STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 3/14/22 through 3/18/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # H1B111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/14/22 through 3/18/22. Event ID # H1B111 Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 1/30/21 and was removed on 9/1/21. An extended survey was conducted. 29 of the 55 complaint allegations were substantiated resulting in deficiencies. Intake #s: NC00175790, NC00175865, NC00175869, NC00176728, NC00177018, NC00177443, NC00178056, NC00179889, NC00180213, NC00181744, NC00182010, NC00182282, NC00184230, NC00184431, NC00184958, NC00185043, NC00185078, NC00185498, NC00186847, NC00187045	F 000		
F 550	Resident Rights/Exercise of Rights	F 550		4/22/22

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

Electronically Signed | 04/15/2022

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F 550 SS=D	Continued From page 1 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. §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	F 550		

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F 550	Continued From page 2 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 resident and staff interviews and record review the facility failed to treat a resident in a dignified manner when assistance was requested with toileting resulting in the resident feeling angry and frustrated for 1 of 6 resident reviewed for dignity (Resident #61). The findings included: Resident #61 was admitted to the facility on 1/27/22. Resident #61 ' s admission Minimum Data Set (MDS) assessment dated 2/2/22 revealed she was cognitively intact and was assessed as total dependence with activities of daily living including toilet use, locomotion, and personal hygiene. Review of a statement written by Nurse #2 on 3/17/22 revealed she overheard NA #3 tell Resident #61 to "back it up" in a very disrespectful manner on 3/17/22 at 4:30 PM. An interview was conducted with Resident #61 on 3/18/22 at 8:41 AM who stated on 3/17/22 at approximately 4:00 PM she requested assistance from Nurse Aide #3 (NA) to use the bedpan. NA #3 told her she would have to wait until she came back from her break. Resident #61 reported she saw NA #3 sitting at the nurse ' s station and she asked again to use the bedpan. The resident stated NA #3 got a lift and told Resident #61 to come on. The resident stated as NA #3 attempted to use the lift it was dangling in her	F 550	1. For Resident #61-the allegation was investigated immediately and NA #3 was escorted from the facility, contract was termed and NA #3 was reported to the NC DHP for abuse. 2. All residents had the potential to be affected by the behaviors exhibited by NA #3. The Social Services Director and Recreational Services Director interviewed all alert and oriented residents regarding Abuse/Resident Rights/Dignity/Respect to determine if any other concerns were noted. 3. All staff have been re-educated by the Director of Nursing and/or the Nurse Practice Educator on the processes for: actions to be taken by the first responder witnessing or hearing about the abuse, the status of healthcare workers as mandated reporters and the process for reporting abuse (including where to find the necessary information and contact numbers). Any staff who has not completed education and/or training prior to or on 04.21.22 will be required to complete education and/or training prior to working a shift. 4. A weekly audit of reported allegations of abuse/neglect will be conducted by the Administrator or designee to ensure all allegations have been thoroughly	

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F 550	Continued From page 3 face, and she was almost hit in her face and Resident #96 asked her to stop. She stated then NA #3 began to have a bad attitude and she asked for someone else to help her. Resident #61 called for Nurse #2 to help her. She reported she saw NA #3 go into Resident #387 ' s room and overhead her yelling and cursing at Resident #387. She reported she was angry and frustrated at the treatment she received from NA #3 but stated she was fine after the nurse aide left the building. During an interview with NA #3 she stated Resident #61 was in her doorway asking for a bed pan. She reported the resident stated two people were needed to assist. NA #3 stated someone walked by and she asked for her assistance. She further stated she asked Resident #61 to back up so she could get in the room. She added that she knew Resident #61 was able to push herself back. NA #3 stated Resident #61 told her she was unable to back up and that she didn ' t need to be so "snappy". NA #3 stated she told Resident #61 to let it go. She further stated Nurse #2 told her that she was disrespectful when talking with Resident #61. NA #3 stated she was then asked to leave. Attempts to interview Nurse #2 were unsuccessful on 3/18/22 at 9:00 AM, 10:30 AM and 1:00 PM. During an interview with NA #4 on 3/18/22 at 9:05 AM she stated she was asked by NA #3 to assist with Resident #61 on 3/17/22. She stated NA #3 was moving the lift around and overhead NA #3 tell the resident "I am not going to go back and forth either get in bed and stay or not". She reported that she left the room at that point and	F 550	investigated and reported in accordance with regulatory guidelines. A monthly audit report will be submitted to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	

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F 550	Continued From page 4 went to the nurse ' s station. NA #4 stated she told Nurse #2 that NA #3 was talking rudely to the resident. She reported that after speaking with the nurse she pushed Resident #61 to the front of the building at Resident #61 ' s request. She reported she was present when Resident #61 described the incident and gave a statement as well to the Senior Nurse Aide. An interview was conducted with the Senior Nurse Aide on 3/18/22 at 10:10 AM she reported Resident #61 approached her at approximately 5:30 PM on 3/17/22 and told her that NA #3 talked rudely to her and behaved aggressively. She reported she asked for assistance with the bedpan and NA #3 told her she would have to wait until she went off break. She further stated Resident #61 indicated NA #3 became upset when she was not able to move her wheelchair. An interview was conducted with the Administrator on 3/18/22 at 8:30 AM. She reported an agency nurse aide spoke disrespectfully to a resident on 3/17/22 at 4:30 PM. She indicated it was reported and an investigation was begun. The Administrator stated the nurse aide had just started that day and was escorted out of the building after the incident.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		4/22/22

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F 609	Continued From page 5 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to submit a 2-hour and a 5-day report to the State Agency and failed to investigate allegations of sexual abuse by males in the facility due to being grabbed in the crotch area for 1 of 2 residents (Resident #23) reviewed for abuse. Findings Included: Resident #23 was admitted to the facility on 11/18/2021 with diagnoses which included lack of oxygen to the brain, heart failure, type II diabetes and anxiety disorder.	F 609	1. The allegation filed by Resident #23 while he was at the hospital was followed up by an external investigation conducted by APS; APS determined the allegation of abuse was unsubstantiated and the resident did not require APS intervention. Resident #23 remains in the center and is free of abuse. 2. All residents have the potential to be affected if a facility fails to report allegations of abuse. The Social Service Director and Recreational Services Director interviewed all alert and oriented residents regarding	

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F 609	Continued From page 6 A review of the Admission Minimum Data Set (MDS) dated 12/23/2021 revealed Resident #23 had moderate cognitive impairment and highly impaired vision. He understood others and was able to make himself understood. He had no behaviors directed towards others and no rejection of care. The assessment also revealed he required total assistance with two-person assist for transfers. A review of Resident #23's medical record revealed he was transferred from the facility to the hospital for complaints of chest pain on December 11, 2021. He was readmitted to the facility on December 17, 2021 at 5:32 pm. A review of the hospital record dated 12/12/2021 revealed an Adult Protective Services (APS) report was filed by a hospital nurse to Department of Social Services (DSS) on 12/12/2021 regarding Resident #23's abuse allegations. A review of the facility Admissions Director's email sent to the Administrator, DON and Social Worker (SW) dated 12/17/2021 at 12:29 pm revealed details regarding the specific abuse allegations and Resident 23's unwillingness to return to the facility. An interview with Resident #23 on 03/15/2022 at 9:29 am revealed he remembered waking up one morning and heard males talking (unsure how many or names) in his room and they were grabbing his crotch area. Resident #23 stated he was legally blind, new to the facility and was not familiar with staff names. Resident #23 continued by stating he yelled for the nurse and heard the males leave his room. Resident #23 stated the nurse came into his room much later,	F 609	Abuse/Neglect/Resident Rights/Dignity/Respect to determine if any other concerns were noted. 3. The policy and procedure of reporting allegations of abuse/neglect has been reviewed and no changes are warranted at this time. The Market President, Administrator, Director of Nursing, Nurse Practice Educator and the Clinical Management team have provided education on the reporting process including reports made to external providers alleging abuse/neglect had occurred at the facility. Any staff who has not completed education and/or training prior to or on 04.21.22, will be required to complete education and/or training prior to working a shift. 4. A weekly audit of reported allegations of abuse/neglect will be conducted by the Administrator or designee to ensure all allegations have been thoroughly investigated and reported in accordance with regulatory guidelines. A monthly audit report will be submitted to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	

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F 609	Continued From page 7	F 609		

(wasn't sure how much time had passed) asked the nurse if he could see the doctor and informed her about the males grabbing his crotch. Resident #23 stated the nurse told him he would not be able to see the doctor that day and stated she would let the doctor and administration know what happened. Resident #23 stated no one else at the facility had discussed or spoken with him about the incident. Resident #23 stated he was sent to the Emergency Room for having chest pain but wasn't sure of the exact date, but he knew it was after this incident occurred. Resident #23 continued and stated he told the hospital staff what happened at the facility and that he "didn't want to go back there." He stated a hospital Social Worker spoke to him about his concerns regarding the facility staff grabbing his crotch area. Resident #23 stated he was sent back to the facility after his chest pain resolved.

The nurse indicated by Resident #23 that was told about the incident was unable to be identified.

An interview with the Director of Nursing (DON) on 03/16/22 at 09:13 am revealed the Admissions Director verbally informed her about the abuse allegations made by Resident #23 before he came back to the facility from the hospital. The DON further stated that since the allegations were made at the hospital and not at this facility, she thought the facility did not have to report or investigate the allegations.

An interview with the Admissions Director on 03/16/2021 at 9:52 am revealed she learned of the abuse allegations from a nurse that called to give report and details about Resident #23. The Admissions Director stated after hearing the

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abuse allegations and the request that Resident #23 did not wish to return to the facility, she verbally told the DON about the allegations prior to Resident #23 coming back to the facility. She also stated she sent an email on Dec 17, 2021, at 12:29 pm to the DON, Administrator and the facility's Social Worker notifying them of the abuse allegations. The Admissions Director stated that due to the allegations being made at the hospital and not at the facility, she thought the hospital had taken care of reporting the incident.

In an interview with the facility Social Worker (SW) at 03/16/22 10:54 am, the SW revealed she went to the DON (unsure of the date and time) and discussed the abuse allegations and made the decision that the allegations were not credible, and she did not further investigate or report the abuse allegations. The SW also stated the abuse policy and protocol was to report and investigate all abuse allegations.

An interview was conducted with the DSS Adult Protective Services worker on 03/16/2021 at 11:42 am and revealed an on-site visit was made to Resident #23 on 12/28/2021 to begin an investigation into the abuse allegations. The APS worker stated the investigation was completed and closed on 01/11/2022 and the allegations were unsubstantiated due to lack of evidence.

An interview with the Administrator on 03/16/22 04:26 PM revealed the facility did not report or investigate the allegations because of the significant psychiatric history of Resident #23 and the abuse allegations were reported to a hospital during an emergency room visit instead of the being reported at the facility. The Administrator

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F 609	Continued From page 9 stated she read the allegations in Resident #23's paperwork when he returned to the facility and took no further action. The Administrator also stated she felt as if the facility dropped the ball on abuse reporting by not investigating the allegations.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code a quarterly Minimum Data Set (MDS) assessment in the section of for vision for 1 of 57 residents reviewed for MDS accuracy (Resident #3). Findings Included: 1. Resident #3 was admitted on 12/04/2019 with current diagnoses which included glaucoma and bilateral cataracts. Review of the quarterly Minimum Data Set (MDS) dated 02/28/2022 revealed Resident #3 was cognitively intact and was not coded for impaired vision. Section B of Resident #3's MDS assessment was coded for adequate vision. An observation of Resident #3 on 03/14/2022 at 12:55 pm revealed a nursing assistant (NA) feeding him at bedside. An interview with Resident #3 on 03/14/2022 at 2:25 pm revealed he had a vision impairment due	F 641	1. The MDS for Resident #3 was updated to reflect vision impairment and submitted on 03/16/22. 2. Any resident has the potential to be impacted by an inaccurate MDS assessment. The clinical team completed a 100% audit of current residents with vision impairments to ensure needs were captured accurately on the MDS Section B. 3. The MDS Nurse and the Social Service Director have completed training on MDS Section B on or before 04.21.22 4. The Regional MDS Nurse will conduct a monthly audit and submit an audit outcome report to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	4/22/22

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F 641	Continued From page 10 to his cataracts. Resident #3 stated could only see blurry images and described it as "knowing something is there but can't make out what it is." He sated he required staff's assistance for Activities of Daily Living (ADLs) including eating, dressing and toileting. An interview with the MDS nurse on 03/15/22 at 11:17 am revealed Resident #3's quarterly MDS dated 02/28/2022 should have been coded for severely impaired vision and the mistake was an oversight on her part. The MDS nurse stated she would edit Resident #3's MDS and make the correction. An interview with the Administrator on 03/15/2022 at 3:26 pm revealed all MDS assessments should be correctly coded according to resident status.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		4/22/22

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F 656	Continued From page 11 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to follow care plan interventions for a resident with a history of falls for 1 of 3 residents reviewed for accidents, (Resident #112). Resident #112 had a history of fall with major injury. Findings included: Resident #112 was admitted to the facility on 09/21/2016 with diagnoses which included cerebral vascular infarction with hemiplegia (CVA).	F 656	1. Fall interventions for Resident #112 were reviewed for accuracy and the fall mat placed at the side of the bed by the assigned nursing aide on 03/17/22. 2. All residents at risk for falls have the potential to be affected. Clinical leadership completed an audit of all current residents with fall mat interventions to ensure the fall mats are in place as ordered/care planned. 3. The Director of Nursing has implemented the use of an intervention	

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F 656	Continued From page 12 The Annual Minimum Data Set (MDS) dated 02/14/2022 revealed Resident #112 was cognitively intact and demonstrated no moods or behaviors. He required extensive assistance with 1 staff physical assistance with bed mobility, transfer, dressing and toileting. Resident #112 was coded for falls prior to admission. A review of the care plan revised 03/12/2022 revealed Resident #112 was at risk for further falls related to CVA with hemiplegia, history of falls, and transfer with interventions to include a floor mat to the left side of his bed. An observation was made on 03/16/2022 at 10:45 am. Resident #112 was observed lying in bed. No floor mat was observed on the floor next to the bed. Another observation was made on 03/17/2022 at 9:05 am. Resident #112 was observed lying in bed. No floor mat was observed on the floor next to the bed. Interview with Nurse #6 on 03/17/2022 at 9:09 am revealed Resident #112 had moved rooms on 03/11/2022 and the fall mat didn't "make it" to his new room and she was aware he was care planned to have a fall mat beside his bed. Interview with the Director of Nursing (DON) on 03/17/2022 at 9:17am revealed Resident #112 should have had a fall mat beside his bed as outlined in his care plan. The DON stated nursing is responsible for making sure the care plans are followed.	F 656	matrix for clinical and non-clinical staff to use when rounding to ensure interventions are in place i.e. fall mat at bedside. On 04.18.22 the Director of Nursing provided education to the non-clinical leadership staff accountable for rounding on how to utilize the matrix. Front-line care staff have been educated by the NPE or designee on locating information relative to care planned interventions. Any staff who has not completed education and/or training prior to or on 04.21.22, will be required to complete education and/or training prior to working a shift. 4. The Nurse Practice Educator will utilize the matrix tool to conduct weekly random audits of fall mats for compliance for 12 weeks. The Nurse Practice Educator will submit a monthly report of audit outcomes to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		4/22/22

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F 657	Continued From page 13 §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 observations, record review, resident representative interview and staff interviews, the facility failed to update the care plan to address range of motion recommendations by physical therapy for 1 of 1 resident (Resident #79) reviewed for position and mobility. Findings included:	F 657	1. An order was obtained for Resident #79 to have PROM performed during routine ADL activities. PROM was added to the Resident Care Card and the Resident care plan. 2. Residents dependent on staff for maintaining ROM have the potential to be affected if PROM is not performed during	

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F 657	Continued From page 14 Resident #79 was admitted to the facility on 8/3/2021. His diagnoses included brain stem stroke syndrome. The quarterly assessment dated 2/3/2022 indicated no change in Resident #79's cognitive state and continued to require total assistance with all activities of daily living due to impairments to both upper and lower extremities. Resident #79's s care plan dated 2/3/2022 revealed a care plan focus for providing total care for all activities of daily living(ADLs), and interventions included assisting with bed mobility and mechanical transfers. A review of the Interdisciplinary Physical Therapy screening dated 2/16/2022 revealed Resident #79 had no functional movement and was dependent on nursing for movement. Treatments consisted of range of motion (ROM), functional motor movement and transfers, and nursing was educated on performing passive ROM while performing ADLs and repositioning in bed. Range of motion was not listed as a task in the resident care card on the electronic medical record for the nursing assistants to performed for Resident #79. Resident #79 was observed on 3/15/2022 at 3:48 p.m. lying on his right side with head of bed elevated. Both arms were observed extended straight at the elbows and rolled hand towels were positioned in both hands. Both lower extremities were extended straight at the knees and the feet were flexed in the downward position.	F 657	routine ADL care. The clinical team and evaluating therapists have completed a 100% screening of current residents requiring assistance with ROM. Residents identified at risk have had on order obtained for PROM with the provision of ADL assistance; orders been added to the Resident Care Card and the Resident care plan. 3. Therapy and clinical managers have provided training to direct-care staff on how to perform PROM during ADL care. Competency skills to perform PROM will be assessed during the CNA orientation process by the Nurse Practice Educator. Any direct-care staff not completing education and/or training prior to or on 04.21.22, will be required to complete education and/or training prior to working a shift. 4. Unit Managers (UMs) will conduct random observations 6 times per week (2 per shift per unit) times 12 weeks during ADL care for residents requiring PROM. Any negative variance will be addressed when identified with appropriate education or corrective action if indicated. UMs will report monthly on audit outcomes to the Quality Assurance and Performance Committee with the QAPI Committee responsible for ongoing compliance.	

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F 657	Continued From page 15	F 657		

On 3/15/2022 at 4:13 p.m. in an interview with Nurse #3, he stated the nursing staff did not have an order to perform range of motion on Resident #79, and he had not been informed by physical therapy to conduct passive range of motion for Resident #79.

On 3/15/2022 at 4:30 p.m. in an interview with the Director of Nursing, she stated a recommendation from physical therapy for passive ROM would need an order and would be communicated to the nursing staff on the resident care card. She stated passive ROM was not listed on Resident #79's care card and was not on his care plan. She stated physical therapy should had informed the MDS nurse of the recommendation for passive range of motion to be added to Resident #79's plan of care.

On 3/16/2022 at 12:37a.m. in an interview with Nurse Aide(NA) #1, she stated she had performed range of motion on Resident #79 during his bath. She stated she had been a NA for over ten years and knew to perform ROM when residents were unable to move themselves. She stated ROM was not part of Resident #79 ' s care card, and she was not able to document in Resident #79 ' s electronic medical record ROM was conducted.

On 3/18/2022 at 9:03 am in an interview with MDS Nurse #1, she stated physical therapy (PT) was unable to update resident care plans, and PT notified the MDS Nurse to update care plans. She stated she was not notified of the recommendation for ROM for Resident #79. She stated Resident #79 needed ROM, and ROM should had been added to his care plan as an intervention with ADLs.

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F 684 SS=D	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 record review and staff interviews the facility failed to complete non-pressure wound dressing changes as ordered by the physician for 1 of 2 residents reviewed for wound care (Resident #33). The findings included: Resident #33 was admitted to the facility on 12/11/19 with a diagnosis of venous insufficiency and lymphedema. The quarterly Minimum Data Set dated 1/1/22 revealed Resident #33 was cognitively intact, and he was independent with activities of daily living. He had no pressure ulcers/injuries but was at risk for developing them. Resident #33 ' s care plan updated on 1/21/22 revealed he was care planned for chronic venous stasis, dermatitis of both lower extremities and risk for further skin breakdown related to limited mobility, shearing, and friction. A review of the physician orders for Resident #33 revealed the following order dated 3/9/22: cleanse	F 684	1. Resident #33 is currently receiving all wound care as per physician's order. 2. Any resident has the potential to be affected if staff fail to follow physician orders. The clinical team conducted a 100% audit of all current TARs to ensure treatment orders are being completed as ordered. 3. The Nurse Practice Educator educated licensed staff on including wound care updates during rounds/shift hand-off. Education also included the importance of signing-off on TARs when treatments are performed. Licensed personnel who have not completed training on or before 04.21.22, will receive education and/or training prior to working a shift. 4. The Health Information Manager (HIM) will conduct a TAR audit of 10 residents times 4 weeks and then a random TAR audit of 5 residents times 8 weeks. HIM will report any negative variance to the Director of Nursing and/or the Assistant	4/22/22

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F 684	Continued From page 17 wounds to left and right posterior thigh with wound cleanser, pat dry, apply a wound barrier to the surrounding tissue, apply a wound dressing to the wound bed and secure with gauze and a transparent dressing every day shift and as needed. A review of the Treatment Administration Record (TAR) revealed Resident #33 ' s dressing change was not documented as being completed on 3/15/22 and 3/16/22. On 3/14/22 at 10:00 AM an interview was conducted with Resident #33. He stated his dressing changes were not getting completed. On 3/17/22 at 10:37 AM an interview was conducted with Nurse #1 who worked with Resident #33 on 3/16/22. She stated she did not do the dressing change for Resident #33. She stated she ran out of time and didn ' t tell anyone his dressing needed changing. On 3/17/22 at 11:26 AM an interview was conducted with Nurse #2 who worked 3/15/22 and was caring for Resident #33. He stated he did not complete the dressing change for Resident #33. He stated he did not have time to do the dressing change and didn ' t recall if he let anyone know Resident #33 ' s dressing needed to be changed. A second interview was conducted with Resident #33 on 3/18/22 at 10:10 AM. He stated his wound care was completed on 3/17/22. An interview was conducted with the Director of Nursing on 3/18/22 at 10:36 AM. She stated she expected dressing changes to be completed as	F 684	Director of Nursing at the time of observation. HIM will submit a monthly report of audit outcomes to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	

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F 684	Continued From page 18 ordered and documented in the TAR.	F 684		
F 686 SS=E	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 review and resident and staff interviews, the facility failed to complete dressing changes for 1 of 2 residents (Resident #23) reviewed for pressure ulcers. Findings Included: Resident #23 was admitted to the facility on 11/18/2021 with diagnoses which included lack of oxygen to the brain, heart failure, type II diabetes and stage IV sacral pressure ulcer. A review of the Admission Minimum Data Set (MDS) dated 12/23/2021 revealed Resident #23 had moderate cognitive impairment and highly impaired vision. He understood others and was able to make himself understood. He had no behaviors directed towards others and no	F 686	1. Wound Care for Resident # 23 is being provided as ordered. 2. Any resident with an order for wound care has the potential to be affected if wound care is not provided as ordered. The clinical team conducted a 100% audit of all current TARs to ensure treatment orders are being completed as ordered. 3. The Nurse Practice Educator educated licensed staff on including wound care updates during rounds/shift hand-off. Education also included the importance of signing off on the TAR when treatments are performed. Current licensed staff not completing education and/or training on or prior to 04.21.22 will be required to	4/22/22

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F 686	Continued From page 19 rejection of care during the look back period. The MDS assessment also revealed Resident #23 was admitted to the facility with a stage 4 sacral pressure ulcer. The assessment also revealed he required total assistance with two-person assist for transfers. A review of Resident #23's care plan last revised on 01/17/2022 revealed Resident #23 was care planned for being dependent for Activities of Daily Living (ADL) care for bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to limited mobility, anoxic brain injury, muscle spasms and severe muscle deconditioning. Resident #23 was also cared planned for increased nutrient needs related to wound healing of his pressure ulcer and decreased ability to feed himself. A review of the physician orders revealed an order was written on 12/22/2021 for Resident #23 to cleanse sacral pressure ulcer wound with skin integrity wound cleanser, apply calcium alginate to wound bed and secure with dry dressing every day on the 7a-3p shift. A review of Resident #23's Treatment Administration Record (TAR) for the month of December 2021 revealed the following dates were not documented as being completed: December 2, 2021 December 9, 2021 A review of Resident #23's Treatment Administration Record (TAR) for the month of January 2022 revealed the following dates were not documented as being completed: January 05, 2022 January 19, 2022	F 686	receive education and/or training prior to working a shift. 4. The Health Information Manager (HIM) will conduct a TAR audit of 10 residents times 4 weeks and then a random TAR audit of 5 residents times 8 weeks. HIM will report any negative variance to the Director of Nursing and/or the Assistant Director of Nursing at the time of observation. HIM will submit a monthly report of audit outcomes to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	

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F 686	Continued From page 20	F 686		

January 20, 2022

A review of the sacral would assessments for the months of December 2021 and January 2022 revealed the sacral pressure ulcer remained a stage IV.

A review of the staff assignment sheets for the months of December 2021and January 2022 revealed Nurse #10 was assigned to Resident #23 on December 02, 2021, December 09, 2021 and January 5, 2022. Nurse #8 was assigned to Resident #23 on January 19, 2022 and January 20, 2022.

An observation of a pressure ulcer dressing change on 03/18/2022 at 1:30 pm revealed physician orders were followed, and no concerns were identified.

Attempts were made to reach Nurse #8 and Nurse #10 via phone but were unsuccessful because they no longer work at the facility and the phone numbers on record had been changed or unable to receive voice messages.

An interview with Resident #23 on 03/15/2022 at 3:15 pm at 9:29 am revealed there were a few times when the nurses did not change his pressure ulcer dressing. Resident #23 stated he wasn't sure of the exact dates, but knew it was in late December and a few times in January. Resident #23 also stated he felt like the dressing changes had been getting done each day since then.

An interview with the Director of Nursing (DON) on 03/17/2:09 PM revealed the nurses are responsible for completing the pressure ulcer

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F 686	Continued From page 21 dressing changes per physician order and documenting on the TAR that the dressing changes have been completed. The DON added the TARs for Resident #23 for the months of December 2021 and January 2022 indicated the pressure ulcer changes were not performed and stated, "In nursing, if it's not documented it's not done."	F 686		
F 689 SS=J	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 observation, record review, police interview, and staff interviews the facility failed to prevent a resident with cognitive impairment and exit seeking behaviors from exiting the facility unsupervised on two occasions. On 1/30/21 Resident #125 exited the building from a first floor window and was found in a bush. This second incident on 5/21/21 resulted in Resident #125 being brought back to the facility by law enforcement after being found approximately a quarter of a mile from the facility. The facility also failed to implement the fall risk intervention of a fall mat at bedside (Resident #112), and to assess a resident (Resident #108) for safe smoking prior to allowing independent smoking and keeping smoking materials in her room. This was for 3 of 4 residents reviewed for accidents.	F 689	1 Resident #125 continues to wear a wander-guard bracelet and has had no episodes of elopement since 05/21/21. Resident #112 has a fall mat placed beside the bed as ordered and care planned. Resident #108 had a smoking assessment completed and is care-planned as an unsupervised smoker. 2. Residents at risk for elopement, residents at risk for falls and residents who smoke are at risk. A. Nursing leadership completed an audit of all current residents identified at risk for	4/22/22

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F 689	Continued From page 22 Immediate Jeopardy began on 1/30/21 when Resident #125 exited the facility unsupervised through a first floor window. Immediate Jeopardy was removed on 9/1/21 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure interventions implemented are effective. Examples #2 and #3 were cited at scope and severity of D. Findings included: 1. Resident #125 was admitted to the facility on 12/10/20 with diagnoses that included dementia. Resident #125 ' s admission Minimum Data Set assessment dated 12/17/20 revealed she was moderately cognitively impaired with no behaviors. She was independent for bed mobility, transfers, walking, and locomotion on and off the unit. She was not coded for wandering. A nurse ' s progress note completed by Nurse #5 dated 1/24/21 revealed wandering occurred daily or almost daily. A wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) was ordered on 1/24/21. There was no plan developed for Resident #125 for wandering when the wanderguard was initiated on 1/24/21.	F 689	elopement to ensure all interventions are in place and care-planned. B. Nursing leadership completed an audit of all current residents with fall mat interventions to ensure that fall mats are in place as ordered and care-planned. C. Nursing leadership completed an audit of all current residents who smoke to ensure that a Smoking Assessment has been completed and care plan implemented. 3. A. Maintenance Director and/or designee checks all doors and windows routinely for security. B. Fall prevention interventions have been added to the rounding matrix to be utilized by clinical and non-clinical personnel. C. Resident Care Cards have been updated to include whether a resident is an independent or supervised smoker. Education provided by the Nurse Practice Educator for all staff on the Elopement Policy, Falls Policy and the Smoking Policy. Any staff who has not completed education and/or training prior to or on 04.21.22, will be required to complete education and/or training prior to working a shift. 4. A. The Administrator will audit door and window checks through the TELs system weekly times 4 weeks, then monthly thereafter to ensure compliance. B. The Nurse Practice Educator will utilize the matrix tool to conduct weekly random audits of fall mats for compliance times 12 weeks.	

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F 689	Continued From page 23 There were no elopement risk assessments completed for Resident #125 on admission or after the wanderguard was implemented on 1/24/21. 1a. A progress note written by Nurse #5 on 1/30/21 at 10:40 AM stated Resident #125 was seen at breakfast at approximately 8:30 AM on 1/30/21. When Nurse #5 went to administer medications at approximately 9:10 AM to Resident #125 she was not in her room. Nurse #5 did a sweep of the building twice and couldn ' t locate Resident #125. At that time Nurse #5 alerted her supervisor and an elopement alert (an elopement alert was when a building-wide alarm was activated notifying staff that a resident was unable to be located. All staff were to assist in searching the facility and grounds to locate the resident) was activated. Resident #125 was found outside of the window in the back of the building by Nurse #4. An event summary report completed by Nurse #4 for an incident on 1/30/21 read in part, "Resident states she was going to her car to go home. Staff assisted her back inside facility, full body assessment completed. Resident placed on 1:1 observation due to elopement and resident had cut off wander guard prior to exiting facility. Compassionate care visit to be completed by family to assist in increased anxiety due to isolation from family [related to] COVID protocols." The report indicated during a full body assessment, scratches to lower extremities and hands were discovered. The event summary report also indicated Resident #125 was discovered missing at 9:10 AM on 1/30/21 and was found at 9:40 AM.	F 689	C. The Director of Nursing and/or the Assistant Director of Nursing to audit all new admissions and new residents with a desire to smoke to ensure that a smoking assessment and care plan are completed as indicated. Results of the above audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

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Observation on 3/15/22 at 11:30 AM of the area behind the building where Resident #125 exited out of on 1/30/21 revealed an approximate two-foot drop from the window to the ground. The bushes outside the window were below the windowsill. The reported temperature on 1/30/21 was 35 degrees Fahrenheit at 9:00 AM (www.wunderground.com). The medical records department was approximately 25 feet from Resident #125 ' s room at the time.

An interview was conducted with Nurse #4 on 3/15/22 at 11:20 AM who stated Resident #125 was found under a window in the back of the building. She reported the window was open. Nurse #4 stated Resident #125 was wearing a blouse and pants. Resident #125 had socks and shoes on. She reported Resident #125 ' s pants were pushed up to her knees as is the resident ' s usual preference.

A phone interview was conducted with Nurse #5 on 3/15/22 at 1:52 PM who stated Resident #125 had attempted to exit the building since she was admitted to the facility on 12/10/20. Nurse #5 stated she could not recall any details regarding Resident #125 being found in the bushes outside the back of the building.

During an interview with the Corporate Maintenance Director (CMD) on 3/15/22 at 11:30 AM he stated a contractor was replacing some of the windows in the building on 1/30/21. He stated the windows in the Medical Records office had been replaced that day. The CMD reported when the contractor left, he zipped up the zip wall that had been placed at the door of Medical Records. Based on the investigation conducted by the facility it was determined Resident #125

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entered the zip wall, opened the window, and pushed the window screen out to exit the building. She was found in the bushes under the window and the screen was ajar with the window raised. He reported locks were placed on the windows in the facility to ensure they are not able to be raised higher than six inches.

The care plan for Resident #125 had a focus area initiated 1/30/21 for wandering and at risk for elopement related to expressions of a desire to leave the facility and resident has made one or more attempts to leave the facility. Interventions included monitor resident ' s location with visual checks encourage participation in activity preferences, utilize and monitor security bracelet, and utilize diversional techniques to redirect resident when she verbalizes or exhibits the desire to leave the facility.

During an interview with the Receptionist #1 on 3/16/22 at 10:01 AM she stated Resident #125 tried to exit the building daily since her admission.

An interview was conducted with Receptionist #2 on 3/16/22 at 4:06 PM who stated she was familiar with Resident #125 and she did wander frequently.

1b. An event summary report prepared by Nurse #5 for an incident that occurred on 5/21/21 read in part, "Dinner trays were served, and resident [Resident #125] was not able to be located for dinner. Resident had been refusing to be in her room for most of the day. Resident wanting to hang out in front lobby throughout the day. Resident last seen sitting in lobby on the couch. Staff completed a search throughout the building

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and notified proper authorities. Resident was located by local authorities and brought back to the facility". There were no injuries.

A phone interview was conducted with Nurse #5 on 3/15/22 at 1:52 PM. She stated she recalled the resident had eloped and was brought back to the facility by the police on one occasion. Nurse #5 stated she could not recall any additional details about e the 5/21/21 incident.

An interview was conducted with the facility Social Worker on 3/16/22 at 9:35 AM. She reported she observed Resident #125 on the afternoon of 5/21/21. She stated Resident #125 attempted to exit the building via the front door but was unable to do so due to her wander alarm at approximately 5:30 PM. She revealed she had not informed any other staff members that Resident #125 attempted to exit through the front door. The social worker indicated the receptionist was present and the wander alarm prevented her from opening the door so was not concerned at that time. The Social Worker stated she was in her office at approximately 5:55 PM and received a phone call from the kitchen staff regarding the alarm going off on one of the dining room doors. She stated she went to the dining room and found the door ajar and turned the alarm off. She stated she looked out the door but did not see anyone so returned to her office. The Social Worker stated she immediately recalled Resident #125 had been at the front door. The Social Worker stated she did not see Resident #125 so she asked the charge nurse to help locate her at 5:56 PM. Resident was unable to be found in the facility or on the grounds so local law enforcement was contacted. Resident #125 was returned to the facility at 6:33 PM by local law

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enforcement. The Social Worker stated she was advised by local law enforcement Resident #125 was located at the intersection of a nearby street. The resident was confirmed to be absent from the facility grounds for 38 minutes. She revealed the law enforcement indicated the location Resident #125 was found was across the highway. When measured by the corporate Maintenance Director the likely path taken by Resident #125 measured 1,407 feet (0.26 miles).

Observation on 3/16/22 at 9:30 AM of the facility revealed the facility front door faced a two-lane highway with a speed limit of 35 miles per hour. The recorded temperature on 5/21/21 at 6:00 PM was 81 degrees Fahrenheit (www.wunderground.com).

During an interview with a former kitchen staff member on 3/16/22 at 7:00 PM she stated she recalled Resident #125 leaving the building on 5/21/21. She reported Resident #125 tried to enter the kitchen several times on that day. The kitchen staff member stated they locked the door to prevent Resident #125 ' s entry. She reported she was unaware of Resident #125 ' s exit from the building until the social worker contacted her after Resident #125 was discovered absent from the facility. She further stated the alarm on the dining room door was not her responsibility and was unaware Resident #125 exited from that door. The former kitchen staff member stated she did not advise anyone of Resident #125 ' s had attempts to enter the kitchen on 5/21/21.

An interview with the local law enforcement agency on 3/15/22 at 4:05 PM revealed no report was filed by the agency and no one recalled the incident.

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F 689	Continued From page 28 The Administrator was notified of Immediate Jeopardy on 3/16/22 at 3:48 PM. On 3/18/22 the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Facility failed to prevent Resident # 125 from exiting the facility unsupervised on 1/30/21 and 5/21/21. A. On 1/30/21, Resident #125 exited the facility through an open window in an unlocked office on Wing 3 that had been under construction. The window had been removed during construction and the construction crew working on this room had left the office door unsecured. Resident # 125 had last been seen at breakfast approximately 8:30 a.m. Nurse went to give a.m. medications and noted resident was not in room. Search initiated, unable to locate resident in the facility, search expanded to exterior and Elopement Code (overhead announcement of an elopement for all staff to respond according to policy to search for missing resident). called at 9:10 a.m. Staff members looked for resident and supervisor found resident outside in a bush behind the building outside of window, all belongings including clothes, walker and cane were outside as well. Resident assessed outside to determine if any major injuries incurred, resident able to move all extremities with no issue no gross injuries noted, resident escorted back inside, resident had total body check performed to further determine no injuries incurred, resident	F 689		

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noted to have 2 scratches to right hand, 2 scratches to left hand and smaller scratches noted to bilateral lower extremities. ADON (Assistant Director of Nursing), DON (Director of Nursing) and administrator notified, family notified.

Immediate Action for the 1/30/21 unsupervised exit included:

An Immediate plan of correction was initiated on 1/30/21 which included placing resident # 125 on 1:1 supervision, followed by implementation of 15 minute checks.

Resident #125 had an updated Elopement Assessment completed on 1/30/21 and Wander Guard alert bracelet was placed on resident.

Facility leadership completed a head count on 1/30/21 of all current residents and all residents were accounted for.

The office door was locked to prevent further egress.

Maintenance completed an egress audit on 1/30/21 to ensure all doors and windows were secure. Windows were secured with metal locking tabs.

B. On 5/21/21 Resident # 125 resident exited the center through the dining room door. The dining room door alarmed at approximately 5:55 pm and the Director of Social Services responded, turned off the alarm, she then asked a nurse for assistance. At 5:58 Elopement Code was called and search initiated. Resident was unable to be located at the facility and the local Police Department as notified at 6:10 p.m. of a missing resident. Resident was found by the police and returned to the facility at approximately 6:33 p.m.

Immediate Action for the 5/21/21 unsupervised

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exit included:

On 5/21/21 Immediate plan of correction started and education initiated.

On the evening of 5/21/21 the Maintenance Director came into the facility to inspect the dining room door and found the door plunger was malfunctioning and provided an immediate repair to the door.

While in the facility on the evening of 5/21/21 the Maintenance Director completed an audit of all doors to ensure secure/function.

On 5/21/21 Facility leadership completed a head count of all current residents and all residents were accounted for.

Resident # 125 remains in the center and has had no Elopements since 5/21/21. Resident # 125 remains an Elopement Risk and has a Wander Guard alert bracelet.

All residents who wander and those identified at risk for Elopement have potential to be effected.

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 1/30/21 Maintenance Director added Window checks to the TELs system to ensure that windows are checked monthly. TELs system is an electronic system that maintenance work orders are entered into and routine maintenance assigned tasks are entered into and documented for compliance by the facility Maintenance Director.

On 02/01/21 Education was completed on Elopement, by the Assistant Director of Nursing. This education included a review of the Elopement Policy and Procedure which includes:

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ensuring a heightened awareness with all staff of the residents at risk for elopement and the systemic measures to prevent unsupervised exits. Policy/ Procedure also includes monitoring and supervising residents who wander.
Wander Guard Audit completed on 1/30/21 and 5/21/21 by nursing leadership on residents identified at risk to ensure that the Wander Guard was on per order and that it was properly functioning, no concerns noted.
On 5/21/21 Education was completed with dietary staff on responding immediately to alarms sounding, by the Assistant Director of Nursing.

On 5/21/21 Re-Education was initiated on Elopement Policy, by the Assistant Director of Nursing for all staff to include full time, part time, as needed (PRN), and contracted staff. This education was a review of the Elopement Policy and Procedure which includes ensuring a heightened awareness with all staff of the residents at risk for elopement and the systemic measures to prevent unsupervised exits. Policy/ Procedure also includes monitoring and supervising residents who wander. Education completed on 5/28/21.

Alleged Date of immediate jeopardy removal: 5/29/21

The credible allegation of immediate jeopardy removal was verified on 3/18/22 by onsite validation. During the verification process it was revealed training was not fully completed until 8/31/21. Staff were interviewed and confirmed they received training from the Assistant Director of Nursing and Corporate Maintenance Director pertaining to elopements. An observation on 3/18/22 at 9:00 AM revealed Resident #125

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interacted with staff in the hallway.

An interview was conducted with the Administrator on 3/17/22 at 5:15 PM who stated the last of the employees were educated on 8/31/21 by the Corporate Maintenance Director when an elopement drill was conducted.

An interview was conducted with Maintenance Worker #1 on 3/18/22 at 9:23 AM. He confirmed he received education regarding elopements on 8/31/21 from the Corporate Maintenance Director.

The facility ' s immediate jeopardy removal date was determined to be 9/1/21 based on the validation.

2. Resident #112 was admitted to the facility on 09/21/2016 with diagnoses which included chronic kidney disease, cerebral vascular infarction with hemiplegia (CVA), diabetes mellitus and hypertension. Resident #112 had a history of falls.

The Annual Minimum Data Set (MDS) dated 02/14/2022 revealed Resident #112 was cognitively intact and demonstrated no moods or behaviors. He required extensive assistance with 1 staff physical assistance with bed mobility related to one-side impairment for upper and lower body, transfer, dressing and toileting.

A review of the care plan dated 03/02/2022 revealed Resident #112 was at risk for falls related to CVA with hemiplegia, lack of safety awareness, a history of falls, and required 1 staff

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assist with transfers. Interventions included a floor mat to the left side of his bed.

A review of the facility falls incident report dated 03/06/2022 revealed Resident #112 attempted to transfer from his bed to electric wheelchair and the wheelchair was not locked. The wheelchair rolled backward, and Resident #112 fell on the floor. Education was provided to Resident #112 to make sure his wheelchair is turned off and locked before transferring to and from the wheelchair. The report also revealed there was not a fall mat beside his bed at the time of the fall.

An interview with Resident #112 on 03/15/2022 at 11:55 am revealed he remembered his fall on 03/06/2022 when he tried to get in his electric wheelchair from his bed. He stated he thought he could do it himself, but he didn't make it.

An interview with Nurse #3 on 03/15/2022 at 12:06 pm revealed Resident #112 had a recent fall on 03/06/2022 after he attempted to transfer to his electric wheelchair from his bed, the wheelchair rolled out from under him, and he fell. Nurse #3 stated there was not a fall mat beside Resident #112's bed at the time of the fall.

Interview with Nurse #6 on 03/17/2022 at 9:09 am revealed Resident #112 had moved rooms on 03/11/2022 and his fall mat didn't "make it" to his new room and was aware he was care planned to have a fall mat beside his bed.

Interview with the Director of Nursing (DON) on 03/17/2022 at 9:17am revealed Resident #112 should have had a fall mat beside his bed as outlined in his care plan. The DON stated nursing is responsible for making sure the care plans are

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followed.

3. Review of the facility's smoking policy reviewed 11/4/19 indicated that the admitting nurse would conduct a Smoking Evaluation on all persons wishing to smoke, the person would only be able to smoke with direct supervision until evaluated by the interdisciplinary team, smoking status would be documented in the Care Plan, and if deemed independent, the resident would not be able to maintain own cigarettes and lighters unless the facility chose to provide a lock box.

Resident #108 was admitted to the facility on 2/11/22 with diagnoses that included cancer and lung disease.

Resident #108's admission Minimum Data Set (MDS) indicated she was cognitively intact and independent for transfers, locomotion on and off unit, and other activities of daily living. Her MDS did not indicate tobacco use.

A Nursing Admission Assessment dated 2/11/22 revealed Resident #108 "used tobacco products daily or almost daily" for the past year.

A Quarterly Recreation Progress Note dated 3/1/22 indicated that Resident #108 enjoyed smoking.

Record review for Resident #108 did not reveal a Smoking Evaluation.

Record review of Resident #108's Care Plan did not indicate she used tobacco.

During an observation on 3/16/22 at 10:25 AM,

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Resident #108 were observed smoking in the designated smoking area of the courtyard.

During an interview on 3/16/22 at 10:30 AM, Resident #108 revealed she was able to smoke independently, and she kept her cigarettes and lighter in her room in her drawer or her jacket pocket. She indicated she received instruction from the other residents not to share cigarettes with other residents. She had not received instructions from staff or been asked about her smoking.

During an interview on 3/16/22 at 11:10 AM, the Director of Nursing (DON) indicated that independent smokers were encouraged to provider lighters to staff to put into a lock box. She revealed residents are asked at admission if they smoked and the admitting nurse would complete a Smoking Evaluation.

During an interview on 3/18/22 at 9:20 AM, Nurse #1 revealed when she had filled out the Admission Nursing Assessment, Resident #108 said she was going to quit smoking since she had been in the hospital for so long. Nurse #1 indicated she did not fill out the Smoking Evaluation because Resident #108 said she was not going to smoke. She further revealed she did not know when Resident #108 started smoking again because she no longer worked on that floor.

During an interview on 3/18/22 at 9:25 AM, Resident #108 revealed she had been smoking in the facility since the day after she arrived. She indicated she had not had an intention to quit smoking.

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F 689	Continued From page 36 During an interview on 3/18/22 at 9:50 AM, the Administrator indicated most residents did not have the lock boxes in their room and were able to keep the cigarettes in their room but were encouraged to give lighters to staff. She further revealed the smoking policy likely needed to be revised to better fit the facility. The administrator revealed that Resident #108 had only recent started smoking again and that was why she did not have Smoking Evaluation completed.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		4/22/22

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F 690	Continued From page 37 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to prevent a urinary catheter bag from being in contact with the floor for 1 of 1 resident reviewed for urinary catheter care (Resident #96) . The finding included: Resident #96 was admitted to the facility on 4/27/21 with diagnoses which included unspecified neuromuscular dysfunction of the bladder, dementia, and cognitive communication deficit. The quarterly Minimum Data Set (MDS) dated 1/4/20 revealed Resident #20 was severely cognitively impaired. He required extensive to total assistance with activities of daily living. He had an indwelling catheter and was incontinent of bowel. The care plan dated 4/28/21 addressed Resident #96 had an indwelling catheter related to neurogenic bladder A continuous observation on 3/15/22 at 3:24 PM until 3:39 PM revealed Resident #96 was sitting in front on the nurse ' s station and the Resident's	F 690	1. The indwelling urinary collection catheter bag for Resident #96 was re-positioned properly on the wheelchair at approximately 3:40 p.m by Nurse Aide #2. Resident #96 currently has an indwelling catheter urinary collection bag secured and stored appropriately. 2. Any resident with a urinary drainage bag has the potential for the bag to be improperly positioned. Nursing leadership completed an audit on 04/15/22 of all current residents with indwelling catheters to ensure appropriate storage and placement to prevent collection bags from being in contact with the floor. 3. The Nurse Practice Educator has educated clinical and non-clinical staff on the proper positioning for catheter bags and catheter tubing. Any staff who has not completed education and/or training prior to or on 04.21.22, will be required to complete education and/or training prior to working a shift. 4. Unit Managers (UMs) will utilize the	

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F 690	Continued From page 38 urinary catheter drainage bag was attached to the left side of her wheelchair. The urinary catheter drainage bag was touching the floor with the tubing on the floor near the left wheel of her wheelchair. NA #2 was observed walking by Resident #96 three times during the observation. An interview was conducted with Nurse Aide #2 on3/15/22 at 3:39 PM. She reported that Resident #96 ' s catheter bag should not be touching the floor. She adjusted the bag so it was not touching the floor and the tubing so it would not be run over by her wheelchair. During an interview with the Director of Nursing on 3/15/22 at 4:10 PM she reported catheter bags should not be touching the floor.	F 690	Rounds Matrix to conduct 5 times a week catheter/catheter bag audits times 12 weeks, correcting any negative variance at the time of observation to include teachable-moment staff education. Audits will be given to the Nurse Practice Educator for reporting monthly audit outcomes to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		4/22/22

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F 693	Continued From page 39 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record reviews, observation and staff interviews, the facility failed to flush a resident's feeding tube between the administration of medications as ordered by the physician for 1 of 1 resident reviewed for feeding tube (Resident #84). Findings included: Resident #84 was admitted to the facility on 10/03/2019 with diagnoses which included gastrostomy and cerebral infarction. A review of Resident #84's physician order dated 11/05/2021 revealed to flush feeding tube with 30 milliliters (MLs) of water between each medication. A review of the Quarterly Minimum Data Set (MDS) dated 02/06/2022 revealed Resident #84 had severe cognitive impairment. The MDS also revealed Resident #84 was coded to have consumed 51% or more of his nutrition via feeding tube. A review of Resident #84's care plan last revised on 03/01/2022 revealed resident had an enteral feeding tube to meet his nutritional needs due to dysphagia with an intervention that included checking patency and placement of tube daily and before administering feedings and medications.	F 693	1. Nurse #7 was educated immediately by the Director of Nursing on the proper administration of medications for Resident #84. Resident #84 is currently having feeding tube flushed between medication administration per policy 2. Any resident requiring medications to be administered via tube has the potential to be affected. The clinical team conducted a 100% audit of Medication Administration Records for the last 30 days for all current residents receiving medications via tube to ensure compliance with the flushing of tubes. Any deviations noted were addressed with education and physician notification. The Director of Nursing and/or designee completed observation audits of all current licensed nurses administering medications via tube to ensure medications were administered in accordance with physician orders. 3. The Nurse Practice Educator has completed in-service education with all current licensed personnel on medication administration via tube. Current licensed staff who have not completed education and/or training prior to or on 04.21.22, will be required to complete education and/or training prior to working a shift.	

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F 693	Continued From page 40 An observation of Nurse #7 on 03/14/2022 at 10:32 am revealed she administered 4 of Resident #84's scheduled medications, apixaban 5mg, levetiracetam 500mg, lisinopril 20mg and paroxetine 10mg, without flushing in between each medication. An interview with Nurse #7 on 03/14/2022 at 11:06 am revealed she knew Resident #84's orders were to flush 30 MLs of water in between each medication but she didn't want to overload him with fluid. Nurse #7 stated she should have followed the physician order. An interview with the Director of Nursing on 03/18/22 at 12:13 PM revealed the physician orders should have been followed by flushing 30 MLs of water between each medication.	F 693	4. Clinical Managers will complete 5 observations per week for 4 weeks of residents receiving medications via tube, then weekly thereafter. Results of these observations will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F 732		4/22/22

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F 732	Continued From page 41 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete daily nurse staffing sheets for 20 of 170 days reviewed for posted daily nurse staffing sheets. (9/29/2021 through 10/11/2021 and 2/1/2022 through 2/7/2022) Findings included: A review of the posted daily nurse staffing sheets from 9/29/2021 to 3/17/2022 revealed no daily nurse staffing sheet had been completed on the days dated 9/29/2021 to 10/11/2021 and dated 2/1/2022 to 2/7/2022. On 3/17/2022 at 4:28 p.m. in an interview with the Central Scheduling Manager, she stated nursing schedules were prepared thirty days in advance and daily census was obtain either during the	F 732	1. The required facility staff posting is currently being posted per regulation. 2. The Director of Nursing is maintaining the staff postings daily in a binder. 3. On 04.13.22 the Administrator educated the staff responsible for posting nurse staffing information on the regulation regarding staff positing. 4. The Health Information Manager will conduct bi-weekly audits of staff information postings times 12 weeks. Any negative variance will be reported to the Director of Nursing at the time it is identified. The HIM will submit monthly reports on audit outcomes to the Quality	

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F 732	Continued From page 42 leadership morning meeting or from the lead nursing assistant. She stated from 9/29/2021 to 10/11/2021 and from 2/1/2022 to 2/7/2022 she was out of work, and advance nursing schedules were given to the Director of Nursing (DON). She stated the DON or Workforce Management were responsible for completing and posting the daily nurse staffing sheets in her absence, and she did not have the daily nurse staffing sheets for the dates she was absence. On 3/17/2022 at 4:37 p.m. in an interview with Workforce Management, she stated she or the DON posted the daily nurse staffing sheet when the Central Scheduling Manager was absent and did not have the daily nurse staffing sheets posted from 9/29/2021 to 10/11/2021 and from 2/1/2022 to 2/7/2022. On 3/17/2022 at 4:39 p.m. in an interview with the Director of Nursing, she stated Workforce Management posted the daily nurse staffing sheets in the absence of the Central Scheduling Manager and would have the posted sheets. The DON stated she did not have the posted daily nurse staffing sheets from 9/29/2021 to 10/11/2021 and from 2/1/2022 to 2/7/2022 and did not know where they were located.	F 732	Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	
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 appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		4/22/22

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F 761	Continued From page 43 §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, staff interviews and record review, the facility failed to date insulin vials and pens when opened, to maintain the required potency guidelines, and failed to dispose of a bottle of vitamins when they were expired on one of two medication carts inspected (Station 3 cart). Findings included: On 3/15/2022 at 4:30 PM the medication cart for Station 3 was checked for expired and undated medications. One bottle of Geri One Daily Multi Vitamin with iron and an expiration date of 10/20. Three vials of Humalog insulin (Diabetes medication) open and not dated. Two vials of Novolin R insulin (Diabetes medication) open and not dated. Two vials of Humulin N insulin (Diabetes medication) open and not dated. One	F 761	1. Outdated or undated medications were discarded and replaced; the Director of Nursing had the medications replaced on the evening of 03/15/22. The ADON educated Nurse #2 on the policy for conducting medication cart checks to ensure all medications are dated and within date for administration. 2. All residents have the potential to be affected. Medication and treatment carts were checked to ensure all medications were labeled and dated correctly; any expired or undated medications were discarded immediately by the ADON. 3. The Nurse Practice Educator has educated night shift nurses on their responsibility to routinely check the	

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F 761	Continued From page 44 vial of Lantus insulin (Diabetes medication) open and not dated. One vial of Glargine insulin (Diabetes medication) open and not dated. Two Basaglar insulin pens (Diabetes medication) open and not dated. Three Glargine insulin pens (Diabetes medication) open and not dated. Nurse #2 was interviewed on 3/15/2022 at 4:45 PM, and stated she thought the 11:00 PM to 7:00 AM shift of nursing was responsible for checking for expired medications on the carts. Nurse #2 said she only checked when she was giving a medication. On 3/15/2022 at 4:55 PM, the Director of Nursing stated she expected all nurses to date medications when they are opened and check the dates when the medications are given.	F 761	medications carts to ensure proper labeling/dating of medications and to remove expired medications. The Nurse Practice Educator has provided education to all current licensed personnel on ensuring medications are labeled and stored properly. Current licensed staff not completing this education and/or training prior to or on 04.21.22, will be required to complete education and/or training prior to working a shift. 4. The Director of Nursing and/or designees will complete med-cart audits for each cart) including emergency carts, one time weekly for 12-weeks and randomly thereafter to ensure medications are properly labeled and dated. Audit outcomes will be reported monthly to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain the area surrounding the dumpster free from trash and debris. This was evident in 2 of 2 observations of the dumpster area. The findings included: An observation on 3/16/2022 at 10:00 AM of the dumpster area revealed there were numerous	F 814	1. All trash and debris surrounding the dumpster area was picked up and disposed of properly by the Dietary Staff. 2. Dumpster area is currently being maintained free of trash and debris. 3. A. Clinical Dietary Manager has	4/22/22

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F 814	Continued From page 45 pieces of paper, latex gloves, empty trash bags, styro foam cups, drink cans and a plastic flowerpot on the ground surrounding the three trash dumpsters. During the same observation, plastic drink straws, small pieces of cardboard, latex gloves and styro foam cups were observed surrounding the 1 cardboard dumpster. An observation on 3/18/2022 at 10:40 AM of the dumpster area revealed 4 pieces of plastic, 5 cigarette butts, a clear plastic cup, a clear plastic cup lid, a paper plate and 8 pieces of paper on the ground area around the trash dumpsters. Staff interview on 3/16/2022 at 1:30 PM with the dietary manager revealed although numerous departments contributed to the trash collected in the dumpsters, the ultimate responsibility to keep the area clean belonged to the dietary department. Staff interview on 3/16/2022 at 2:15 PM with the administrator revealed she thought the dietary department was responsible for keeping the area clean, but her expectation was that if any staff member was taking a bag of trash to the dumpster and trash spilled on the ground, the staff would be expected to pick up the trash and dispose of it.	F 814	informed dietary staff of their regulatory responsibility to keep the dumpster area clean of debris. Dietary staff will be responsible for checking the areas around the dumpsters at the beginning and end of every dietary shift. B. The Administrator has educated the facility leadership team that all staff members are capable of and expected to, pick-up debris left on the ground. C. Environmental Services personnel will be accountable for checking dumpsters around 1200. D. The Central Supply Clerk will be accountable for ridding the area of debris at the end of assigned shifts. E. Maintenance has been scheduled within the TELS system for policing the exterior grounds on Monday, Wednesday and Friday. 4. Customer Experience Liaison will conduct random audits of the dumpster area (correcting any negative variance at the time of observation), 5 times per week times 12 weeks and will submit a monthly audit outcome report to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		4/22/22

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F 880	Continued From page 46	F 880		

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:
(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

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F 880	Continued From page 47 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 staff interviews, the facility that was located in a county with a high COVID-19 transmission level failed to implement their infection control policy and procedures and the Center for Disease Control and Prevention Guidance for COVID-19 when (1) Nurse #3 failed to wear a N-95 mask, gown and eye protective wear when performing tracheostomy suctioning and care and failed to perform hand hygiene after removing gloves for 1 of 1 resident (Resident #79) reviewed for respiratory care and (2) when COVID-19 screening was not performed for Physician Assistant #1 prior to entering the resident care area. This occurred during a COVID-19 pandemic.	F 880	1. a. Resident #79 - On 03/15/22 Nurse #3 was immediately in-serviced by the Director of Nursing on the infection control/preventive measures to be utilized during trach care. Resident #79 is currently receiving tracheostomy care in accordance with infection control protocol. b. On 03/14/22 the Director of Nursing educated Physician Assistant # 1 regarding the requirement for COVID-19 screening to be completed prior to entering a resident care area; occasionally this requires waiting in line while other guests are being screened.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(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 880	Continued From page 48 Findings included: 1. The Center for Disease Control and Prevention "Infection Control Guidance" dated February 2, 2022 stated if SARS-CoV-2 infection was not suspected in a patient presenting for care, the healthcare personnel (HCP) should follow standard precautions, and if working in facilities located in counties with a substantial or high COVID -19 transmission level, the HCP should also use a NIOSH approved N-95 or equivalent or higher level respirators should be used for all aerosol-generating procedures, and eye protection should be worn during all patient care encounters. The Center for Disease Control and Prevention "Recommendations for Application of Standard Precautions for the Care of all Patients in all Healthcare Settings" dated 2007 recommended use of gown, gloves, mask and eye protection during procedures when secretions were anticipated. The facility's "Tracheostomy Care" policy dated revised 7/15/2021 stated supplies included personal protective equipment (PPE) as indicated and gloves. The policy also stated cleansing the hands after removing gloves. On 3/15/2022 at 3:48p.m., Nurse #3 was observed providing Resident #79's suctioning and tracheostomy care wearing a surgical face mask, his personal eyeglasses and sterile gloves. Nurse #3 was observed conducting tracheostomy suctioning at three different intervals due to Resident #79 experiencing coughing episodes after suctioning was performed and removing	F 880	2. a. Any resident with a tracheostomy has the potential to be affected by not following the procedure for proper trach care. Nursing leadership completed an audit of all current residents with tracheostomies to ensure that there were no signs/symptoms of infections were present. b. All residents have the potential to be affected if staff, visitors or providers fail to complete the COVID-19 screening process. All residents were assessed and negative for COVID symptoms. The facility routinely assesses all residents for signs or symptoms of COVID-19 and follows CDC/CMS testing protocols. 3. a. The Director of Nursing and/or designee has completed education with licensed nursing personnel on the procedure for providing proper tracheostomy care. b. Outside practitioners have been educated by the Nurse Practice Educator and/or designee on checking in for the COVID screening process prior to entering resident care areas. The Director of Nursing and/or designee has re-educated staff in all departments on the importance of, and the regulatory requirements related to COVID-19 screening prior to entering resident care areas. Any staff who has not completed education and/or training prior to or on 04.21.22, will be required to complete education and/or training prior to working a shift. 4. a. The Nurse Practice Educator and/or	

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F 880	Continued From page 49 sterile gloves four different times while performing suctioning and tracheostomy care on Resident #79 and not performing hand sanitation before applying a new pair of sterile gloves. On 3/15/2022 at 4:13 p.m. in an interview with Nurse #3, he stated he had received education on the use of personal protective equipment and when performing aerosol procedures on Resident #79, a gown, gloves, eye protective wear and N-95 mask were required. He stated he did not wear a gown, eye protective wear or N-95 mask because Resident #79 did not leave the room and had tested negative for COVID-19. Nurse #3 also stated hand sanitation was required when changing gloves and he did not perform hand sanitation when removing his gloves every time. On 3/15/2022 at 4:30 p.m. in an interview with the Director of Nursing/Interim Infection Preventionist, she stated hand sanitation or hand washing was required between changing gloves. On 3/16/2022 at 6:06 a.m. in an interview with the Director of Nursing/Interim Infection Preventionist, she stated Nurse #3 should had worn full PPE (gown, gloves, N-95 mask and eyewear protection) when providing tracheostomy care and suctioning. 2. A review of the facility ' s COVID-19 Prevention Program updated July 2021 stated all employees, visiting healthcare personnel and visitors must be screened prior to entry into the facility.	F 880	designee will conduct weekly observations of tracheostomy care for 12 weeks to monitor for proper utilization of PPE and proper hand-washing; any negative variance will be corrected at the time of observation with education and demonstration of proper process. Observation outcomes will be reported monthly to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance. b. The Administrator and/or designee will conduct observation audits of the COVID-19 screening process a minimum of 5 times weekly times 12 weeks to ensure compliance. The Administrator will provide a monthly audit outcome report to the Quality Assurance and Performance Improvement Committee with the QAPI Committee responsible for ongoing compliance.	

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F 880	Continued From page 50	F 880		

On 3/14/22 at 9:20 a.m., Physician Assistant #1 (PA) was observed entering the facility without wearing a face mask or eye protective wear, walking past the screening area in the lobby and down the resident care hallway passing resident rooms #11, #12, #13, #14, and #15.

On 3/14/2022 at 11:23 a.m., an interview was conducted with the PA #1. He stated he knew he was supposed to enter the facility with a face mask on and was to perform a COVID-19 screening prior to entering the hallway into the resident care areas. He stated he didn ' t perform the COVID-19 screening because there were a lot of people standing in the lobby, and he didn ' t know what was going on. He stated he put his face mask on when he arrived at nurse ' s station #2 which was located across from resident room #15.

On 3/18/2022 at 10:36 a.m., an interview was conducted with the Director of Nursing. She stated everyone, including healthcare workers, who entered the facility were expected to complete a COVID-19 screening.