that was present on admission. The goal for the pressure ulcer would show signs of healing and would not develop infection would be attained by utilizing interventions that included providing treatments as ordered by the physician.

The quarterly Minimum Data Set (MDS) assessment dated 12/22/21 revealed Resident #18 was cognitively intact and had no behaviors of rejection of care. The MDS indicated the Resident was independent with bed mobility and required extensive assistance of one staff for transfers. The Resident had a suprapubic catheter and was incontinent of bowel. The MDS also indicated Resident #18 had a stage IV pressure ulcer.

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A review of Resident #18's Physician orders dated 01/23/22 revealed, cleanse stage IV sacrum pressure ulcer with Dakin's solution, apply Collagen and pack with silver alginate rope, cover pressure ulcer with foam dressing every two days on day shift.

A review of Resident #18's Treatment Administration Record (TAR) for February 2022 revealed, the treatment was not signed off as completed for Wednesday 02/02/22.

A review of the staffing assignment for 02/02/22 day shift revealed Medication Aide #2 was assigned to Resident #18.
During an interview and observation made of Resident #18 on 02/03/22 at 2:30 PM the Resident was sitting up in his wheelchair and explained that the dressing on his sacrum was supposed to be changed every other day and was supposed to be changed yesterday (02/02/22) but the dressing was not changed yesterday. The Resident stated that it was not uncommon for his dressing to go days without being changed.

During an interview with Medication Aide (MA) #2 on 02/03/22 at 4:05 PM the MA explained that she could not do any of the residents' treatments so the treatment nurse would have been responsible for doing he treatments if they had a treatment nurse scheduled that day. The MA continued to explain that if there was not a treatment nurse scheduled then the nurse working the hall next to her which was Nurse #20 would have been responsible for doing the treatments.

On 02/04/22 at 10:20 AM an interview was conducted with Nurse #20 who explained that she

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F 686	Continued From page 124 did not do the dressing change for Resident #18 on 02/02/22 because she had informed the management team before that day that she would not accept the responsibility for doing a medication aide's treatments. The Nurse stated she did not remind the management of that nor did she report it to the oncoming shift that the treatments were not done. During an interview with the Administrator and Interim Director of Nursing (DON) on 02/07/22 at 3:40 PM they explained that they were aware that the Wound Management system in the facility needed some attention and the facility currently did not have a designated Wound Care Nurse (WCN) but that it was a priority on their list to hire a full time WCN that will be responsible for the Wound Management process.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview this facility failed to investigate a fall and failed to update a smoking resident's smoking assessment when the resident began to smoke to determine if the resident was safe to smoke independently (Resident#3) for 1 of 3 residents reviewed for accidents and failed to	F 689	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to complete an updated smoking assessment to determine if the	3/25/22

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secure a full oxygen tank that was left lying on a table in the facility chapel where residents and staff were noted to visit intermittently for 1 of 1 chapel observed.

The findings included:

1a. Resident #3 was readmitted to the facility on 12/07/20 with diagnoses that included bilateral amputation to lower extremity, heart disease, dementia, and others.

A care plan revised on 08/30/21 read in part, Resident #3 had an activity of daily living self-care performance deficit related to history of dementia and bilateral lower extremity amputations. The goal read; Resident #3 will maintain/improve current level of function in activities of daily living through the review period. The interventions included: Resident #3 required total assistance with mechanical lift and 2-person assistance to transfer.

The significant change Minimum Data Set (MDS) dated 12/15/21 indicated that Resident #3 was cognitively intact and required total assistance with transfers. The MDS also indicted that Resident #3 had 1 fall with no injury since the previous assessment.

Review of the facility's incident and accident log for December 2021 revealed no falls were reported for Resident #3 on 12/22/21.

Review of a Fall Care Area Assessment dated 02/01/22 read in part, Resident #3 was a double amputee and required assistance with transfers and had one fall noted during the review period.

resident was a safe smoker or needed supervision while smoking cigarettes for resident #3. Resident #3 smoking assessment was updated on 2/7/2022 to reflect residents ability to smoke safely.

The facility failed to investigate a fall resident #3. On 3/10/22, the licensed nurse completed an incident report and updated resident fall care plan.

The facility failed to secure a full oxygen tank that was left laying on a table in the facility chapel. Oxygen tank removed from chapel on 2/7/2022 and properly stored in designated oxygen storage room.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Effective 3/14/2022 the Director of Nursing (DON) and/or designee assessed current residents that smoke to ensure smoking assessments and care plans were updated and accurate.

Effective 3/14/22, the DON and/or designee reviewed residents will fall incidents between 2/7/22 and 3/7/22 to ensure appropriate investigation, incident report and care plan revisions were made. No additional concerns identified.

On 3/14/22, the DON completed an audit by rounding observations to ensure all portable oxygen tanks not currently in use were properly stored in designated oxygen room. No additional concerns identified.

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F 689	Continued From page 126 An observation and interview with Resident #3 were conducted on 02/02/22 at 8:32 AM. Resident #3 was resting in bed and was alert. He stated that he recalled falling from the bed on 12/22/21. He denied any injury from the fall and stated that when the staff finally came in to help, they used the lift to get him off the floor and up to my wheelchair. Nurse Aide (NA) #8 was interviewed on 02/02/22 at 3:39 PM. NA #8 confirmed that she was working on the COVID-19 unit on 12/22/21 when NA #7 came over and asked me and NA #9 to help get Resident #3 off the floor. NA #8 stated that when she entered Resident #3's room on 12/22/21 he was sitting on his buttock and denied any pain or injury. The floor had a puddle of liquid on it that had to be cleaned up before we could get Resident #3 off the floor. NA #8 stated that they "cleaned up the liquid that was on floor and then put the lift pad under Resident #3 then transferred him from the floor to his bed." Once Resident #3 was back in the bed NA #8 stated she and NA #9 returned to the COVID-19 unit to finish their shift. NA #9 was interviewed on 02/03/22 at 10:01 AM. NA #9 stated that on 12/22/21 she and NA #8 were working on the COVID-19 unit and were asked by NA #7 to help get Resident #3 off the floor, so we walked to over to help. NA #9 stated she could not recall what time it was but stated that Nurse #14, NA #7, NA #8, and herself were in the room and there was a liquid on the floor but could not tell if it was urine or water but stated that they had to clean that up before they could get Resident #3 off the floor. Resident #3 was sitting on his buttocks between the 2 beds in the room and stated he denied any pain or injury. NA	F 689	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022, Director of Nursing and/or designee educated current facility and agency licensed nurses on assessing residents for smoking status and completion of smoking assessment and care plan . The licensed nurse will complete smoking assessments upon admission, quarterly and with changes in resident smoking status. Effective 3/24/2022 Director of Nursing and/or designee educated current facility licensed nurses on investigating a fall and completing an incident report. The licensed nurse will complete an incident report following a resident fall and will update care plan. Effective 3/24/22, the DON and/or designee provided education to licensed nurses, certified nursing assistances and transporter on ensuring proper storage of portable oxygen tanks. Newly hired facility and agency licensed nurses will receive education during orientation and prior to working. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit 5 residents for accurate, completed	

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F 689	Continued From page 127 #9 stated that and once the liquid that was on the floor was cleaned up, they used the lift and transferred Resident #3 back to the bed and once he was back in the bed, they (NA #8 and NA #9) returned to the COVID-19 unit to finish their shift. NA #7 was interviewed on 02/03/22 at 10:46 AM. NA #7 confirmed that she had worked on 12/22/21 and was initially responsible for Resident #3. Shortly after arriving at work on 12/22/21 NA #7 stated that the former Director of Nursing (DON) called a meeting with all staff to report that several residents including Resident #3 had tested positive for COVID-19. Resident #3 had been quarantined to his room since he was in a room by himself. NA #7 stated that she had voiced some concerns with taking care of Resident #3 due to his current COVID-19 status and the DON stated that she would provide care to Resident #3 to ease the hesitation that NA #7 had. NA #7 stated that when breakfast trays arrived at the unit, Nurse #14 had taken Resident #3's breakfast tray into him and when he was done the tray was set outside of his door. Then when Nurse #14 entered Resident #3's room to deliver his lunch tray she found him on the floor. She further explained that the DON had been in the room around 10:30 AM - 11:00 AM and provided care to him and then when Nurse #14 entered the room around 12:30 PM she found Resident #3 on the floor. NA #7 stated that the floor in Resident #3's room was a mess with either urine or water and tissue and stated she reported the fall to the DON assuming she would get him off the floor. She stated that she quickly realized that the DON was not going to come and get Resident #3 off the floor and since she was on the hall by herself that day, she went and found NA #8 and NA #9 and asked them to come	F 689	smoking assessments and care plans and resident falls for proper investigation, incident report and care plan revision. Monitoring via observational rounding will be completed to ensure proper oxygen storage. Monitoring will be completed 3 times weekly for 4 weeks then, weekly for 8 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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and help get Resident #3 off the floor. NA #7 stated that Nurse #14 assessed Resident #3 and he had no injuries and denied any pain. After they cleaned the floor up NA #7, NA #8, and NA #9 were able to get Resident #3 off the floor and back to bed and NA #7 stated she warmed up his lunch and he was able to feed himself lunch after that.

Attempts to reach Nurse #14 were made on 02/02/22 and 02/03/22 without success.

The former DON was interviewed on 02/03/22 at 11:20 AM. The former DON stated on 12/22/21 she had met with the staff to alert them that the facility had some residents that had tested positive for COVID-19 including Resident #3. During the meeting the DON stated that NA #7 voiced some concerns in providing care to Resident #3 with his COVID-19 status so I told her that I would provide care to Resident #3 that day. The DON stated that she went into Resident #3's room early that morning and checked on him and emptied his urinal then around 10:30 AM she was made aware that he was on the floor. The DON could not recall who got Resident #3 off the floor but stated that Nurse #14 should have completed the incident report and documented the fall in the medical record. The DON stated she did not even think about it being a fall and stated retrospectively it was certainly a fall but at the time she did not think about it being a fall. Normally after a fall there was an incident report done and then the fall was discussed the following morning in the clinical meeting and the care plan updated at that time, the DON stated that did not happen with Resident #3's fall on 12/22/21 because she just never considered it a fall.

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The Administrator and current DON were interviewed on 02/07/22 at 3:40 PM. The DON stated that the fall should have been investigated and an incident report completed. The fall should have then been discussed in the facility's clinical stand-up meeting held the following morning. The Administrator stated she had spoken with the resident about the fall and indicated that Resident #3 told her about the fall as well and she expected the nursing staff to complete the required paperwork.

1b. Review of a facility policy titled: Resident Smoking implemented 11/01/20 read in part; All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive Minimum Data Set (MDS) assessment process. Resident who smokes will be further assessed using the Resident Safe Smoking Assessment, to see if resident is safe to smoke at all. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether any additional safety measures are indicated.

Resident #3 was readmitted to the facility on 12/07/20 with diagnoses that included bilateral amputation to lower extremity, heart disease, dementia, and others.

Review of a Safe Smoking Screen dated 09/07/21 indicated that Resident #3 was not a smoker. The assessment was signed by Nurse #15.

Review of a care plan revised on 09/23/21 read in part, Resident #3 is a smoker. The goal read;

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Resident #3 will not smoke without supervision through the review date. The interventions included: instruct resident about smoking risk and hazards and about smoking cessation aides, instruct the resident about the facility policy on smoking, monitor oral hygiene, notify charge nurse immediately if it is suspected resident has violated the facility smoking policy, observe clothing and skin for sign of cigarette burns, and the resident requires supervision while smoking.

The significant change Minimum Data Set (MDS) dated 12/15/21 indicated that Resident #3 was cognitively intact and required extensive to total assistance with activities of daily living. The MDS also indicted that Resident #3 used tobacco.

An observation of Resident #3 was made on 02/02/22 at 11:42 AM. Resident #3 was observed outside in the courtyard with 3 other residents smoking a cigarette. No staff members were present it the courtyard.

An observation of Resident #3 was made on 02/03/22 at 11:55 AM. Resident #3 was observed outside in the courtyard with 2 other resident smoking a cigarette. No staff members were present in the courtyard.

Nurse #10 was interviewed on 02/07/22 at 1:01 PM. Nurse #10 confirmed that she was the Unit Manager for Resident #3. She confirmed that Resident #3 began going to the smoking area around 3-4 weeks ago, she explained that he had quit smoking for a while then 3-4 weeks ago started smoking again. Nurse #10 stated she did not complete his smoking assessment so she could not verify if he was an independent smoker or not but stated if Resident #3 require

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supervision, then a staff member must be with him when he was smoking.

The Activities Director (AD) was interviewed on 02/07/21 at 2:31 PM. The AD stated that she had worked at the facility since July 2020 and was not aware that Resident #3 smoked until about 2 weeks ago. She stated that Resident #3 went out to smoke whenever he wanted to, and no staff had to be present with him as far as she knew.

Attempt to speak to Nurse #15 was made on 02/06/22 and again on 02/07/22 without success.

The Administrator and current Director of Nursing (DON) were interviewed on 02/07/22 at 3:40 PM. The Administrator stated that she had never seen Resident #3 smoke but if he was smoking then we should have assessed him. The DON confirmed that Resident #3 should have an updated smoking assessment and indicated that they would speak to him about smoking cessation programs to see if he was interested.

3. Review of a facility policy titled, Oxygen Safety implemented on 11/01/20 read in part; Oxygen Storage-cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty.

An observation was made on 02/02/22 at 11:49 AM of the facility chapel. There was a full oxygen cylinder tank lying on a table not secured in anyway. There was a resident noted to be sitting in the chapel visiting. Numerous staff members were in and out of the chapel throughout the day.

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F 689	Continued From page 132 An observation was made on 02/03/22 at 11:11 AM of the facility chapel. There was a full oxygen cylinder tank lying on a table not secured in anyway. Numerous staff members were in and out of the chapel throughout the day. An observation was made on 02/04/22 at 9:00 AM of the facility chapel. There was a full oxygen cylinder tank lying on a table not secured in anyway. There was a resident noted to be sitting in the chapel visiting. Numerous staff members were in and out of the chapel throughout the day. An interview was conducted with the acting Director of Nursing (DON) on 02/04/22 at 4:34 PM. The DON stated that the oxygen cylinder tank should not be lying on the table it should be secured upright in the storage rack. The Administrator was interviewed on 02/07/22 at 3:40 PM. The Administrator stated that the oxygen tank should have been secured. She stated she did not know how it got put on the table but stated they had a meeting in the chapel on 01/31/22 and felt certain if the tank had been there they would have seen it and taken care of it.	F 689		
F 725 SS=H	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	F 725		3/25/22

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F 725	Continued From page 133 diagnoses of the facility's resident population in 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 reviews and resident and staff interviews, the facility failed to maintain sufficient staff to treat residents in a dignified manner to prevent a resident from being spoken rudely to, to provide incontinence care when requested, to reframe from double and triple briefing the residents and failed to honor a resident's request to get out of bed at his preferred time of day. The facility also failed to maintain sufficient staff to develop, implement and complete baseline and comprehensive care plans and failed to complete resident assessments. The facility failed to maintain sufficient staff to provide scheduled showers and Physician ordered medications. The facility further failed to maintain sufficient staff to provide Physician ordered treatments for wounds and provide care and services to maintain skin integrity. These failures affected 14 of 43	F 725	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1) F550 The facility failed to treat resident in a dignified manner when requesting medication for resident #4. On 3/7/22 Administrator provided 1:1 reeducation to MA #1 on speaking to residents in a dignified manner. The facility failed to treat resident in a dignified manner by not providing incontinence are when requested and double, triple briefing resident #3, resident # 5, resident #9, resident #10 and resident #11. On 2/11/22, residents received	

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F 725	Continued From page 134 residents in the areas of dignity, choices, activities of daily living, Minimum Data Set assessment completion and accuracy and baseline and comprehensive care plans, quality of care and pressure ulcer care (Residents #1, #2, #3, #4, #5, #6, #7, #9, #10, #11, #12, #14, #15 and #18). The findings included: This tag is cross referred to: 1. F-550 Based on observations, record review, cell phone video footage, resident and staff interview the facility failed to treat a resident in a dignified manner when a medication aide spoke rudely to the resident when he requested his medication (Resident #4), failed to treat residents in a dignified manner by not providing incontinence care when requested and double and triple briefing the residents (Resident 3, Resident #5, Resident #9, Resident #10, and Resident #11) for 6 of 9 residents reviewed. The residents stated that waiting on incontinence care and wearing multiple briefs made them feel bad, low like less of a man, demeaning, embarrassed and degraded. 2. F- 561 Based on observations, record reviews and staff and Resident interviews, the facility failed to honor a resident's request to get out of bed at his preferred time of day for 1 of 1 resident reviewed for choices (Resident #5). 3. F-636 Based on record review and staff interview the facility failed complete comprehensive Minimum Data Set assessments with the subsequent care area assessments within the required time frame for 3 of 3 resident	F 725	incontinence care and single briefed. F561 The facility failed to honor a resident #5 request to get out of bed at preferred time of day. Resident #5 request was honored on 2/11/2022 and care plan/task list updated to reflect resident preferred time of getting in/out of bed. F636 The facility failed to complete a Comprehensive Minimum Data Set assessment for resident #3, resident #6 and resident #7, within 14 days. Resident #3 was transmitted and accepted on 2/2/22. Resident # 6 was transmitted and accepted on 2/7/22. Resident #7 Comprehensive assessment on 1/10/22 transmitted and accepted 2/7/22. F641 The facility failed to accurately code an Admission Minimum Data Set for resident #4. The facility modified resident #4 to reflect discharge as “planned” on discharge assessment on 10/28/2021 and retransmitted on 3/4/2022. The facility modified resident #4 to reflect	

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F 725	Continued From page 135 reviewed (Resident #3, Resident #6, and Resident #7). 4. F- 677 Based on observations, record review, resident, staff, and family member interview the facility failed to provide incontinence care when requested by the resident (Resident #3, Resident #5, Resident #9, Resident #10, Resident #11) and failed to provide shower activities (Resident #2, Resident #7, and Resident #12) for 8 of 8 resident reviewed for activities of daily living. 5. F-641 Based on record review, and facility staff and resident interviews, the facility failed to accurately code an admission minimum data set assessment for height and discharge planning for 1 of 3 residents reviewed (Resident #4). 6. F-655 Based on record review and staff interview the facility failed to develop a baseline care within 48 hours of admission that addressed surgical wound care or smoking status of the resident for 1 of 3 residents reviewed for smoking (Resident #6). 7. F-657 Based on record review and staff interview, the facility failed to revise comprehensive care plans in the areas of anticoagulation for 1 of 1 resident reviewed for Coumadin therapy (Resident #1) and 1 of 1 resident reviewed for pressure ulcer (Resident #2). 8. F-684 Based on observations, record review, resident, and staff interview the facility failed to follow physician orders for treatment to a venous stasis ulcer (Resident #7), failed to follow physician order for treatment to a diabetic foot ulcer (Resident #18), and failed to follow	F 725	"height" on admission on 10/28/2021 and retransmitted on 3/4/2022. F655 The facility failed to develop a baseline care plan in the area of smoking and surgical wound care within 48 hours of admission for resident #6. F657 Resident #1 comprehensive care plan revised on 2/7/2022 by the licensed nurse for use of anticoagulant medication. Resident #2 comprehensive care plan revised on 2/7/2022 by the licensed nurse for care of pressure ulcer. F677 Resident #2, resident #7 resident #12 task list updated for bathing type and frequency preference and residents continue to receive showers per plan of care Incontinence care for resident #3, resident #5, resident #9, resident #10 and resident #11 will continue to be provided to maintain incontinence care needs. F684 Treatment for resident #7 venous statis ulcer was provided on 3/3/2022 and will continue to be provided as ordered by the physician. Treatment for resident #18 diabetic foot ulcer was provided on 3/5/2022 and will continue to be provided as ordered by the physician. The facility failed to follow physician order	

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F 725	Continued From page 136 physician order for treatment of surgical wounds (Resident #6) for 3 of 5 residents reviewed. 9. F-686 Based on observation, record reviews, staff, Resident, Wound Physician and Physician interviews the facility failed to provide the necessary goods and services to maintain skin integrity for a resident with a history of skin breakdown. Resident #2 called for staff assistance after smelling a foul odor and was observed with a stage IV pressure ulcer (the pressure ulcer will become very deep and as the ulcer deepens, muscle or bone may be visible, making infection a strong possibility if not cared for) on his right buttock. The facility also failed to provide pressure ulcer treatments for 2 of 3 residents (Resident #2 and Resident # 18) reviewed for pressure ulcers. On 02/02/22 at 7:00 AM an interview was conducted with Nurse #4 who worked the 7:00 PM to 7:00 AM shift. The Nurse explained that it was normal staffing to have 4 nurses and 4 to 5 nurse aides but recently the staffing had been only 3 nurse aides which meant the nurses work would often get behind because they were stopping and helping the nurse aides take care of the residents. The Nurse continued to explain that it was the case last weekend (01/28/22, 01/29/22 and 01/30/22) that there was only 3 nurse aides in the building and the facility did not have staff to call in and no agency staff would come in to work so they had to do the best they could to take care of the residents. The Nurse stated the residents do not get their showers on second shift because there was not enough staff scheduled to give them their showers. On 02/02/22 at 7:20 AM an interview was	F 725	for treatment of surgical wounds for resident #6. Resident discharged on 2/8/2022. F686 The facility failed to prevent and identify a pressure ulcer Resident #2 who was at risk for pressure ulcers. On 2/3/22, the Wound Physician evaluated Resident #2 right buttock pressure ulcer. Wound staged as a Stage 4 wound with heavy serous exudate and 100% necrotic. Scalpel debridement was completed on the wound and new orders implemented. Resident #2 will continue to receive wound care to heal and prevent further skin breakdown. Care plan updated by MDS Coordinator. 2) Effective 3/14/2022 Administrator and Director of Nursing completed an audit of current staffing levels to determine sufficient staffing needed to ensure resident care is provided to assure dignity, choices, activities of daily living, Minimum Data Set assessment completion and accuracy and baseline and comprehensive care plans, quality of care and pressure ulcer care. As a result of this review, the facility has posted additional job openings for multiple licensed nurses and nurse aides. The facility hired a full-time wound nurse and staff development coordinator and will continue recruitment and retention efforts ongoing. 3) Administrator provided education to staffing coordinator on staffing based on	

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conducted with Nurse #20 who explained that she was hired to be the Treatment Nurse but the vaccine mandate came out and a lot of nurses did not get vaccinated which made the facility short of nurses and now she had on the hall working as a hall nurse and not the Treatment Nurse for at least 2 weeks. The Nurse continued to explain that she had not been oriented to the facility's electronic medical record system or the wound management policy.

On 02/02/22 at 8:25 AM an interview was conducted with Nurse #11 who stated he normally worked the night shift. The Nurse explained that staffing was hit or miss because they utilized agency staff that will not show up when they were scheduled to work, and it put the facility in a bind. The Nurse continued to explain that it was the case last night when he had to work as a nurse aide because they were short of nurse aides. The Nurse indicated that it did not do any good to call agency staff to come in because they would not come in and work.

On 02/02/22 at 11:03 AM an interview was conducted with the Scheduler who explained that she staffed the nursing department according to the daily resident census and currently she could utilize a total of 27 nursing individuals which was a mixture of nurses and nurse aides in a 24 hour period. The Scheduler continued to explain that she normally could meet the staffing numbers but since the mandated vaccine came into effect, staffing had become more challenging and she was struggling to meet the minimum staffing because the facility lost nursing staff and the agency staffing the facility utilized decreased as well. The Scheduler indicated that often the agency staff that was scheduled were call outs or

ratios/PPD level and resident acuity. Education completed on 3/10/22. The Administrator and DON will review resident acuity and census to determine staffing levels and will share this information with the staffing coordinator for appropriate staffing each shift/day. Staffing needs will be reviewed in daily morning meeting and determined staffing needs reported to staffing coordinator to ensure sufficient staffing is provided to ensure resident care is provided to assure dignity, choices, activities of daily living, Minimum Data Set assessment completion and accuracy and baseline and comprehensive care plans, quality of care and pressure ulcer care.

4) Administrator or designee to audit schedules, daily staffing sheets, daily labor reports, actual employees presence in the building along with callout to adjust the schedule appropriately to ensure adequate staffing to meet resident care needs. Monitoring will be completed at a frequency of 5x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Administrator or designee will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement and makes changes to the plan as necessary to maintain compliance with sufficient staffing.

Completion date: 3/25/2022

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no call no shows which resulted in the facility being short staffed and the facility would not allow her to over staff the shifts in order to compensate for the short staffing. The Scheduled stated that she staffed for 2 aides on first and second shifts to be scheduled to give showers but when they had call outs or no call no shows they had to rearrange the staffing pattern and the workload of the showers fell on the floor staff. The Scheduler stated there was no accountability for the agency staff and they had to utilize what they could get and when they could get them.

On 02/03/22 at 10:46 AM an interview was conducted with Nurse Aide (NA) #7 who explained she normally worked first shift and usually had 24 residents to provide all their activities of daily living which included, feeding them if they required feeding, checking and changing them every two hours if they were incontinent, getting them out of bed if they desired and putting them back to bed, providing their showers if scheduled and answering the call lights when possible. The NA continued to explain that on that day, she changed the incontinent residents twice and fed their meals but she was not able to provide the scheduled showers nor was she able to provide any personal care like brush their teeth because of not having enough staff to take care of the residents like they needed taking care of.

At 11:20 AM on 02/03/22 an interview was conducted with Nurse Aide (NA) #9 who explained that the shower schedules were not kept up to date so the nurse aide had to take time to look through the electronic record for each resident they were assigned to in order find out who was scheduled for showers. The NA

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continued to explain that when there was enough staff scheduled to have a shower team then the shower team would be responsible for the showers but here lately there have been no extra staff scheduled to give the showers. The NA stated she had to 7:00 PM to give the showers and only if it was possible to give showers then the most vocal residents received their showers.

An interview was conducted with Nurse #2 on 02/03/22 at 3:15 PM. The Nurse stated he worked from 7:00 AM to 7:00 PM and explained that staffing was difficult because of all the call outs. He continued to explain that he felt that the biggest barrier to sufficient staffing was the mandated vaccine. The Nurse explained that if there was not a wound nurse then the nurse on the hall next to the medication aide had to cover the medication aide in that the nurse had to do the treatments that the medication aide cannot do. The Nurse continued to explain that some days it is not possible to be responsible for both halls because things can get so hectic that it is unrealistic to get it all done. The Nurse stated he had had to let some treatments go and he has also had to do extra treatments that were scheduled for another shift that did not get done. The Nurse stated he thought Nurse #20 was a wound nurse, but she was not scheduled to do wounds much because she had to work the hall. The Nurse explained that the aides did not routinely pass out ice water nor do they give showers because of being short staffed.

During an interview with Nurse #12 on 02/03/22 at 4:45 PM the Nurse explained that the facility was chaotic in that there was no administrative leadership to oversee the systems. The Nurse stated that staffing was short, and the residents

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did not get the care they needed. The Nurse explained that there was no wound nurse which made it difficult for the hall nurses because it put the wound treatments on the nurses who already have a huge workload with the meds, admitting residents and working two medication carts if you have to cover the hall that has a medication aide.

On 02/04/22 at 3:15 PM an interview was conducted with Nurse #19 who explained in her opinion the problem with staffing was miscommunication. The Nurse indicated there was no one responsible to supervise the schedule to ensure that the people that were assigned to work came into work their shift. An example the Nurse gave was on 02/03/22 for the 7:00 PM to 7:00 AM shift they thought they had 5 nurse aides for the building but around 10:00 PM they realized they only had 3 nurse aides which meant the residents that were on the 2 nurse aides assignments that did not show up for work did not receive any care. The Nurse continued to explain that she tried to call the Scheduler and Administrator to report only having 3 nurse aides for the shift but could not get in touch with them so she decided to get her friend who was a nurse aide and who worked in a different building to come and help them out. The Nurse explained that it was not unusual for third shift to work with only 2 nurse aides in the building to provide care for as many as 40 residents a piece and that made it difficult to provide the care the residents needed.

On 02/04/22 at 3:23 PM during an interview with Nurse Aide (NA) #20 she explained that she was asked to come into the facility and work as a NA because the facility was short staffed and needed the help. The NA stated when she got to the

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facility around 10:30 PM she was given an assignment of residents that according to the staff on duty had not been attended to since 7:00 PM because they did not know that the scheduled staff did not show up to work. The NA continued to explain that she had to change multiple residents and their beds because they were soaking wet.

On 02/05/22 at 1:00 PM an interview was conducted with Nurse Aide (NA) #12 who stated he was agency staff that worked second and third shift and worked an average of 5 to 6 days a week for the facility. The NA explained that staffing at the facility was very short especially since they mandated the vaccine. The NA continued to explain that it was unrealistic to get all the work done and take care of the residents the way they deserved but you had to do the best you could.

On 02/07/22 at 12:10 PM an interview was conducted with Nurse Aide (NA) #17 who stated he was agency staff who worked first and second shift. The NA explained the staffing was "pretty bad" because the facility did not have but 5 or 6 facility staff and the rest was agency staff. The NA continued to explain that there have been times that he has had to work the whole unit by himself which meant he had about 50 residents to take care of and provide all their activities of daily living by himself. The NA stated he had to do the best he could to take care of the residents.

During an interview with the Minimum Data Set (MDS) Nurse on 02/08/22 at 11:50 AM the Nurse explained that the MDS Coordinator had recently left and the workload of the Resident Assessment Instrument (RAI) process was left to her. She

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continued to explain that she only had about a year's experience with the RAI process and she felt like she was still learning the process which was very overwhelming when it was all up to her to do.

On 02/03/22 at 11:23 AM an interview was conducted with the former Director of Nursing (DON) who explained that she spent many days as the Nurse on the cart because of short staffing and was not able to do her duties as the DON and monitoring systems that needed to be monitored. The DON continued to explain that the facility was constantly short of nurse aides and the residents did not get the care they required and needed because of short staffing. The DON stated before she left her employment, she and the Administrator had multiple conversations about short staffing and how systems were not being monitored and followed.

On 02/07/22 at 3:40 PM an interview was conducted with the Administrator and Interim Director of Nursing (DON). The two acknowledged that the lack of staffing in the facility was an area that needed immediate attention. The DON stated she has asked the Corporation to be able to increase the number of nurse aides and the Administrator was trying to obtain new agency contracts in order to get more staff in the facility. The DON explained that she has asked the Corporation permission to add a Certified Wound Nurse position for 7 days a week in order to manage the wound situation in the facility. The Administrator continued to explain that a new Director of Nursing was hired and would be starting in a couple of days. The Administrator stated she was unaware that the Minimum Data Set (MDS) assessments were

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F 725	Continued From page 143 incomplete and not submitted and also did not know that the MDS Nurse did not know how to do the complete process but that she would make sure that the MDS Nurse received Corporate training in the area of the Resident Assessment Instrument.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 726		3/25/22

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F 726	Continued From page 144 assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to ensure Nurse Aide (NA) #20 had facility specific training and competencies to work as a nurse aide for 1 of 5 staff members reviewed. The findings included: 1. Nurse #19 was interviewed on 02/04/22 at 3:15 PM. Nurse #19 confirmed that she had worked the previous night on third shift 02/03/22. She stated that they thought they had five Nurse Aides (NA) working on that shift but sometime around 10:00 PM discovered that they did not have five NAs in the building they only had three. Nurse #19 explained that she tried to the call the Administrator and Scheduling Coordinator (SC) to see if we could bring some help in and were unable to get in touch with them. Nurse #19 further explained that her best friend who was an agency NA that worked in a different part of a neighboring county and had worked in other nursing facilities was at her house for the weekend, so she called her (NA #20) and asked her to come to the facility and help and she agreed. Nurse #19 stated she briefly left the facility to go to her house and pick up NA #20 and brought her to the facility to help. Nurse #19 confirmed that NA #20 had never worked at the facility before, but they were short and needed some help and she agreed to come and help. NA #20 was interviewed on 02/04/22 at 3:23 PM. NA #20 confirmed that she was staying at Nurse #19's house for the weekend and got a call around 10:00 PM on 02/03/22. She stated that	F 726	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to ensure Nurse Aide #20 had facility required training and competencies to work as a nurse aide. Nurse Aide #20 is not employed by the facility and therefore no corrective action is possible. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/2022 Director of Nursing and/or designee reviewed nurse aide staffing to ensure they received training and competencies before working in the facility. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/22, current facility and agency nurse aide were audited to ensure proper training and competencies. Additional education and skills competencies completed by the licensed nurse to ensure all nurse aides are trained and competent to provide resident care. Effective 3/24/2022 Staffing Development	

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F 726	Continued From page 145 Nurse #19 asked if I could come to the facility and help because they were short staffed. NA #19 explained that she was a NA that worked through an agency in a different part of a neighboring county and had worked in other nursing facilities. NA #19 stated she agreed to come and in and help, and Nurse #19 came and picked her up and they arrived back at the facility around 10:30 PM. NA #20 confirmed that she had never worked at the facility before and was helping because Nurse #19 was her best friend, and she did not want them to work short. NA #20 stated that when she arrived at the facility, she was given her assignment and told that no residents on that assignment had been touched because they did not realize that the assigned staff members had not shown up for work. She stated she started providing care to people on the assignment she was given and most of those residents were soaking wet clear through to the bed which required a linen change as well. An interview was conducted with the SC on 02/04/22 at 4:44 PM. The SC confirmed that the facility had called her phone several times through the night, but she was not sure what they needed because she was asleep and did not hear her phone. The SC confirmed that NA #20 had never worked at the facility before and she did not have the packet of information that all new agency employees received when they came to the facility. The SC was also not sure which agency NA #20 worked for but stated she would try and find out. The interim Director of Nursing (DON) and Administrator were interviewed on 02/07/22 at 3:40 PM. The DON stated she knew nothing about NA #20 and did not know if she had ever	F 726	Coordinator or designee will ensure agency staff received training and competencies before working in the facility. Effective 3/24/22, contact information for the DON and Administrator will be posted at the nurses station in the event of nurse aide call outs or shortages and the DON and/or Administrator will ensure trained, competent nurse aide coverage is provided as required to meet resident needs. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit 3 nurse aides weekly x 12 weeks to ensure they meet facility training and competencies. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 726	Continued From page 146 worked at any of the facilities in their corporation or not. The Administrator stated she knew nothing about NA #20 and could not confirm that she was a NA or not. All agency staff were expected to receive orientation through the SC before they worked at the facility. The expectation was that all staff were properly trained with proper documentation of that training before working at the facility. A follow up interview was conducted with NA #20 on 02/23/22 at 3:35 PM. NA #20 stated she worked for a local staffing agency and stated that the facility had a contract with them. She also confirmed that she had never worked in the facility prior to 02/03/22 and has not worked at the facility since the end of her shift that day. A follow up interview was conducted with the Administrator on 02/23/22 at 5:26 PM. The Administrator confirmed that the facility had a contract with the local staffing agency that NA #20 worked for.	F 726		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		3/25/22

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F 756	Continued From page 147 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews from staff, Nurse Practitioner, Physician, and Pharmacy Consultant, the facility failed to have a pharmacy review that included identification of missing and abnormal PT/INRs for Resident #1 during the months of December 2021 and January 2022 for 1 of 1 resident reviewed for anticoagulant therapy (Resident #1). Findings included: Resident #1 was admitted to the facility on	F 756	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to have a pharmacy review that included identification of missing and abnormal PT/INRs for resident #1 during the months of December 2021 and January 2022. Resident #1 drug regimen review was	

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F 756	Continued From page 148 10/21/21 and most recently readmitted on 12/16/21 with diagnoses of atrial fibrillation and acute embolism and thrombosis of deep vein of the lower extremity. According to the hospital discharge summary dated 12/16/21, Resident #1 was to maintain a PT/INR therapeutic range of 2.0 to 3.0 while on Coumadin therapy. A Physician's order dated 12/17/21 indicated daily PT/INRs were to be obtained due to anticoagulant usage. A review of the daily PT/INR laboratory results for Resident #1 from 12/17/21 through 1/13/22 revealed the following: - There were no PT/INR laboratory results for 15 of the 27 dates that PT/INRs were ordered (12/17/21, 12/19/21, 12/22/21, 12/23/21, 12/28/21, 12/30/21, 1/1/22 through 1/6/22, and 1/9/22 through 1/11/22) in the medical record. There was no documentation to indicate the Provider was contacted and made aware these labs were not obtained. - There were six (6) PT/INR results that were outside of the therapeutic range of 2.0 to 3.0 (12/24/21 - 6.32, 12/25/21 - 3.29, 12/26/21 - 3.31, 12/31/21 - 4.47, 1/7/22 - 5.24, and 1/8/22 - 4.59). There was no documentation to indicate the Provider was notified of these PT/INR results which fell outside the provided parameters for Resident #1. On 1/13/22 the Nurse Practitioner wrote an order for PT/INRs to be changed from being required daily to every Monday and Friday.	F 756	completed by pharmacy consultant on 2/18/2022 and 3/7/2022 with no further irregularities noted. How the facility will identify other residents having the potential to be affected by the same deficient practice; All current residents receiving Coumadin will be reviewed by the pharmacy consultant. This audit will be completed by 3/14/2022. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 2/7/2022 Regional Director of Clinical Services educated Director of Nursing and nurse management on reviewing pharmacy recommendations and residents on Coumadin to ensure no irregularities were missed. This education will be completed by 3/24/2022. Effective 3/24/2022 newly hired facility or agency Director of Nursing and/or nurse management will receive education during orientation and prior to working. Facility to provide consultant pharmacist a copy of PT/INR lab results for all residents receiving Coumadin therapy on a weekly basis for 3 months. Lab results will be uploaded, made readily accessible and reviewable by Consultant pharmacist. Consultant pharmacist will review weekly lab results as provided and identify any missing and/or abnormal PT/INRs as part	

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F 756	Continued From page 149 On 1/13/22 the Nurse Practitioner wrote an order for PT/INRs to be changed from being required daily to every Monday and Friday. A review of PT/INR laboratory results ordered for Mondays and Fridays for Resident #1 from 1/13/22 through 1/26/22 revealed the following: - There were no PT/INR laboratory results for 4 of the 4 dates that PT/INRs were ordered (1/14/22, 1/17/22, 1/21/22, and 1/24/22) in the medical record. There was no documentation to indicate the Provider was contacted and made aware these labs were not obtained. A review of the monthly Pharmacy progress notes and recommendations submitted to the facility revealed the Pharmacy Consultant reviewed Resident #1's medical record on 01/14/22 which reflected the medical review from readmission on 12/16/21 to 01/14/22 and read in part: Resident #1 was readmitted with anemia and an abdominal hematoma requiring Coumadin therapy and to maintain INRs within goal. The note further reflected INR values from 12/20/21 through 1/12/22 to be 2.98, 6.32, 4.4, 5.24, and 2.38 with INR's drawn routinely and no reference to missing lab reports related to the ordered daily INRs and no recommendations suggested related to Coumadin monitoring. A written interview statement provided by the Pharmacy Consultant dated 2/7/22 regarding a telephone interview on 2/5/22 at 1:42 PM was reviewed. The Pharmacy Consultant's statement read in part: During the Medical Record Review (MRR), the Pharmacist noted that Resident #1 was ordered Coumadin. A review of his past medial history showed that he had failed Eliquis.	F 756	of an interim medication regimen review. Consultant pharmacist will make any recommendations for missing and/or abnormal labs to the facility DON, NHA, medical director and/or prescribing physician. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will review pharmacy recommendations to ensure identification of irregularities with residents on Coumadin weekly x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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A review of his medical record and progress noted did also show on 12/1/21 that a goal of 3.0 to 3.5 was set due to patient history of DVT failure while on Eliquis. This suggested a possible hyper-coagulable state. The PT/INRs results were reviewed and were drawn routinely given that they had been drawn at least weekly being week of 12/16/21: INR was drawn on 12/20/21, Week of 12/23/21: INR was drawn on 12/24/21, Week of 12/30/21: INR was drawn on 12/30/21, Week of 1/7/22: INR was drawn on 1/7/22 and 1/12/22. The Pharmacy Consultant indicated she reviewed the results of the INR values and intervention by the primary medical team. This review yielded on 12/31/21 the INR resulted in a value of 4.4 which the Provider adjusted the Coumadin dosage as well as on 1/7/22 when the INR resulted in a value of 5.2 and the Coumadin dosage was held from 1/7 through 1/11 and redrawn on 1/12 which resulted in a value of 2.3 which was in a therapeutic range set on 12/16/21 of 2.0-3.0. The Pharmacy Consultant wrote in her written statement, that based on her review, she thought the medical team had intervened appropriately which did not warrant a Pharmacy recommendation regarding Coumadin therapy at that time. The written document further read in part: "I agreed that if the facility did not follow Physician's orders as written, that was of concern", but in her clinical judgement "an order for daily PT/INRs might be considered excessive in the long-term care setting". She elaborated to say based on her clinical experience, she would only be looking to see that PT/INRs were drawn at least once weekly.

An interview on 02/08/22 at 12:21 PM with the Administrator and Interim Director of Nursing (Regional Consultant) revealed the facility did not

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F 756	Continued From page 151 receive any recommendations from the Pharmacy Consultant's review for Resident #1 during the December or January review periods. Each would expect the Pharmacy Consultant to make appropriate recommendations to the facility during the medical record review.	F 756		
F 757 SS=K	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner (NP), and Physician (MD) interviews, the facility failed to follow physician's orders for obtaining scheduled Prothrombin Time Test/ International Normalized Ratio (PT/INR), a test	F 757	How corrective action will be accomplished for those residents found to have been affected by the deficient practice;	3/25/22

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F 757	Continued From page 152 used to help detect and diagnose a bleeding disorder or excessive clotting disorder, laboratory (lab) studies. The facility also failed to notify the medical provider of abnormal laboratory results outside the perimeters of 2.0-3.0 for 1 of 2 residents reviewed for unnecessary medications (Resident #1) which resulted in Resident #1 undergoing exploratory abdominal surgery and removal of a very large hematoma. The immediate jeopardy began on 12/17/21 when the facility failed to obtain a PT/INR for Resident #1 for anticoagulant therapy monitoring per physicians orders. The immediate jeopardy was removed on 2/9/22 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity of an E (a pattern of no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure staff education has been completed and monitoring systems put into place are effective. Findings included: 1. Resident #1 was admitted to the facility on 10/21/21 with diagnoses that included atrial fibrillation (irregular heart rhythm) and acute embolism and deep vein thrombosis (blood clot) of the lower extremity. A hospital discharge summary dated 12/16/21 indicated Resident #1 was admitted to the hospital Intensive Care Unit (ICU) on 12/4/21 for an abdominal wall hematoma (significant bruise where a collection of blood pools under the skin surface), supratherapeutic INR (abnormal higher level that increases risk of bleeding), and	F 757	The facility failed to follow a physician's order for obtaining scheduled PT/INR labs and failing to notify the physician or nurse practitioner when PT/INRs were not obtained. On 2/7/22, the MDS nurse updated Resident #1's anticoagulant therapy care plan to include monitoring for adverse side effects: discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, SOB or nose bleeds. Care plan also includes notification to physician/nurse practitioner of all PT/INR results and of any adverse side effects to anticoagulant drug use. How the facility will identify other residents having the potential to be affected by the same deficient practice; Residents with scheduled PT/INR lab orders are at risk of labs not being obtained as ordered and reported to the physician/nurse practitioner to ensure therapeutic levels are maintained. Therefore, effective 2/7/2022, the Interim Director of Nursing and licensed charge nurse reviewed current facility residents with orders for PT/INR labs to ensure labs are being obtained as ordered by the physician/nurse practitioner. One additional resident was identified with PT/INR orders. Orders were reviewed and PT/INRs were obtained as ordered. PT/INR flow record initiated, anticoagulant care plan and MAR updated by the	

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symptomatic anemia from an active bleed which required 13 units of packed red blood cells. The Discharge summary also indicated upon discharge, Resident #1's Coumadin dose had been reversed and was currently subtherapeutic (abnormally lower level that decreases risk of bleeding) with a PT/INR level of 1.27 on 12/16/21 and Resident #1's was ordered Coumadin 10 mg (an anticoagulant blood thinner) daily and PT/INRs to be obtained daily with therapeutic parameters to be between 2.0 to 3.0. A review of the Computer Tomography scan of the abdomen and pelvis performed in the Emergency Department (ER) revealed 2 large collections of blood measuring 18x22 centimeters (cm) and 15x18 cm.

A review of a quarterly Minimum Data Set (MDS) dated 12/25/21 indicated Resident #1 was cognitively intact and exhibited no behaviors to include refusals of care.

Resident #1's admission documents revealed a physician's order dated 12/16/21 indicated Resident #1 was to receive Coumadin 10 mg daily and a physician's order dated 12/17/21 which indicated daily PT/INRs were to be obtained due to anticoagulant usage.

Resident #1's lab studies revealed no lab reports were available for the PT/INR on 12/17/21.

A lab report dated 12/18/21 indicated Resident #1's PT/INR was subtherapeutic with a level of 1.6.

The medication administration record (MAR) revealed Resident #1 was administered Coumadin 10 mg daily on 12/16/21 through

licensed nurse to include monitoring for adverse side effects and reporting to physician/nurse practitioner all PT/INR lab results and adverse side effects for follow-up intervention.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 2/7/22, the Director of Regulatory and Risk Management provided education to the Administrator, Interim Director of Nursing, SDC (Staff Development Coordinator) and Licensed Charge Nurses on the lab process for residents on coumadin therapy to include; obtaining PT/INR labs as ordered, the corresponding lab results, sub/supratherapeutic levels, signs of coumadin toxicity, treatment for toxicity, drawing blood samples for PT/INRs, requisitions to contracted lab provider and reporting to nurse supervisor for alternate options to obtain the sample as ordered and reporting all lab results to the Physician/Nurse Practitioner.

On 3/24/22, Director of Nursing and Licensed Charge Nurses provided education to facility and agency licensed nurses on lab process for residents on coumadin therapy. Reporting to medical provider if unable to obtain and education on the use of the PT/INR flow records for current PT/INR parameters, documenting lab results, next lab draw date and current and/or changing coumadin orders to

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F 757	Continued From page 154 12/19/21. No lab report was available for PT/INR ordered to be obtained on 12/19/21. A lab report dated 12/20/21 indicated Resident #1's had a therapeutic PT/INR of 2.98. A physician's order dated 12/20/21 indicated Resident #1 was to be administered Coumadin 8 mg daily. A lab report dated 12/21/21 indicated Resident #1 had a therapeutic PT/INR of 2.7. No lab report was available for a PT/INR scheduled to be obtained on 12/22/21 or 12/23/21. The MAR revealed Resident #1's Coumadin 8 mg was administered on 12/20/21 through 12/23/21. A nurse's note dated 12/23/21 indicated a PT/INR was not obtained due to lack of available tourniquets in supply and upper management had been made aware. A lab report dated 12/24/21 indicated Resident #1 had a critical PT/INR level of 6.32. There was no documentation to reflect notification of the physician or the nurse practitioner. The MAR revealed Resident #1's Coumadin 8 mg was administered on 12/24/21 despite supratherapeutic PT/INR. The MAR revealed Resident #1's Coumadin was not administered on 12/25/21. No orders were written for this held dose.	F 757	maintain each resident therapeutic INR range and reporting all results outside of parameters to the Physician/Nurse Practitioner Effective 3/24/2022 all License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on facility lab process for residents on coumadin therapy. Reporting to medical provider if unable to obtain and education on the use of the PT/INR flow records for current PT/INR parameters, documenting lab results, next lab draw date and current and/or changing coumadin orders to maintain each resident therapeutic INR range and reporting all results outside of parameters to the Physician/Nurse Practitioner Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 3/24/22, the Administrator or Director of Nursing will monitor residents with PT/INR orders to ensure compliance with obtaining, reporting and monitoring as ordered. Audits will be completed three times weekly x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

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F 757	Continued From page 155 A lab report dated 12/25/21 indicated Resident #1 had a supratherapeutic PT/INR of 3.29. A lab report dated 12/26/21 indicated Resident #1 had a slightly supratherapeutic PT/INR of 3.31. A lab report dated 12/27/21 indicated Resident #1 had a therapeutic PT/INR of 2.81. No lab reports were available for the PT/INR on 12/28/21. The MAR revealed Resident #1's Coumadin 8 mg was administered on 12/26/21 through 12/29/21. A nurses noted dated 12/28/21 revealed PT/INR may be obtained on 12/29/21 per NP. A lab report dated 12/29/21 indicated a PT/INR level of 2.47. No lab reports were available for the PT/INR on 12/30/21. A physician's order dated 12/31/21 revealed Resident #1 was to be administered Coumadin 8 mg daily. The MAR revealed Resident #1's Coumadin 8 mg was administered on 12/30/21 through 12/31/21. A lab report dated 12/31/21 revealed Resident #1's INR level was supratherapeutic at 4.47. There was no documentation to reflect the physician or nurse practitioner were notified of the supratherapeutic INR. A physician's order dated 12/31/21 indicated	F 757	Completion date: 3/25/2022	

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Resident #1 was to receive Coumadin 7 mg daily.

A review of all laboratory data from 12/16/21 through 12/31/21 revealed PT/INRs were not obtained as ordered on 6 days.

The MAR indicated Resident #1 continued to receive Coumadin 7 mg daily from 1/1/22 through 1/7/22.

No PT/INR lab reports were available from 1/1/22 to 1/5/22.

A provider progress noted dated 1/6/22 revealed Resident #1's PT/INR was unable to be located and therefore the provider ordered a stat PT/INR and CBC.

No lab reports were available for the STAT PT/INR ordered on 1/6/22.

A lab report dated 1/7/22 revealed Resident #1 had a supratherapeutic PT/INR level of 5.24. There was no documentation in the medical record to reflect the provider had been notified.

A lab report dated 1/8/22 revealed Resident #1 had a supratherapeutic PT/INR level of 4.59. There was no documentation in the medical record to reflect the provider had been notified.

There was no physician order located in the medical record to hold the 1/8/22 through 1/10/22 or to start the Coumadin 7 mg back 1/11/22.

A nurses note dated 1/10/22 indicated the NP was made aware on 1/10/22 of Resident #1's lab INR being supratherapeutic from a lab on 1/7/22 with a PT/INR level of 5.24 and was provided

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orders to hold the Coumadin dose for 1/10/22, but when chart review was conducted, the nurse realized the Coumadin had already been held on 1/8/22 and 1/9/22 already

No PT/INR lab reports were available from 1/9/22 through 1/11/22.

The MAR revealed Coumadin 7 mg was administered on 1/11/22 and 1/12/22.

A PT/ INR lab report dated 1/12/22 indicated a therapeutic level of 2.38.

A physician's progress note dated 1/13/22 indicated PT/INR orders were changed from daily to every Monday and Friday.

The MAR revealed Coumadin 7 mg was administered on 1/13/22-1/19/22.

No PT/INR lab reports were available for 1/14/22 or 1/17/22.

An unscheduled PT/ INR lab report dated 1/19/22 indicated a therapeutic level of 2.86.

The MAR revealed Coumadin 7 mg was administered on 1/20/22- 1/26/22.

No lab reports were available for 1/21/22 or 1/24/22.

A review of all laboratory data for 1/1/2022 through 1/24/22 revealed PT/INRs were not obtained as ordered on 13 days.

A Situation, Background, Assessment, Recommendations (SBAR) report dated 1/26/22

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revealed a change of condition for bleeding (other than GI) with instructions to send Resident #1 to the ER for an evaluation.

A hospital discharge summary dated 1/28/22 indicated Resident #1 arrived at the ER around 11PM on 1/26/22 for a ruptured abdominal hematoma with visible oozing of blood. He was found to have a supratherapeutic PT/INR of 4.57 upon arrival. An area on Resident #1's right abdomen was sutured but began to bleed with symptoms developing to include a significant decrease in blood pressure during initial attempts at imaging at which time the ER physician felt this to be a potential of a life- threatening emergency, given Vitamin K (used to help control bleeding), and admitted Resident #1 to the hospital's ICU department. Resident #1 was stabilized and discharged to the facility on 1/28/22 around 6 PM with a subtherapeutic PT/INR of 1.28.

A hospital discharge summary dated 02/03/22 revealed shortly after returning to the facility from previous hospital discharge on 1/28/22, Resident #1 was transferred back to the ER via EMS after he was transferring from his chair to the toilet at the facility and he felt a warm and wet sensation in his abdomen and found himself to be bleeding from the same site that had been sutured in the hospital. Upon arrival of the Emergency Medical Services (EMS), he was felt to have lost approximately 300 cubic centimeter/millimeter (cc/mL) of blood. Given these findings and the inability of the ER staff to stop the bleeding from direct pressure, Resident #1 was re-admitted to the hospital's ICU department. Surgical services were consulted on 1/29/22 and Resident #1 underwent abdominal wall exploratory surgery. The exploratory abdominal surgery revealed a

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removal of a very large hematoma which was 30 centimeters (cm) in length, 20 cm in width, and 10 cm in depth. Approximately 2600 cc of old blood was evacuated from the hematoma.

An interview on 2/9/22 at 7:23 PM with Nurse #22 revealed she had worked as an agency nurse at the facility with resident #1 on 12/22/21 and 12/23/21 and stated she was not able to draw labs in the facility at times due to the lack of supplies such as tourniquets and lab tubes. Nurse #22 verbalized there were also times when the outside contracted lab company would not show up on the designated days when they were scheduled, and staff did not always know they had not shown up and therefore didn't know to draw labs on these days.

An interview on 2/3/22 at 2:53 PM with Medication Aide (MA #1) revealed she worked the medication cart on 1/1/22. She indicated she noticed the order for Resident #1 to have a PT/INR drawn on her shift, but she knew she was not qualified to perform the task and felt like the nursing supervisor would have known the lab was to be drawn and therefore she did not notify anyone it needed to be drawn.

An interview on 2/3/22 at 1:00 PM with Nurse #2 revealed he was an out of state agency nurse where they did not allow licensed practical nurses to perform venipunctures and had not been trained on how to do so by facility staff. He further indicated he worked with Resident #1 on 1/2/22 and noticed the order, but he did not notify a shift supervisor or the provider of his inability to obtain the ordered lab but reported the inability to obtain the lab to the oncoming shift.

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An interview on 02/08/22 at 11:40 AM with Nurse #3 revealed she had times when the facility did not have supplies to draw ordered labs and there had been times when the outside contracted lab provider had not shown up to draw labs, but staff were not made aware the lab was not drawn.

An interview on 02/10/22 at 1:35 PM with Nurse #21 revealed she had worked in the facility and recalled times she had worked at times when she was unable to perform venipunctures due to lack of supplies in the facility. She indicated she had made nurse supervisors aware.

An interview on 02/10/22 at 1:45 PM with Nurse #1 revealed she was an agency nurse and stated she had been unable to obtain labs at times due to lack of butterfly needles and blue lab tubes. Nurse #20 indicated nursing supervisors had been made aware, but the problem seemed to be ongoing.

An interview on 02/03/22 at 3:40 PM with the NP revealed facility staff did not obtain and provide laboratory results to the providers to regulate Coumadin dosing for the set parameters provided upon admission of 2-3.5. The NP indicated she had to independently remember to search the results system to locate lab results and frequently was unable to locate lab reports due to lack of lab being drawn. The NP indicated because of these orders not being followed, Resident #1 had multiple elevated PT/INR levels which resulted in hospitalizations with exploratory abdominal surgery. The NP indicated if she had been notified routinely, she could have potentially adjusted his Coumadin dosage to prevent his rehospitalization.

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An interview on 02/09/22 at 5:30 PM with the MD revealed she expected nursing staff to obtain labs as ordered and if the outside contracted lab provider did not obtain the lab as scheduled, she expected facility staff to obtain the lab and send it to the local contracted hospital lab for results. The MD indicated a medical provider was on-call 24/7 who should be made aware of abnormal lab results or the inability to obtain a scheduled lab to seek further direction in the event the Coumadin dosage or frequency needed to be adjusted. The MD stated she has had trouble contacting nursing staff in the evening to check on lab result and believed it was the facility's responsibility to contact the provider instead of the provider being required to manually look up lab values. The MD explained copies of all labs were to be placed in the physician's contact binder, but all abnormal values should be called immediately. The MD elaborated for the safety of Resident #1 and others on Coumadin therapy, all residents receiving anticoagulant therapy should be closely monitored for adverse reactions and side effects of the medication usage.

An interview on 02/08/22 at 12:20 PM with the Administrator and Interim Director of Nursing (Corporate Nurse) revealed they each expected staff to monitor all residents on anticoagulant therapy to include: follow orders for lab, notify the provider when labs are unable to be obtained or any lab results in an abnormal value outside the resident's set perimeters and all nursing staff who were expected to draw labs should receive education and demonstrate competencies for obtaining labs.

The Administrator was notified of the Immediate Jeopardy on 02/06/22 at 10:25 AM.

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The facility provided the following IJ removal plan.

F757: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome because of the noncompliance:

The facility failed to follow a physician's order for obtaining scheduled PT/INR labs and failing to notify the physician or nurse practitioner when PT/INRs were not obtained.

Resident #1 was admitted to the facility on 10/21/21 with diagnosis of atrial fibrillation (AFib) and acute embolism and thrombosis of unspecified deep vein (DVT) of the lower extremity. Physician orders included anticoagulation therapy (Coumadin) which requires lab monitoring to ensure therapeutic ranges of 2.0 -3.0. Between the dates of 12/17/2021 - 1/24/2022, Resident #1 had physician orders for PT/INRs to be obtained. The facility failed to obtain PT/INRs labs for Resident #1 based upon physician orders with missing lab results for 6 days between the dates of 12/17/21 - 12/31/21 and 13 days of missing lab results between the dates of 1/1/22 - 1/24/22. Additionally, Resident #1 had supratherapeutic INR levels between the dates of 12/24/21 - 1/10/2022 with no notification to physician or nurse practitioner. Subsequently, Resident #1 had a change in condition (bleeding) which required transfer to the hospital for treatment on 1/26/22. Hospital records revealed Resident #1 had a ruptured abdominal hematoma with visible oozing of blood. He was found to have a supratherapeutic PT/INR of 4.57 upon arrival to the hospital. The resident continued to bleed from his abdomen which required stabilization in the

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intensive care unit. Resident #1 was stabilized and discharged back to the facility on 1/28/22 around 6PM with a subtherapeutic PT/INR of 1.28. Resident #1 required transfer back to the hospital on 1/28/2022 due to bleeding from abdominal area which in turn required a surgical procedure to evacuate a large hematoma from Resident #1 abdomen.

On 2/7/22, the MDS nurse updated Resident #1's anticoagulant therapy care plan to include monitoring for adverse side effects: discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, SOB or nose bleeds. Care plan also includes notification to physician/nurse practitioner of all PT/INR results and of any adverse side effects to anticoagulant drug use. PT/INR flow record initiated for Resident #1 and maintained in the lab binder on the unit.

Residents with scheduled PT/INR lab orders are at risk of labs not being obtained as ordered and reported to the physician/nurse practitioner to ensure therapeutic levels are maintained. Therefore, effective 2/7/2022, the Interim Director of Nursing and licensed charge nurse reviewed current facility residents with orders for PT/INR labs to ensure labs are being obtained as ordered by the physician/nurse practitioner. One additional resident was identified with PT/INR orders. Orders were reviewed and PT/INRs were obtained as ordered. PT/INR flow record initiated, anticoagulant care plan and MAR updated by the licensed nurse to include monitoring for adverse side effects and reporting to physician/nurse practitioner all PT/INR lab results and adverse

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side effects for follow-up intervention.
Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 2/7/2022, the Administrator, Interim Director of Nursing, Regional Director of Operations, Director of Regulatory and Risk Management and Medical Director conducted an Ad Hoc QAPI meeting to discuss root cause analysis of the facilities failure to maintain a process for obtaining labs as ordered by the Physician/Nurse Practitioner and failing to notify the physician or nurse practitioner when PT/INRs were not obtained. Facility corrective action plan formulated to include education, lab process update, monitoring/audits, and follow-up reviews by QAPI Committee. Root cause analysis determined that 1) the facility failed to have a process of ensuring PT/INR labs were drawn as ordered and that the licensed nurse was responsible for ensuring that blood samples are collected as ordered including when not drawn by contracted lab provider and 2) licenses nurses failed to implement PT/INR procedure of notifying the medical provider when PT/INR blood samples were unable to be obtained as ordered and when PT/INR levels were outside the given parameters for Resident #1. After interviewing licensed nurses to determine reason for not following lab process, the facility concludes; a) while Licensed Nurses could verbalize process of notifying the Charge Nurse when unable to obtain a PT/INR as ordered, they could not provide a reason for not following the process and b) while Licensed Nurses could verbalize the process of notifying the medical provider when PT/INR levels were outside the given parameters, they could not

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provide a reason for not following the process.

On 2/7/22, the Director of Regulatory and Risk Management provided education to the Administrator, Interim Director of Nursing, SDC (Staff Development Coordinator) and Licensed Charge Nurses on the lab process for residents on coumadin therapy to include; obtaining PT/INR labs as ordered, the corresponding lab results, sub/supratherapeutic levels, signs of coumadin toxicity, treatment for toxicity, drawing blood samples for PT/INRs, requisitions to contracted lab provider and reporting to nurse supervisor for alternate options to obtain the sample as ordered and reporting all lab results to the Physician/Nurse Practitioner. Education also included 1) responsibility of the licensed nurse to ensure blood samples are collected as ordered including when not drawn by contracted lab provider and that 2) the licensed nurse communicates inability to obtain lab as ordered to the Charge Nurse for alternate interventions to obtain blood sample and 3) reporting to medical provider if unable to obtain and 4) education on the use of the PT/INR flow records for documenting lab results, next lab draw date and current and/or changing coumadin orders to maintain each resident therapeutic INR range and reporting all results outside of parameters to the Physician/Nurse Practitioner. Newly hired Administrators, Directors of Nursing, SDCs and Licensed Charge Nurses receive education during orientation.

On 2/7/22, the Interim Director of Nursing and Licensed Charge Nurses provided education to current facility and agency licensed nurses on lab process for residents on coumadin therapy to include; obtaining PT/INR labs as ordered, the

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corresponding lab results, sub/supratherapeutic levels, signs of coumadin toxicity, treatment for toxicity, drawing blood samples for PT/INRs, requisitions to contracted lab provider and reporting to nurse supervisor for alternate options to obtain the sample as ordered and reporting all lab results to the Physician/Nurse Practitioner. Education also included 1) responsibility of the licensed nurse to ensure blood samples are collected as ordered including when not drawn by contracted lab provider and that 2) the licensed nurse communicates inability to obtain lab as ordered to the Charge Nurse for alternate interventions to obtain blood sample and 3) reporting to medical provider if unable to obtain and 4) education on the use of the PT/INR flow records for current PT/INR parameters, documenting lab results, next lab draw date and current and/or changing coumadin orders to maintain each resident therapeutic INR range and reporting all results outside of parameters to the Physician/Nurse Practitioner. Effective 2/8/2022, Nurse Aides were educated by the Director of Nurses concerning reporting to Licensed Nurses any adverse side effects of coumadin therapy including discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath or nose bleeds.

The Director of Nursing will utilize a master employee list to track completion of education. This responsibility was communicated to the Director of Nursing by the Director of Regulatory and Risk on 2/7/22. Staff will not be allowed to work until education is completed. Education will also be included during orientation for newly hired staff.

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Effective 2/7/22, the licensed nurse assigned the day resident lab is ordered to be drawn will ensure PT/INR labs are obtained as ordered, documented on the MAR and on the individual PT/INR flow record and all results reported to the physician/nurse practitioner. The licensed nurse will complete a lab requisition, place requisition in the lab binder on the nursing unit and document on the lab log all orders for PT/INRs. The lab order will be transcribed into the resident electronic medical record which will display new order on the Medication Administration Record (MAR). Licensed Nurses will refer to electronic medical record for all new PT/INR physician orders. If PT/INRs order are to be drawn on Mondays, Wednesdays, or Fridays the contracted lab provider will obtain blood samples. The licensed nurse is responsible for obtaining on alternate dates or in the absence of the contracted lab provider. If the licensed nurse or nurse supervisor is unable to obtain lab draw as ordered, the Physician/Nurse Practitioner will be notified, interventions and/or new orders implemented and documented in the medical record. The licensed nurse receiving PT/INR lab results will report results to physician/nurse practitioner and implement new orders as indicated. The individual resident PT/INR flow record will be updated by the licensed nurse and maintained in the lab binder on the nursing unit. Flow records will be reviewed by nursing management in clinical morning meeting to monitor ongoing compliance. Education was initiated on 2/7/22 by the Interim Director of Nursing for all Licensed Nurses (including agency Licensed Nurses) concerning this systemic change in PT/INR lab process. The Director of Nursing will utilize a master employee list to track

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completion of education. This responsibility was communicated to the Director of Nursing by the Director of Regulatory and Risk on 2/7/22. Licensed facility and agency licensed nurses not receiving education on 2/7/22 will not work until education completed. Education will also be included during orientation for newly hired staff.

On 2/7/22, the Regional Director of Clinical Services provided education to the Administrator, DON (Director of Nursing) and charge nurses on monitoring PT/INR flow records during morning clinical meeting to validate labs are obtained as ordered and reported to the physician. Education also included validating with the physician/nurse practitioner if INRs are not within the residents' therapeutic level to ensure appropriate additional interventions were followed to protect the resident from serious side effects. Newly hired Administrators, DONs and charge nurses will receive education during orientation.

Effective 2/7/22, the Administrator or Director of Nursing will monitor residents with PT/INR orders to ensure compliance with obtaining, reporting, and monitoring as ordered. Audits will be completed five times weekly.

Effective 2/7/2022, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged Date of IJ Removal: 2/9/22

A credible allegation validation for unnecessary medications was conducted in the facility on 02/11/22. Record review included Resident #1's care plan updates, nurse charting, physician's

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F 757	Continued From page 169 orders and lab results. Review included an in-service training of all nurses to include the importance of following physician's orders for obtaining PT/INR's and reporting all abnormal values to the provider promptly. The in-service also provided education on monitoring residents on Coumadin therapy by utilizing PT/INR logs which included the following for each resident: set PT/INR perimeters, when labs were drawn, current Coumadin dosage, when the next lab was to be drawn, as well as any Coumadin dosage changes. The facility's IJ removal date of 2/9/22 was confirmed.	F 757		
F 760 SS=E	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 and staff, Nurse Practitioner (NP), and Physician interviews the facility failed to administer insulin per physician's orders for 2 of 2 sampled residents (Resident #16 and #17). 1. Resident #16 was admitted to the facility on 2/24/20 with diagnoses that included diabetes. Resident #16 care plan for diabetes mellitus revised on 4/5/21 included interventions that included provide diabetes medication as ordered by doctor. A physician's order dated 11/30/21 indicated Resident #16 was to receive Humalog Kwikpen 100 u/mL solution pen injector- give 10 units three	F 760	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to administer insulin per physician orders for resident #16 and resident #17. On 2/14/2022 the licensed nurse notified Physician on missed insulin administration. No adverse side effects noted. Resident #16 and resident #17 will continue to receive insulin medication as ordered. How the facility will identify other residents	3/25/22

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F 760	Continued From page 170 times daily. A physician's order dated 12/24/21 indicated Resident #16 was to receive Lantus SoloStar 100 u/mL (units/milliliter) solution pen injector- give 30 units daily. Review of Resident #16's physician orders revealed there was no active order to check blood sugar. An Annual Minimum Data Set (MDS) dated 01/07/22 indicated Resident #16 was cognitively intact and received 7 days of insulin injections during the reference period. The review of the Medication Administration Record (MAR) for January 2022 revealed no documentation that Resident #16 was administered her scheduled insulin on 6 days. According to the MAR, Resident #16 did not receive Humalog Kwikpen on 01/01/22, 01/02/22, 01/03/22 and 01/04/22. There was no documentation on the January MAR that Lantus insulin was administered on 01/03/22, 01/05/22 and 01/06/22. An interview on 02/08/22 at 11:40 AM with Nurse #3 revealed she worked with Resident #16 on 01/01/22 and 01/02/22 and did not administer the scheduled insulin to Resident #16 because the insulin was not available. An interview on 2/10/22 at 1:35 PM with Nurse #21 revealed she worked with Resident #16 on 01/03/22 and did not administer the scheduled insulin to Resident #16 because the insulin was not available.	F 760	having the potential to be affected by the same deficient practice; Effective 3/14/2022 the Director of Nursing and/or designee reviewed current residents insulin orders to ensure insulin is administered per physician order. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Director of Nursing and/or designee educated current facility and agency Licensed Nurses on ensuring insulin is administered per physician order. Education included medication availability, ordering, reordering and follow-up with pharmacy and physician if medication is not available as ordered for administration. The licensed nurse will administer insulin as ordered by the physician. To ensure medication availability, the licensed nurse recieving order will transcribe order upon receipt from physician into the Electronic Medical Record (EMR)for pharmacy fill. The licensed nurse receiving medications from pharmacy will promptly store medication on the medication cart for that resident. Refills requests will be made by the licensed nurse within three days of completion of current medication supply to ensure delivery of refill for administration as ordered. If medication is not available for administration as ordered, the licensed nurse will notify the physician and	

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F 760	Continued From page 171 Nurse #23 was assigned to Resident #16 on 01/04/22 and was unable to be reached for an interview. An interview on 02/03/22 at 3:40 PM with the Nurse Practitioner revealed not receiving ordered insulin placed Resident #16 at increased health risk and was a significant medication error. An interview on 02/09/22 at 5:30 PM with the Physician revealed she expected all residents to receive all medications as ordered. An interview on 02/08/22 at 12:21 PM with the Administrator and Interim Director of Nursing revealed they expected medications to be administered as ordered and residents who receive insulin should be monitored for adverse effects. 2. Resident #17 was admitted to the facility on 11/23/21 with diagnoses that included diabetes. Resident #17 care plan for diabetes mellitus revised on 4/2/21 included interventions that included provide diabetes medication as ordered by doctor. A physician's order dated 12/17/21 indicated Resident #17 was to receive Insulin Glargine-yfgn 100 u/mL solution pen injector- give 27 units daily and Resident #17's blood sugars were to be obtained when administering the insulin daily. A quarterly MDS dated 1/9/22 indicated Resident #17 was cognitively impaired and received 7 days of insulin injections during the reference period. The review of the Medication Administration	F 760	follow-up as advised. Effective 3/24/2022 any facility and agency Licensed Nurses that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee. Effective 3/24/2022 newly hired facility and agency Licensed nurses will receive education during orientation and prior to working. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit 3 residents insulin orders to ensure it is available and administered per physician order 3x a week x 4 weeks, 2x a week x 4 weeks and weekly x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 760	Continued From page 172 Record (MAR) for January 2022 documented Resident #17 was not administered Insulin-Glargine-yfgn 27 units as ordered on the following dates 01/05/22, 01/06/22 and 01/07/22. The MAR also indicated Resident #17's blood sugars fluctuated between 119-263 and she had no recent A1C's available on the chart. An interview on 2/9/22 at 7:23 PM with Nurse #22 revealed she worked with Resident #17 on 01/05/22, 01/06/22 and 01/07/22 and did not administer her ordered insulin due to it being unavailable from pharmacy and did not locate the ordered insulin in the backup supply. An interview on 2/3/22 at 3:40 PM with the Nurse Practitioner revealed not receiving ordered insulin placed Resident #16 at increased health risk and was a significant medication error. An interview on 02/09/22 at 5:30 PM with the Physician revealed she expected all residents to receive all medications as ordered. An interview on 02/08/22 at 12:21 PM with the Administrator and Interim Director of Nursing revealed they expected medications to be administered as ordered and residents who receive insulin should be monitored for adverse effects.	F 760		
F 761 SS=E	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	F 761		3/25/22

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ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 173 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §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 interview the facility failed to store controlled substances in a permanently affixed compartment of the refrigerator for 1 of 2 medication rooms reviewed (back 200 hall medication room) and the facility also failed to store over the counter medications in their original package for 2 of 4 medication carts reviewed (400 hall (COVID) and 100 hall (front)). The findings included: 1. An observation of the 200 hall back medication room was conducted on 02/03/22 at 2:47 PM with Nurse #10. The observation revealed an unlocked medication refrigerator that contained	F 761	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to store controlled substances in a permanently affixed compartment of the refrigerator under double lock and key. Controlled substances permanently affixed to refrigerator on 3/9/2022. The facility failed to store over the counter medications in their original package. Improperly packaged medications were disposed of on 3/7/22.	

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F 761	Continued From page 174 the following: lorazepam (controlled substance) 2 milligrams (mg)/1 milliliter (ml) 4 vials and lorazepam 2 mg/ml 1 bottle of 30 ml. The controlled substances were lying in the refrigerator not in any secured compartment. Nurse #10 was interviewed on 02/03/22 at 2:53 PM. Nurse #10 stated that the medication refrigerator should have been locked because all controlled substances needed to be secured under double lock. Nurse #10 stated that she took the lorazepam and put it in the other medication room that had a permanently affixed compartment that was under double lock and notified the nurses where to find the medication if they needed it. The interim Director of Nursing (DON) was interviewed on 02/07/22 at 3:40 PM. The DON stated that controlled substances should be kept under double lock in a permanently affixed locked container. 2.a. On 02/02/22 at 6:00 AM an observation was made of the 400 Hall (COVID) medication cart that had over the counter medications stored in plastic medication cups with the names of the medications written on the cups. The medications were: 16 Colace capsules, 23 Senna plus tablets, 2 Aspirin tablets, 14 Aspirin 81 tablets, 7 Zinc 220 tablets and 8 Vitamin C tablets. An interview with Nurse #16 on 02/02/22 at 6:00 AM revealed the nurses will borrow over the counter medications from the other medication carts because sometimes the facility will run out of over the counter medications. The Nurse acknowledged that nurses should not be pouring medications from containers that were not	F 761	How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/2022 all medication rooms were reviewed by the Director of Nursing (DON) to ensure controlled substance box are permanently affixed to refrigerator under double lock and key. No additional concerns identified. Effective 3/14/2022 over the counter medications were reviewed by the DON to ensure proper packaging and storage. Improperly stored medication that were not in original package were disposed of. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Director of Nursing and/or designee will educate current facility and agency License Nurses and Medication Aides on controlled substance box being permanently affixed to refrigerator and over the counter medications being kept in its original package. The Unit Coordinators will monitor medication storage rooms and carts at least weekly for proper storage. Newly hired facility and agency licensed nurses and medication aides will receive education during orientation and prior to working.	

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F 761	Continued From page 175 appropriately labeled by the manufacture. b. On 02/02/22 at 6:25 AM an observation was made of the 100 Hall (Front) medication cart that had an unlabeled plastic medication cup with 10 white oblong pills in the cups. An interview was conducted with Nurse #8 on 02/02/22 at 6:25 AM. The Nurse explained that when the facility ran out of stocked over the counter medications the nurses borrowed the medications from another cart until the medication room was restocked. The Nurse acknowledged that the nurses should not be pouring medications from unidentified containers. During an interview with the Supply Clerk on 02/04/22 at 10:18 AM she explained that she was in charge of the central supply room and recently took over the responsibility of ordering the over the counter medications a couple of months ago but was still very much learning how to do it. She continued to explain that she asked a couple of nurses to make a list of the needed over the counter medications and ordered them and the medications were in her office and ready to be put in the medication rooms. An observation of multiple bottles of over the counter medications were stored on a cart in the Supply Clerk's office. A follow up interview with the Supply Clerk on 02/04/22 at 12:25 PM revealed the delivery truck with the over the counter medications was delayed for two weeks and some of the medications were on back order. Regardless, the Supply Clerk stated there was no reason for the over the counter medications to run out of stock because she could always order the medications from the facility's pharmacy and could go to the	F 761	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit medication rooms to ensure controlled substance box is permanently affixed to refrigerator and over the counter medications are in its original package weekly x 12 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 761	Continued From page 176 local pharmacy to get the medications. During an interview with the Administrator and acting Director of Nursing (DON) on 02/07/22 at 3:40 PM the DON explained that there should not be any reason why the medication rooms would run out of medications especially over the counter medications because the Supply Clerk could go to the local pharmacy and purchase enough medications until the regular supply order arrived. The Administrator stated that her expectation was that there would be enough medications to supply each of the medication carts.	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, test tray, resident, and staff interview the facility failed to serve palatable food that was appetizing in appearance, taste, and temperature for 2 of 4 residents reviewed with food concerns (Resident #6 and Resident #10). The findings included: 1. An observation of the breakfast tray line was conducted on 02/02/22 at 7:32 AM and a test tray	F 804	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to serve palatable food that was appetizing in appearance, taste, and temperature for resident #6 and resident #10. How the facility will identify other residents	3/25/22

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F 804	Continued From page 177 was requested at this time. The menu for the meal consisted of biscuits with gravy, scrambled eggs, and oatmeal. Temperature monitoring was conducted with Cook #1 on 02/02/22 at 7:35 AM. The test tray was plated at 8:22 AM and left the kitchen at 8:24 AM and arrived at the unit at 8:25 AM. The test tray was sampled on 02/02/22 at 9:05 AM after the last of the breakfast trays on the hall had been served. The Dietary Manager was present when the lid of the test tray was removed. There was no visible steam noted when the lid was lifted, and the hot plate was also cool to touch. A pat of butter was placed in the oatmeal bowl and slowly began to melt. The scrambled egg and gravy biscuit were tasted and were cool, not room temperature. The bottom of the biscuit was dark brown almost black and was tough to chew through. The oatmeal was warm but bland with no sweetness noted. The DM did not taste the test tray. When asked about why the scrambled eggs were cool not even warm temperature, she stated that they worked very hard to keep the food warm, but the nursing staff had to help them by passing the trays out to the resident immediately when they delivered them to the hallway. She explained when they sit on the hallway the food gets cold even with the hot plate, the lid, and the covered cart. The Administrator was interviewed on 02/07/22 at 3:40 PM. The Administrator stated that she expected the food served to the residents to be palatable and served at the right temperature and texture. She added she had never tried the food at the facility so she could not attest to the taste or temperature of any of the food due to her diet.	F 804	having the potential to be affected by the same deficient practice; Effective 3/14/2022 the Dietary Manager and Administrator completed a test tray to ensure food is appetizing in appearance, taste, and temperature and it was. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Dietary Manager or designee educated dietary staff on ensuring meals are palatable and appetizing in appearance, taste, and temperature. Newly hired dietary staff will be educated during orientation by Dietary Manager on ensuring meals served are palatable. The Dietary Manager will complete test trays weekly to ensure compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator and/or designee will audit a test tray twice weekly x 4 weeks, then weekly for 8 weeks to ensure food palatability. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

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F 804	Continued From page 178	F 804	Completion date: 3/25/2022	

The Administrator stated she expected the food to be served to the resident as soon as it arrived at the unit, so the food was hot for the residents to enjoy.

2a. Resident #10 was readmitted to the facility on 03/01/05.

Review of the quarterly Minimum Data Set (MDS) dated 01/09/22 indicated that Resident #10 was cognitively intact.

An observation and interview were conducted with Resident #10 on 02/02/22 at 9:24 AM. Resident #10 was up in her wheelchair sitting beside her bed. Her breakfast tray remained on her bedside table. The tray contained a plate that had a biscuit covered in gravy, scrambled eggs, and a small bowl of oatmeal. There was a bite or two of the biscuit gone and the rest of the tray remained untouched. Resident #10 stated that her breakfast was cold and did not taste very good but "I ate what I could."

2b. Resident #6 was admitted to the facility on 01/05/22.

Review of the admission Minimum Data Set (MDS) dated 01/13/22 revealed that Resident #6 was cognitively intact.

Resident #6 was interviewed on 02/02/22 at 11:49 AM. Resident #6 stated that he had been served a biscuit with gravy, eggs, and oatmeal for breakfast that day. He stated that food was "cold cold cold" it tasted a little bland, but the biscuit was so burnt it looked like a "dog biscuit." Resident #6 explained that the food was always cold because the dietary staff pushed the cart to

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F 804	Continued From page 179 the hallway and then it sat there for 30 minutes or more waiting on the staff to deliver it to us. Resident #6 stated the staff barely had enough time to bring us our tray let alone go and heat something up for us, so I just make do with what I get served which is usually room temperature or cold but never hot. Cook #1 was interviewed on 02/02/22 at 8:32 AM. Cook #1 stated that she temped the food each day just before they started plating the meal to ensure that the food was cooked to the appropriate temperature. Cook #1 stated that she was certain that when the food left the kitchen it was warm but added that "the trays seem to sit on the hallway a bit before the residents get them." The Dietary Manager (DM) was interviewed on 02/02/22 at 9:05 AM. The DM stated that when the food trays left the kitchen, she knew the food was hot, but the trays sat on the hallway for a while before getting served to the resident and the food gets cold. The DM stated she tried her best to serve hot food but "the nursing staff has to help us at some point."	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a	F 806		3/25/22

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F 806	Continued From page 180 different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interview the facility failed to provide the requested food preferences for the breakfast meal for 1 of 3 residents reviewed for preferences (Resident #8). The findings included: Resident #8 was admitted to the facility on 02/02/21. Review of the annual Minimum Data Set (MDS) dated 01/01/22 revealed that Resident #8 was cognitively intact. An observation and interview were conducted with Resident #8 on 02/04/22 at 9:16 AM. Resident #8 was sitting in her wheelchair next to her bed and had her breakfast tray in front of her that appeared to have little food eaten off of the tray. Resident #8 stated that she did not get what she ordered and explained that since she could not circle what she wanted from the menu, Nurse #1 had taken her order yesterday for this morning's breakfast meal. Resident #8 stated she ordered bacon, grits, toast, and jelly with orange juice to drink. She explained but she got oatmeal, sausage, and 2 french toast sticks, she further explained that she did not eat oatmeal and the french toast sticks were not what she wanted. Resident #8 stated that she had eaten the piece of sausage from the tray and drank her juice but that was it. Nurse #1 was interviewed on 02/04/22 at 10:23 AM. Nurse #1 confirmed that she had taken	F 806	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to provide the requested food preferences for resident #8. On 3/7/22 Dietary Manager provided 1:1 reeducation to dietary cook on plating food as indicated on resident meal tickets. How the facility will identify other residents having the potential to be affected by the same deficient practice; On 3/14/2022 Dietary Manager and/or designee completed a tray line observation during lunch to ensure meal tray are properly plated according to resident meal tickets. All meals plated according to meal ticket and resident preference. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Dietary Manager or designee educated dietary staff on ensuring resident receives what is ordered and indicated on meal ticket. The dietary staff are responsible for accurately reviewing meal tickets and meal trays to ensure accuracy before sending food to residents. Newly hired dietary staff will be	

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F 806	Continued From page 181 Resident #8's breakfast order for 02/04/22. She stated that Resident #8 had ordered grits, bacon, toast with jelly and wanted orange juice to drink. Nurse #1 stated she had circled the items on the menu and placed it back on Resident #8's meal tray to go back to the kitchen so the kitchen staff knew what she wanted to eat at breakfast on 02/04/22. The Dietary Manager (DM) was interviewed on 02/04/22 at 2:25 PM. The DM stated she could not explain what happened to Resident #8's menu for the day, she stated that the kitchen never received it so they served her what was on the regular menu. The DM stated that something happened to the menu between the hallway and the carts being returned to the kitchen but added she would follow up with Resident #8 so she could get what she wanted for lunch and dinner. The DM explained that the process was the menus for the following day would go out on the breakfast trays and either the resident or the nursing staff would circle what the resident wanted and then place the menu back on the tray to be returned to the kitchen. Once in the kitchen they would enter what the resident requested and print the tray ticket to be plated and served to the resident. Again, the DM could not explain what happened to Resident #8's menu but stated without her menu she would have been served what was on the regular menu which for breakfast that day which was french toast sticks, sausage, and oatmeal. The Administrator was interviewed on 02/07/22 at 3:40 PM. The Administrator stated that she expected that everyone that was able to decide what they wanted to eat, was given the opportunity to do so and the nursing staff would	F 806	educated during orientation by Dietary Manager on ensuring resident received what was requested on meal ticket. Effective 3/24/2022 Director of Nursing or designee will enhanced the education to facility and agency certified nursing assistants on ensuring when residents fill out the choice menu it is sent back on the meal tray to the kitchen or turned into Dietary Manager mailbox. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator and/or designee will audit 3 resident trays 3x weekly x 4 weeks, weekly x 4 weeks, bi-weekly x 4 weeks to ensure accuracy of food received per meal ticket. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 806	Continued From page 182 fill out the form and return it to the kitchen. The Administrator added then she expected the kitchen staff to serve what the resident requested.	F 806		
F 807 SS=E	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to provide fresh ice water for 5 of 5 residents reviewed for fluid preferences (Resident #2, #5, #12, #13 and #19). The finding included: 1. Resident #2 was admitted to the facility on 02/02/21. The quarterly Minimum Data Set assessment dated 11/24/21 revealed Resident #2 was cognitively intact. During an observation and interview with Resident #2 on 02/02/22 at 3:10 PM the Resident pointed to a Styrofoam cup which was approximately one fourth full of water and explained that the facility did not give him fresh ice water. He continued to explain that he normally got water from the faucet when he got up out of his bed.	F 807	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to provide fresh ice water for resident #2, resident #5, resident #12, resident #13 and resident #19. Fresh ice water was made available to resident #2, resident #5, resident #12, resident #13 and resident #19 on 2/7/2022 and daily thereafter. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/2022 the Director of Nursing and/or designee assessed current residents to ensure fresh water are available at bedside and within reach. Fresh ice water provided as needed.	3/25/22

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F 807	Continued From page 183 During an interview on 02/02/22 at 6:40 AM Nurse Aide (NA) #3 explained they passed out fresh ice water twice a shift on third shift. On 02/02/22 at 8:25 AM an interview was conducted with Nurse #11 who explained that ice water was passed out once a shift on third shift. On 02/03/22 at 3:15 PM an interview was conducted with Nurse #2 who stated he worked from 7:00 AM to 7:00 PM. The Nurse explained that the staff did not pass out fresh ice water on a routine basis and that he gave extra fluids when he gave the residents their medications. On 02/05/22 at 10:40 AM an interview was conducted with Nurse Aide (NA) #15 who stated she worked 7:00 PM to 7:00 AM. The NA explained that fresh ice water was passed out every day and that included changing out the ice cup every day as well. On 02/05/22 at 11:45 AM an interview was conducted with Nurse Aide (NA) #7 who explained that fresh ice water was passed out once a shift and the ice cups were changed out every day on third shift. On 02/05/22 at 12:20 PM an interview was conducted with Nurse Aide (NA) #16 who worked first and second shifts. The NA explained that fresh ice water was passed out once a shift and the ice cups were changed out on third shift. An interview was conducted with Nurse #4 on 02/10/22 at 12:00 PM. The Nurse explained that she worked from 7:00 AM to 7:00 PM and fresh ice water should be passed out at the beginning and the end of the shift. The Nurse stated the	F 807	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Director of Nursing and/or designee educated current Certified Nursing Assistants and License Nurses on ensuring residents have fresh water available at bedside and within reach. Certified Nursing Assistants will be responsible for passing ice water each shift and as requested by the resident to ensure proper hydration. Effective 3/24/2022 any Certified Nursing Assistances and License Nurses that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee. Effective 3/24/2022 all Certified Nursing Assistances and License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on “ensuring residents have fresh water available at bedside and within reach.” Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit 3 residents to ensure fresh water are available at the bedside and within reach 3 X week X 4 weeks, weekly X 4 weeks, and bi-weekly X 4 weeks.	

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F 807	Continued From page 184 Styrofoam cups should be changed every day on third shift. An interview was conducted with Nurse Aide (NA) #17 on 02/10/22 at 12:10 PM. The NA explained that he worked first and second shift and he passed out fresh ice water in the mornings and checked at 10:00 AM and after lunch to see if the resident needed more water. The NA stated the ice chest stayed on the hall for easy access when the residents requested more water. 2. Resident #5 was admitted to the facility on 04/14/16. The quarterly Minimum Data Set assessment dated 10/24/21 revealed Resident #5 was cognitively intact. During an observation and interview with Resident #5 on 02/03/22 at 10:40 AM the Resident explained that a few months ago the Resident Council voiced concerns that the residents were not receiving fresh ice water and the staff got better at passing out fresh ice water every shift. The Resident continued to explain that now the staff do not give them fresh ice water and pointed to an empty Styrofoam cup dated 01/29/22. The Resident stated the staff told him that he had to ask for the fresh ice water and he did not believe he should have to ask for fresh ice water. During an observation and interview with Resident #5 on 02/03/22 at 2:45 PM the Resident pointed out that he still did not have fresh ice water. During an interview on 02/02/22 at 6:40 AM	F 807	Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 807	Continued From page 185	F 807		

Nurse Aide (NA) #3 explained they passed out fresh ice water twice a shift on third shift.

On 02/02/22 at 8:25 AM an interview was conducted with Nurse #11 who explained that ice water was passed out once a shift on third shift.

On 02/03/22 at 3:15 PM an interview was conducted with Nurse #2 who stated he worked from 7:00 AM to 7:00 PM. The Nurse explained that the staff did not pass out fresh ice water on a routine basis and that he gave extra fluids when he gave the residents their medications.

During an observation and interview with Resident #5 on 02/04/22 at 9:30 AM and 12:15 PM the Resident pointed out that he still did not have fresh ice water and the cup was dated 01/29/22.

On 02/05/22 at 10:40 AM an interview was conducted with Nurse Aide (NA) #15 who stated she worked 7:00 PM to 7:00 AM. The NA explained that fresh ice water was passed out every day and that included changing out the ice cup every day as well.

On 02/05/22 at 11:45 AM an interview was conducted with Nurse Aide (NA) #7 who explained that fresh ice water was passed out once a shift and the ice cups were changed out every day on third shift.

On 02/05/22 at 12:20 PM an interview was conducted with Nurse Aide (NA) #16 who worked first and second shifts. The NA explained that fresh ice water was passed out once a shift and the ice cups were changed out on third shift.

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An interview was conducted with Nurse #4 on 02/10/22 at 12:00 PM. The Nurse explained that she worked from 7:00 AM to 7:00 PM and fresh ice water should be passed out at the beginning and the end of the shift. The Nurse stated the Styrofoam cups should be changed every day on third shift.

An interview was conducted with Nurse Aide (NA) #17 on 02/10/22 at 12:10 PM. The NA explained that he worked first and second shift and he passed out fresh ice water in the mornings and checked at 10:00 AM and after lunch to see if the resident needed more water. The NA stated the ice chest stayed on the hall for easy access when the residents requested more water.

3. Resident #12 was admitted to the facility on 09/12/21.

The quarterly Minimum Data Set assessment dated 12/12/21 revealed Resident #12 was cognitively intact.

During an interview on 02/02/22 at 6:40 AM Nurse Aide (NA) #3 explained they passed out fresh ice water twice a shift on third shift.

On 02/02/22 at 8:25 AM an interview was conducted with Nurse #11 who explained that ice water was passed out once a shift on third shift.

During an observation and interview with Resident #12 on 02/03/22 at 11:00 AM the Resident explained that the staff did not pass out fresh ice water on a routine basis and pointed to him empty Styrofoam cup dated 01/29/22. The Resident continued to explain that he was able to ambulate to the bathroom and would get a drink

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F 807	Continued From page 187	F 807		

of water from the faucet when he needed it.

During an observation and interview with Resident #12 on 02/03/22 at 2:45 PM the Resident pointed out that he still did not have fresh ice water.

On 02/03/22 at 3:15 PM an interview was conducted with Nurse #2 who stated he worked from 7:00 AM to 7:00 PM. The Nurse explained that the staff did not pass out fresh ice water on a routine basis and that he gave extra fluids when he gave the residents their medications.

During an observation and interview with Resident #12 on 02/04/22 at 9:30 AM and 12:15 PM the Resident pointed out that he still did not have fresh ice water and the cup was dated 01/29/22.

On 02/05/22 at 10:40 AM an interview was conducted with Nurse Aide (NA) #15 who stated she worked 7:00 PM to 7:00 AM. The NA explained that fresh ice water was passed out every day and that included changing out the ice cup every day as well.

On 02/05/22 at 11:45 AM an interview was conducted with Nurse Aide (NA) #7 who explained that fresh ice water was passed out once a shift and the ice cups were changed out every day on third shift.

On 02/05/22 at 12:20 PM an interview was conducted with Nurse Aide (NA) #16 who worked first and second shifts. The NA explained that fresh ice water was passed out once a shift and the ice cups were changed out on third shift.

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An interview was conducted with Nurse #4 on 02/10/22 at 12:00 PM. The Nurse explained that she worked from 7:00 AM to 7:00 PM and fresh ice water should be passed out at the beginning and the end of the shift. The Nurse stated the Styrofoam cups should be changed every day on third shift.

An interview was conducted with Nurse Aide (NA) #17 on 02/10/22 at 12:10 PM. The NA explained that he worked first and second shift and he passed out fresh ice water in the mornings and checked at 10:00 AM and after lunch to see if the resident needed more water. The NA stated the ice chest stayed on the hall for easy access when the residents requested more water.

4. Resident #13 was admitted to the facility on 07/16/16.

The annual Minimum Data Set assessment dated 12/19/21 revealed Resident #13 was cognitively intact.

During an interview on 02/02/22 at 6:40 AM Nurse Aide (NA) #3 explained they passed out fresh ice water twice a shift on third shift.

On 02/02/22 at 8:25 AM an interview was conducted with Nurse #11 who explained that ice water was passed out once a shift on third shift.

On 02/03/22 at 3:15 PM an interview was conducted with Nurse #2 who stated he worked from 7:00 AM to 7:00 PM. The Nurse explained that the staff did not pass out fresh ice water on a routine basis and that he gave extra fluids when he gave the residents their medications.

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During an observation and interview with Resident #13 on 02/04/22 at 9:20 AM the Resident did not have fresh ice water or water cup in her room. The Resident stated they have not brought her fresh water yet.

During an observation and interview with Resident #13 on 02/04/22 at 5:15 PM the Resident did not have fresh water at her bedside and stated they still have not brought her fresh water yet today.

On 02/05/22 at 10:40 AM an interview was conducted with Nurse Aide (NA) #15 who stated she worked 7:00 PM to 7:00 AM. The NA explained that fresh ice water was passed out every day and that included changing out the ice cup every day as well.

On 02/05/22 at 11:45 AM an interview was conducted with Nurse Aide (NA) #7 who explained that fresh ice water was passed out once a shift and the ice cups were changed out every day on third shift.

On 02/05/22 at 12:20 PM an interview was conducted with Nurse Aide (NA) #16 who worked first and second shifts. The NA explained that fresh ice water was passed out once a shift and the ice cups were changed out on third shift.

An interview was conducted with Nurse #4 on 02/10/22 at 12:00 PM. The Nurse explained that she worked from 7:00 AM to 7:00 PM and fresh ice water should be passed out at the beginning and the end of the shift. The Nurse stated the Styrofoam cups should be changed every day on third shift.

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F 807	Continued From page 190	F 807		

An interview was conducted with Nurse Aide (NA) #17 on 02/10/22 at 12:10 PM. The NA explained that he worked first and second shift and he passed out fresh ice water in the mornings and checked at 10:00 AM and after lunch to see if the resident needed more water. The NA stated the ice chest stayed on the hall for easy access when the residents requested more water.

5. Resident #19 was admitted to the facility on 10/14/21.

The admission Minimum Data Set assessment dated 10/19/21 revealed Resident #19 was cognitively intact.

During an interview on 02/02/22 at 6:40 AM Nurse Aide (NA) #3 explained they passed out fresh ice water twice a shift on third shift.

On 02/02/22 at 8:25 AM an interview was conducted with Nurse #11 who explained that ice water was passed out once a shift on third shift.

During an observation and interview with Resident #19 on 02/03/22 at 9:30 AM the Resident explained that a few months ago in a Resident Council meeting the residents brought up that they were not getting fresh ice water. The Resident continued to explain that the staff got better for a while about giving them fresh ice water every shift but recently COVID hit the facility and the facility lost a lot of staff and now they were back to not getting fresh ice water on a routine basis. The Resident stated she could go days without fresh ice water. The Resident pointed to an undated Styrofoam cup that was about half full of water and stated they were supposed to get fresh ice water every shift and a

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new cup every day. The Resident stated it had been a month since she has had a new Styrofoam cup. Observation of the cup revealed no debris on the inside of the cup.

On 02/03/22 at 3:15 PM an interview was conducted with Nurse #2 who stated he worked from 7:00 AM to 7:00 PM. The Nurse explained that the staff did not pass out fresh ice water on a routine basis and that he gave extra fluids when he gave the residents their medications.

During an observation and interview with Resident #19 on 02/04/22 at 3:05 PM the Resident pointed to her undated Styrofoam cup that was half full of water. The Resident stated she still did not have fresh water.

On 02/05/22 at 10:40 AM an interview was conducted with Nurse Aide (NA) #15 who stated she worked 7:00 PM to 7:00 AM. The NA explained that fresh ice water was passed out every day and that included changing out the ice cup every day as well.

On 02/05/22 at 11:45 AM an interview was conducted with Nurse Aide (NA) #7 who explained that fresh ice water was passed out once a shift and the ice cups were changed out every day on third shift.

On 02/05/22 at 12:20 PM an interview was conducted with Nurse Aide (NA) #16 who worked first and second shifts. The NA explained that fresh ice water was passed out once a shift and the ice cups were changed out on third shift.

An interview was conducted with Nurse #4 on 02/10/22 at 12:00 PM. The Nurse explained that

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F 807	Continued From page 192 she worked from 7:00 AM to 7:00 PM and fresh ice water should be passed out at the beginning and the end of the shift. The Nurse stated the Styrofoam cups should be changed every day on third shift. An interview was conducted with Nurse Aide (NA) #17 on 02/10/22 at 12:10 PM. The NA explained that he worked first and second shift and he passed out fresh ice water in the mornings and checked at 10:00 AM and after lunch to see if the resident needed more water. The NA stated the ice chest stayed on the hall for easy access when the residents requested more water. On 02/07/22 at 3:45 PM during an interview with the Administrator and Interim Director of Nursing (DON) the Administrator confirmed that Resident Council voiced a concern about not getting fresh ice water on a routine basis and she put a system in place that ice water would be passed out every shift and upon request and that a fresh water cup would be given out on third shift. The Administrator continued to explain that she monitored the system for a while and then COVID hit the building and the vaccine was mandated which caused the facility to be staff challenged and the system fell through. The Administrator stated she was not aware that the residents were not getting fresh ice water but that it was her expectation for the residents to get fresh ice water every shift and a new water cup every day.	F 807		
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 -	F 812		3/25/22

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F 812	Continued From page 193 §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 staff interview the facility failed to remove expired milk from 2 of 2 refrigerator storage areas (reach in refrigerator and refrigerator), failed to seal open food items in 2 of 4 storage areas (reach in freezer and refrigerator) and failed to remove 2 heads of cabbage with signs of spoilage from 1 of 2 refrigerator storage areas (refrigerator). These practices had the potential to affect food served to residents. The findings included: a. An observation of the reach in refrigerator was made on 02/02/22 at 6:37 AM along with Cook #1. The observation revealed 25 cartons of fat free milk that expired on 01/29/22 and one gallon of whole milk that expired on 01/31/22. Cook #1 was interviewed on 02/02/22 at 6:40 AM. Cook #1 stated that generally the dietary aides	F 812	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to remove expired milk from refrigerator storage area. Item discarded on 2/2/22. The facility failed to seal open food items and failed to remove spoiled item. Items discarded on 2/2/22. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/14/2022 Dietary staff checked dry storage, refrigerator and freezer section for expired and/or open and	

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F 812	Continued From page 194 went through refrigerator/freezers and removed expired items. Cook #1 instructed one of the dietary aides to discard the expired milk and stated that the Dietary Manager was on her way to the facility. b. An observation of the refrigerator was made on 02/02/22 at 6:47 AM along with Cook #1. The observation revealed 2 gallons of whole milk that expired on 01/27/22, 3 gallons of Vitamin D milk that expired on 01/30/22, and 3 gallons of 2% milk that expired on 01/30/22. There were also 2 heads of cabbage that were lying on the cold rack in the refrigerator and was noted to have black/brown leaves on the outer layers of both heads of cabbage. There was also a bag of hot dogs that were open to air and not sealed. Cook #1 was interviewed on 02/02/22 at 6:49 AM. Cook #1 stated that generally the dietary aides went through refrigerator/freezers and removed expired items. She stated that all open items should be labelled and dated and should be sealed up when done with the item. Cook #1 instructed one of the dietary aides to discard the expired milk and stated that the Dietary Manager was on her way to the facility and could decide what to do with the cabbage. c. An observation of the reach in freezer was made on 02/02/22 at 6:41 AM along with Cook #1. The observation revealed 2 boxes of cookies that were open to air and had not been sealed. The cookies appeared to have ice crystals on them. There was also an open bag of cinnamon rolls that were left open to air and had not been sealed. There was no ice crystals noted on the cinnamon rolls with no obvious freezer burn.	F 812	unwrapped food items. No additional concerns identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Dietary Manager or designee educated dietary staff on discarding spoiled items, expired items, and when opening items, wrap, label and date items. The Dietary Manager and cooks will monitor dry storage, refrigerator and freezer section for spoilage, expired and/or open and unwrapped food items daily during their shift. Effective 3/24/2022 newly hired dietary staff will be educated during orientation by Dietary Manager discarding expired items, and when opening items wrapping, label and dating. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit will be completed by Dietary Manager or designee as follows: 5 times weekly x 4 weeks, weekly x 4 weeks, bi-weekly x 4 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

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F 812	Continued From page 195 Cook #1 was interviewed on 02/02/22 at 6:49 AM. She stated that all open items should be labelled and dated and should be sealed up when done with the item. The Dietary Manager (DM) was interviewed on 02/03/22 at 9:27 AM. The DM stated that anyone who put things in the refrigerator or freezer was supposed to date everything "7 days in and 7 days out." The Cooks were responsible for checking to ensure that the food items were not expired. The DM explained that for some reason the facility had not gotten milk on their delivery truck, and they had to go buy gallons of milk until the next truck was delivered to the facility. She added that she had instructed the staff last week to throw out the expired milk products and was adamant that the staff were aware that when they open a bag, they must close and seal the bag, "they got lazy." The DM further stated that the cabbage should have been discarded when the leaves turned brown/black. The Administrator was interviewed on 02/07/22 at 3:40 PM. The Administrator stated that she expected all expired food products to be discarded and any open food item should be resealed and dated.	F 812	Completion date: 3/25/2022	
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 835		3/25/22

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F 835	Continued From page 196 by: Based on record review and staff, Nurse Practitioner (NP), and Physician interviews, the facility failed to provide leadership and oversight to ensure effective systems were in place for obtaining PT/INRs (Prothrombin Time Test/ International Normalized Ratio) as ordered by the MD/NP and communicating laboratory results of the PT/INRs for monitoring and regulating of Coumadin (an oral blood thinner) dosage. The facility also failed to have the supplies needed for staff to obtain the PT/INRs for 1 of 1 resident reviewed for unnecessary medication (Resident #1). The immediate jeopardy began on 12/17/21 when the facility failed to have a system in place to ensure orders for daily PT/INRs were followed and supplies to obtain PT/INRs were available for staff to use. The immediate jeopardy was removed on 02/8/22 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity of a E (harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings included: This tag is cross referred to F757. Based on record review and staff, Nurse Practitioner (NP), and Physician (MD) interviews, the facility failed to follow physician's orders for obtaining scheduled Prothrombin Time Test/ International Normalized Ratio (PT/INR), a test used to help detect and diagnose a bleeding disorder or excessive clotting disorder, laboratory	F 835	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Administration failed to have effective systems in place for obtaining PT/INRs as ordered by the Physician/Nurse Practitioner and communicating results of the PT/INRs for monitoring and regulating of Coumadin dosage. This failure occurred due to administration not effectively monitoring compliance of PT/INR management which resulted in Resident #1 PT/INRs not being completed as per physician order and the medical provider not being notified of PT/INR levels outside the given parameters of 2.0- 3.0 for Resident #1. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 2/7/22, the Interim Director of Nursing and licensed charge nurse reviewed current facility residents with orders for PT/INR labs to ensure labs are being obtained as ordered and reported to the physician/nurse practitioner. One additional resident identified with PT/INR results outside given levels not being documented as reported to the medical provider as ordered. The licensed nurse notified Nurse Practitioner on 2/7/22. PT/INR flow record initiated, anticoagulant care plan and MAR updated by the licensed nurse to include monitoring for	

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F 835	Continued From page 197 (lab) studies. The facility also failed to notify the medical provider of abnormal laboratory results outside the perimeters of 2.0-3.0 for 1 of 2 residents reviewed for unnecessary medications (Resident #1) which resulted in Resident #1 undergoing exploratory abdominal surgery and removal of a very large hematoma. The Administrator was notified of immediate jeopardy on 02/06/21 at 10:25 AM. The facility submitted the following immediate jeopardy removal plan. F835: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: Administration failed to have effective systems in place for obtaining PT/INRs as ordered by the Physician/Nurse Practitioner and communicating results of the PT/INRs for monitoring and regulating of Coumadin dosage. This failure occurred due to administration not effectively monitoring compliance of PT/INR management which resulted in Resident #1 PT/INRs not being completed as per physician order and the medical provider not being notified of PT/INR levels outside the given parameters of 2.0- 3.0 for Resident #1. Effective 2/7/22, the Interim Director of Nursing and licensed charge nurse reviewed current facility residents with orders for PT/INR labs to ensure labs are being obtained as ordered and reported to the physician/nurse practitioner. One additional resident identified with PT/INR results outside given levels not being documented as reported to the medical provider as ordered. The	F 835	adverse side effects and reporting to physician/nurse practitioner all PT/INR lab results and adverse side effects for follow-up intervention. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 2/7/22, the Director of Regulatory and Risk Management provided education to the Administrator, Interim Director of Nursing, SDC (Staff Development Coordinator) and Licensed Charge Nurses on the facility lab process and oversight of PT/INR management which includes ensuring the process is monitored by Administration for compliance. Effective 3/24/2022 Director of Nursing and/or designee educated current license nurses on the facility lab process. Effective 3/24/2022 any License Nurses that has not been educated will not be allowed to work until receive education in-person or via telephone by Director of Nursing and/or designee. Effective 3/24/2022 all License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on facility lab process. Indicate how the facility plans to monitor	

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F 835	Continued From page 198 licensed nurse notified Nurse Practitioner on 2/7/22. PT/INR flow record initiated, anticoagulant care plan and MAR updated by the licensed nurse to include monitoring for adverse side effects and reporting to physician/nurse practitioner all PT/INR lab results and adverse side effects for follow-up intervention. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 2/7/22, the Administrator, Interim Director of Nursing, Regional Director of Operations and the Director of Regulatory and Risk Management conducted an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting to discuss root cause analysis of the facilities failure to have an effective system in place for obtaining Resident #1 PT/INRs as ordered by the physician/nurse practitioner and communicating results of the PT/INRs for monitoring and regulating of Coumadin dosage. Facility corrective action plan was formulated to include coumadin management policy review without revisions, education, lab process update, required monitoring/audits, and needed follow-up reviews for compliance by the QAPI Committee. Root cause determined that Administration did not have effective oversight of PT/INR management due to lack of compliance monitoring of system which resulted in failure to obtain PT/INRs as ordered for residents on Coumadin and communicating results of the PT/INRs for monitoring and regulating of Coumadin dosage. This failure was the result of the facility not fully implementing the lab process to include review of labs (PT/INR orders/results) during daily clinical meeting.	F 835	its performance to make sure that solutions are sustained: Effective 3/24/22, the Director of Nursing will monitor residents on Coumadin therapy for administrative oversight to ensure compliance with obtaining, reporting and monitoring as ordered during morning clinical meetings and weekly risk meetings x 12 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 835	Continued From page 199	F 835		

The failure to monitor the lab process by Administration resulted in PT/INRs not being completed as ordered and results outside parameters not being communicated to the medical provider. Therefore,on 2/7/22, the Director of Regulatory and Risk Management provided education to the Administrator, Interim Director of Nursing, SDC (Staff Development Coordinator) and Licensed Charge Nurses on the facility lab process and oversight of PT/INR management which includes ensuring the process is monitored by Administration for compliance. Licensed Charge Nurses should provide oversight to the Licensed Nurses to ensure the PT/INRs are obtained as ordered. Additional monitoring of the lab process for PT/INRs should occur in morning clinical meeting by the Administrator, Director of Nursing, SDC and Licensed Charge Nurses utilizing the facility lab process for PT/INR management. Director of Nursing should ensure the lab process is followed with review of all residents on Coumadin in the morning clinical meeting. The review should ensure labs (PT/INRs) orders are completed as ordered with notification to the provider for results outside of the PT/INR parameters. This notification should be documented in the medical record for the resident by the Licensed Nurse. Administration (Director of Nursing, SDC, or Licensed Charge Nurses) should provide re-education to Licensed Nurses if oversight monitoring of the PT/INR lab process reveals non-compliance from Licensed Nurses. This education should be documented. Newly hired Administrators, Directors of Nursing, SDCs and Licensed Charge Nurses receive education during orientation.

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On 2/7/22, the Regional Director of Clinical Services provided education to the Administrator, DON (Director of Nursing) and charge nurses on new process for PT/INR flow records review in clinical meeting. This new process includes charge nurses bringing PT/INR flow records to the morning clinical meeting. This responsibility was communicated to the charge nurses by the Regional Director of Clinical Services on 2/7/22. The PT/INR flow records will be reviewed during morning clinical meeting to validate labs are obtained as ordered and reported to the physician. Additionally, education included validating with the physician/nurse practitioner if INRs are not within the residents' therapeutic level to ensure appropriate additional interventions were followed to protect the resident from serious side effects. Newly hired Administrators, DONs and charge nurses will receive education during orientation.

Effective 2/7/22, the Director of Nursing will monitor residents on Coumadin therapy for administrative oversight to ensure compliance with obtaining, reporting and monitoring as ordered during morning clinical meetings and weekly risk meetings.

Effective 2/7/22, the Administrator will monitor weekly risk meeting minutes to ensure an effective system continues to be in place for obtaining and monitoring PT/INRs as ordered by the Physician/Nurse Practitioner and communicating results of the PT/INRs for the regulation of Coumadin dosage. Monitoring will be completed weekly.

Effective 2/7/22, the Regional Director of Clinical Services or Regional Director of Operations will

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F 835	Continued From page 201 review the facilities PT/INR monitoring system and weekly risk meeting minutes to determine ongoing compliance and effectiveness and to provide additional education and/or resource as necessary. Monitoring will be completed weekly. Effective 2/7/2022, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance. Alleged Date of IJ Removal: 2/8/22 A credible allegation validation for quality of care was conducted in the facility on 02/18/22. Record review included an in-service training by the Regional Director of Clinical Services provided education to the Administrator, DON (Director of Nursing) and charge nurses on new process for PT/INR flow records review in clinical meeting. An in-service was provided for all nurses to include the importance of following physician's orders for obtaining PT/INR's and reporting all abnormal values to the provider promptly. The in-service also provided education on monitoring residents on Coumadin therapy by utilizing PT/INR logs which included the following for each resident: set PT/INR perimeters, when labs were drawn, current Coumadin dosage, when the next lab was to be drawn, as well as any Coumadin dosage changes. The facility's IJ removal date of 2/8/22 was validated.	F 835		
F 867 SS=H	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and	F 867		3/25/22

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F 867	Continued From page 202 assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place on 10/15/21. This was for 10 deficiencies in the areas of Safe, Clean and Homelike Environment, Comprehensive Assessments and Timing, Accuracy of Assessments, Baseline Care Plans, Activities of Daily Living, Quality of Care, Treatment/Services to Prevent/Heal Pressure Ulcers and Food Procurement Store/Prepare/Serve/Sanitary and Infection Control that were originally cited on the 09/03/21 recertification survey. The continued failure of the facility during the two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This citation is crossed referred to: F-677 Based on observations, record review, resident, staff, and family member interview the facility failed to provide incontinence care when requested by the resident (Resident #3, Resident #5, Resident #9, Resident #10, Resident #11) and failed to provide shower activities (Resident #2, Resident #7, and Resident #12) for 8 of 8 resident reviewed for activities of daily living. During the recertification survey completed on	F 867	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility failed to maintain implemented procedures and monitor the interventions that the committee put into place on 10/15/21 for F584, F636, F641, F655, F677, F684, F686, F689, F812 and F880. How the facility will identify other residents having the potential to be affected by the same deficient practice; Effective 3/24/2022 Quality Assessment and Assurance committee will review previous Quality Assessment and Assurance minutes and ongoing monitoring monthly to ensure repeat citation does not occur. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Administrator will implement monthly QAPI meetings instead of quarterly QAPI meetings to ensure the continue review and monitoring of the continued compliance of previously cited deficient practices. Corrective action will be implemented as	

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F 867	Continued From page 203 09/03/21 the facility failed to provide showers for 2 of 5 dependent resident reviewed for Activities of Daily Living. F-684 Based on observations, record review, resident, and staff interview the facility failed to follow physician orders for treatment to a venous stasis ulcer (Resident #7), failed to follow physician order for treatment to a diabetic foot ulcer (Resident #18), and failed to follow physician order for treatment of surgical wounds (Resident #6) for 3 of 5 residents reviewed. During the recertification survey completed on 09/03/21 the facility failed to hold an anticoagulation medication as ordered for 1 of 5 residents reviewed for unnecessary medications and failed to provide a daily treatment as ordered for 1 of 1 resident reviewed for skin condition. F-689 Based on observations, record review, resident, and staff interview this facility failed to investigate a fall and failed to update a smoking resident's smoking assessment when the resident began to smoke to determine if the resident was safe to smoke independently (Resident#3) for 1 of 3 residents reviewed for accidents and failed to secure a full oxygen tank that was left lying on a table in the facility chapel where residents and staff were noted to visit intermittently for 1 of 1 chapel observed. During the recertification survey completed on 09/03/21 the facility failed to complete a new admission smoking assessment to determine if the resident was a safe smoker or needed supervision while smoking cigarettes for 1 of 2 residents reviewed for smoking.	F 867	necessary and may include additional monitoring, education or process updates as determined by the QAPI committee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will audit Quality Assurance monthly x 3 months to ensure procedures are implemented and monitored to ensure deficient practices maintain compliance. Monitoring tools will be reviewed for accuracy. Completion and ongoing compliance. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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F 867	Continued From page 204	F 867		

F-812 Based on observations and staff interview the facility failed to remove expired milk from 2 of 2 refrigerator storage areas (reach in refrigerator and refrigerator), failed to seal open food items in 2 of 4 storage areas (reach in freezer and refrigerator) and failed to remove 2 heads of cabbage with signs of spoilage from 1 of 2 refrigerator storage areas (refrigerator). These practices had the potential to affect food served to residents.

During the recertification survey completed on 09/03/21 the facility failed to discard expired food and label a frozen food item stored in 1 of 1 walk-in freezer. These practices had the potential to affect food served to residents.

F-880 Based on observations, record review and interviews with staff, Nurse Practitioner (NP), and the Medical Director (MD), the facility failed to implement their infection control policies and procedures and the Center for Disease Control and Prevention (CDC) guidance for COVID-19 when 2 of 2 Nurse Aides (NA #1 and NA#2) failed to wear eye protection during resident care encounters and did not doff gloves and perform hand hygiene before entering the hallway. The facility also failed to follow CDC recommended guidelines for resident's room labeled Enhanced Droplet Control Precautions (ECDP) when 2 staff members (Housekeeper #2 and Nurse #10) and failed to don/doff required personal protective equipment and remove gloves and perform hand hygiene. In addition, Housekeeper #1 did not wear her mask to cover both her mouth and nose and did not doff gloves and perform hand hygiene. These observations occurred for 5 of 5 staff members reviewed for infection control practices.

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During the recertification survey completed on 09/03/21 the facility failed to follow general infection control guidelines when 1 of 1 staff member was observed throwing a feces soiled washcloth in the floor after providing care to a resident and failed to remove gloves and perform hand hygiene between providing care to 2 residents who resided in the same room.

F-636 Based on record review and staff interview the facility failed complete comprehensive Minimum Data Set assessments with the subsequent care area assessments within the required time frame for 3 of 3 resident reviewed (Resident #3, Resident #6, and Resident #7).

During the recertification survey completed on 09/03/21 the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment for 1 of 4 resident reviewed for resident assessment.

F-641 Based on record review, and facility staff and resident interviews, the facility failed to accurately code an admission minimum data set assessment for height and discharge planning for 1 of 3 residents reviewed (Resident #4).

During the recertification survey completed on 09/03/21 the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 2 residents reviewed for discharge, for 1 of 5 residents reviewed for unnecessary medications, and for 1 of 5 residents reviewed for resident assessment.

F-655 Based on record review and staff interview the facility failed to develop a baseline care within 48 hours of admission that addressed surgical

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wound care or smoking status of the resident for 1 of 3 residents reviewed for smoking (Resident #6).

During the recertification survey completed on 09/03/21 the facility failed to develop a baseline care plan in the area of smoking within 48 hours of admission for a resident who elected to smoke for 1 of 2 residents reviewed for smoking.

F-686 Based on observation, record reviews, staff, Resident, Wound Physician and Physician interviews the facility failed to provide the necessary goods and services to maintain skin integrity for a resident with a history of skin breakdown. Resident #2 called for staff assistance after smelling a foul odor and was observed with a stage IV pressure ulcer (the pressure ulcer will become very deep and as the ulcer deepens, muscle or bone may be visible, making infection a strong possibility if not cared for) on his right buttock. The facility also failed to provide pressure ulcer treatments for 2 of 3 residents (Resident #2 and Resident # 18) reviewed for pressure ulcers.

During the recertification survey completed on 09/03/21 the facility failed to provide a pressure ulcer treatment as ordered for 1 of 2 residents reviewed for pressure ulcers.

F-584 Based on observations, record review, and staff interviews the facility failed to repair cabinetry in 1 of 2 resident dining areas, failed to paint and/or repair dry wall in resident rooms (Room #134, Room #234, and Room #229), failed to clean up a soiled brief in the floor (Room #116), failed to remove a large bag of soiled linen (Room #130), and failed to clean a spill of feeding

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F 867	Continued From page 207 tube formula from the floor (Room #102) for 2 of 4 hallways. The facility also failed to repair a bedside table that had a missing drawer facing for 1 of 1 resident reviewed (Resident #2). During the recertification survey completed on 09/03/21 the facility failed to repair and/or paint dry wall in resident rooms for 12 of 53 resident rooms on 2 of 4 resident hallways, failed to clean resident rooms for 4 of 53 resident rooms on 2 of 4 resident hallways from debris and litter, failed to provide clean linen for 1 of 4 resident reviewed for linen, and failed to protect resident personal belonging from being lost or misplaced for 3 of 4 residents reviewed for personal property. On 02/11/22 at 4:38 PM during an interview with the Administrator, Regional Quality Assurance Nurse (RQAN), Director of Nursing (DON) and Unit Manager #1 and #2 the Administrator explained that after the recertification follow up the facility underwent multiple unplanned changes in several key management positions such as the DON, Admission Director and Social Worker and then losing a lot of staff because of the COVID vaccine mandate made it difficult to spend the amount of time on auditing the plan of corrections that put in place. The Administrator continued to explain that it was difficult to focus on one thing (meaning staffing challenge) and she depended on people to do their jobs and in some cases that did not happen. The RQAN stated that now with the new DON in place and with Corporate approval to hire more staff and a Certified Wound Nurse she thought it will make an improvement in the stability of the facility.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/25/22

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F 880	Continued From page 208 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 209 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with staff, Nurse Practitioner (NP), and the Medical Director (MD), the facility failed to implement their infection control policies and procedures and the Center for Disease Control and Prevention (CDC) guidance for COVID-19 when 2 of 2 Nurse Aides (NA #1 and NA#2) failed to wear eye protection during resident care encounters and did not doff gloves and perform hand hygiene before entering the hallway. The facility also failed to follow CDC recommended	F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Effective 2/25/21 Nurse Aide #1, Nurse Aide #2, Nurse #10, Housekeeper #1 and Housekeeper #2 received corrective action and reeducation on appropriate infection prevention practices including	

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F 880	Continued From page 210 guidelines for resident ' s room labeled Enhanced Droplet Control Precautions (ECDP) when 2 staff members (Housekeeper #2 and Nurse #10) and failed to don/doff required personal protective equipment and remove gloves and perform hand hygiene. In addition, Housekeeper #1 did not wear her mask to cover both her mouth and nose and did not doff gloves and perform hand hygiene. These observations occurred for 5 of 5 staff members reviewed for infection control practices. Findings included: A facility policy titled "Standard Precautions Infection Control" implemented 11/01/20 read in part: all staff are to assume all residents are potentially infected or colonized with an organism that could be transmitted during providing resident care services. Therefore, all staff shall adhere to "Standard Precautions" to prevent the spread of infection. It further read, all staff who have contact with residents and/or their environments wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, bodily fluids, or potentially infectious materials is likely. A review of the facility's Personal Protective Equipment policy dated 11/1/20 indicated PPE included the use of gowns, gloves, face protection (face shield or goggles), and respiratory protection covering the nose and mouth. It further revealed gloves were to be worn as part of universal precautions, hand hygiene should be performed before and after application, and discarded after each encounter.	F 880	appropriate use of PPE and hand hygiene and preventing cross contamination during direct and indirect resident care. Education validated by competency completion. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the alleged deficiency. Effective 3/14/22 current staff members were observed during rounding observation by Staff Development Coordinator and/or designee wearing eye wear, donning, doffing gloves and performing proper hand hygiene after doffing gloves. Effective 3/14/22 current staff member were observed during rounding observation by Staff Development Coordinator and/or designee properly handling soiled items. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/22 Director of Nursing and/or will educate current staff on performing proper hand hygiene, appropriate PPE use including wearing eye wear and proper handling of soiled linens to prevent the spread of infections.	

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F 880	Continued From page 211 The Center for Disease Control and Prevention (CDC) guidance titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic" updated on 09/10/21 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for Healthcare Personnel (HCP): If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), the HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. The CDC Covid19 Tracker was reviewed on 02/02/22 and revealed that Iredell County was in the red (high) for transmission of COVID19. 1. An observation on 02/02/22 at 5:30 AM revealed Housekeeper #1 approached the front entrance door to allow visitors to enter the facility wearing a mask below her chin and gloves to bilateral hands. Housekeeper #1 opened the door using the keypad then pushed the door open for the 3 visitors (surveyors) to enter the building then immediately turned and left the visitors and proceeded back to the residential care unit. While walking past residents both in the front lobby and hallway, Housekeeper #1 was not observed to remove her gloves before opening the door nor perform hand hygiene before continuing to clean a handrail in the hallway. An interview on 02/02/22 at 5:35 AM with Housekeeper #1 revealed she worked on night	F 880	Effective 3/24/22 any staff that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee. Effective 3/24/22 all staff including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on "performing proper hand hygiene when providing incontinence care Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing will audit three designated staff members weekly x 4 weeks, bi-weekly x 4 weeks, monthly x 1 for proper hand hygiene, PPE use and linen handling. Results of the audit will be reported to the Administrator. Any staff found not to be following infection control protocols will have progressive disciplinary action. Results of these audits will be reviewed at monthly Quality Assurance Meeting for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	

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shift and was assigned to clean community residential care areas and perform laundry services. She indicated she was aware she should have removed her gloves and performed hand hygiene before opening the front entrance.

An interview on 02/03/22 at 11:00 AM with the Staff Development Coordinator (SDC) /Infection Control Nurse (IC) revealed she expected all staff to always follow the CDC guideline recommendation and perform hand hygiene before and after PPE usage.

The Housekeeping Supervisor was unavailable for interview on 02/04/22 at 3:30 PM.

An interview on 02/08/22 at 12:20 PM with the Administrator and Interim Director of Nursing revealed they expected all staff to follow the CDC recommendations to wear a face mask correctly always covering her nose and mouth.

2. An observation on 02/02/22 at 5:38 AM revealed Nurse Aide (NA) #1 was in the hallway at the nurses' station touching the nurses ' station counter with gloves on both hands. Then she went over to the med cart and began speaking to the nurse at the medication cart. NA #1 was observed to be wearing a face mask, but she was not wearing eye protection and had gloves on both hands and was not observed to perform hand hygiene before touching the nurses' station and medication cart.

An interview with NA #1 on 02/02/22 at 5:39 AM revealed she was unaware she was required to wear eye protection when in a residential care area but acknowledged she should not have had gloves on her hands in the hallway and

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understood she potentially contaminated multiple surfaces from not removing her gloves and performing hand hygiene.

A follow-up interview on 02/02/22 at 7:15 AM with NA #1 revealed that night shift on 2/1/22 was her first night working in the facility and she was provided a facemask from the facility but was not offered eye protection upon entry to the facility and she had been told the only rooms that required eye protection were residents in the COVID-19 care unit.

An interview on 02/08/22 at 12:20 PM with the Administrator and Interim Director of Nursing revealed they expected all staff to follow the CDC recommendations to always wear eye protection while in the facility, doff gloves when in the hallway, and perform hand hygiene before touching environmental surfaces in the facility.

3. An observation on 02/02/22 at 5:40 with NA # 2 revealed she was in a resident's room (Room 216) performing incontinence care. NA #2 was wearing her face mask and gloves on both her hands. She was not observed to wear eyewear or perform hand hygiene during the observation. NA #2 was observed to remove the soiled brief from the resident and toss it on the floor next to the bed while she placed a clean brief on the resident. After completing incontinence care, NA #2 picked up the brief from the floor and brought the brief to the hallway in her gloved hands. NA #2 opened the trash receptacle in the hallway with her soiled glove hand and placed the soiled brief in the trash receptacle with the other hand then closed the lid and re-entered the resident ' s room without removing her gloves or performing hand hygiene.

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An interview on 02/02/22 at 6:00 AM with NA #2 revealed she placed the brief in the floor because there were no trash bag liners available in the room. NA #2 indicated she didn't think about potentially contaminating the trash receptacle when she opened the lid using her soiled gloved hands nor did she know any alternatives to placing the brief in the floor during incontinence care. NA #2 acknowledged she should have placed the brief in a disposable trash can liner and then placed it in the trash receptacle on the hallway, removed her gloves and performed hand hygiene before returning to the resident's room. NA #2 indicated she was unaware eye protection was required except when providing care in the COVID-19 care units.

An interview on 02/08/22 at 12:20 PM with the Administrator and Interim Director of Nursing revealed they expected all staff to follow the CDC recommendations to always wear eye protection while in the facility. Both indicated the NA should not have put the brief on the floor, but bagged immediately, disposed of it in the trash can in the hallway, doff the gloves, and perform hand hygiene.

4. A continuous observation on 02/02/22 beginning at 7:32 AM and ending at 7:36 AM revealed Nurse #10 in Resident #3's room with door signage that indicated EDCP which required the use of a gown, gloves, face mask, and eye protection as well as staff were to perform hand hygiene. Nurse #10 was wearing a face mask, but not observed to don eye protection, a gown, or gloves upon entry. Nurse #10 approached Resident #3's bed and spoke to him. Nurse #10 then turned off the call light and exited the room

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and proceeded to her bedside table outside the door and pushed it down the hallway. She was not observed to perform hand hygiene before continuing down the hallway with the bedside table.

An interview on 02/10/22 at 1:50 PM with Nurse #10 revealed she thought the ECDP had been discontinued for Resident #3 and therefore did not think it was needed to follow the signage placed on Resident #3's door which indicated a mask, eye protection, gown, and gloves were to be worn and hand hygiene completed when the PPE was removed. Nurse #10 indicated she had been educated to follow all posted signage for isolation precautions and she should have performed hand hygiene after exiting the room and before touching the bedside table in the hallway.

An interview on 02/03/22 at 11:00 AM with the Staff Development Coordinator (SDC) /Infection Control Nurse (IC) revealed she expected all staff to follow the signage posted on resident doors. She expected all staff to wear a gown, gloves, mask, and eye protection in these rooms. She indicated staff should change all PPE each time they enter and exit an isolation room and perform hand hygiene.

An interview on 02/08/22 at 12:20 PM with the Administrator and Interim Director of Nursing revealed they expected all staff to follow the signage posted to include wearing full PPE of a facemask, eye protection, gown, and gloves and perform hand hygiene before and after PPE usage

5. A continuous observation on 02/02/22

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beginning at 7:44 AM and ending at 7:54 AM revealed Housekeeper #2 approached Resident #3's room wearing a face mask and carrying a face shield in her hand. The signage on the outside of the door indicated EDCP which required the use of a gown, gloves, face mask, and eye protection as well as staff were to perform hand hygiene. She laid the face shield on her housekeeping cart and opened the side door of the cart to obtain a plastic gown. Housekeeper #2 then donned the plastic gown, face shield and a pair of gloves and grabbed a rag and a bottle of solution then entered the room. Housekeeper began cleaning surfaces in the bathroom and quickly returned the rag and spray bottle as well as a bag of trash to the cart, retrieved a toilet brush and returned to the bathroom to clean the toilet. Housekeeper #2 then brough the dirty toilet brush to the cart and sat it on the cart surface, picked up the mop and returned to the room and began mopping the floor. She sat the mop against the wall in the room and picked up Resident #3's mini cooler and emptied the cooler in Resident #3's bathroom sink and sat it back on the overbed table. She then picked up the mop and exited the room and removed her PPE and pushed her cart on to the next room.

An interview on 02/02/22 at 7:55 AM with Housekeeper #2 revealed she had learned this morning full PPE was to be worn when in Resident #3's room; however, she did not think about the need to doff soiled PPE and don clean PPE each time she came to the hallway to retrieve items from her housekeeping cart.

An interview on 02/03/22 at 11:00 AM with the Staff Development Coordinator (SDC) /Infection Control Nurse (IC) revealed she was new to the

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F 880	Continued From page 217 position, and she expects all staff to follow the signage posted on resident doors. She expected all staff to wear a gown, gloves, mask, and eye protection in these rooms. She indicated staff should change all PPE each time they enter and exit an isolation room and perform hand hygiene. The Housekeeping Supervisor was unavailable for interview on 02/04/22 at 3:30 PM. An interview on 02/08/22 at 12:20 PM with the Administrator and Interim Director of Nursing revealed they expected all staff to follow the signage posted to include wearing full PPE of a facemask, eye protection, gown, and gloves and perform hand hygiene before and after PPE usage.	F 880		