STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	C 04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/04/2022 through 04/08/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 004911.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation survey was conducted on 04/04/2022 through 04/08/2022 at Event ID# 004911. 3 of 8 complaint allegations were substantiated resulting in deficiencies. Intake #s: NC00186486, NC00186940, NC00187306 Past Non-Compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. An extended survey was conducted. On 5/2/22, the scope of tag F 806 was changed from an E to a D. The scope of F688 was changed from D to E. Edits were made to F641. Tag F 689 was corrected on 3/25/22.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		5/12/22

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

Electronically Signed | 04/28/2022

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F 561	Continued From page 1 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with the resident and facility staff the facility failed to honor a resident ' s preference for time of day to receive a shower for 1 (Resident #39) of 3 reviewed for choices. The findings included: Resident#39 was admitted to the facility on 10/23/18. The care plan initiated on 6/10/19 revealed Resident #39 required assistance for bathing related to impaired mobility and documented he	F 561	Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Barbour Court Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor	

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F 561	Continued From page 2 preferred showers about 11:00 AM. The care plan again documented "Prefers shower at around before lunch." The quarterly Minimum Data Set assessment dated 1/4/22 documented Resident #39 was cognitively intact. He required extensive assistance with most activities of daily living and was totally dependent for bathing. On 4/4/22 at 1:22 PM Resident #39 stated his shower schedule changed to the 3:00 PM to 11:00 PM shift because they did not have time on the 7:00 AM - 3:00 PM shift to give him a shower. Resident #39 also said his shower schedule was changed but he still does not get a shower when he wants one. On 4/8/22 at 9:13 AM Resident #39 said they changed his shower schedule about 3 months ago and he had been very unhappy since that happened. He stated he was never told why his shower schedule changed but he told the nurse aide he did not like it. He added he did not remember which nurse aide it was. Resident #39 said he felt he had to go with what they say. On 4/8/22 at 12:13 PM Nurse #4 stated he was unsure why the shower schedule changed but the schedule was based on the resident ' s room number, and he thought Resident #39 ' s shower schedule changed when he moved to his current room. On 4/8/22 at 2:20 PM the Director of Nursing stated she was unaware Resident #39 ' s shower schedule was changed, and she was not aware he preferred to have a shower on the 7:00 AM to 3:00 PM shift.	F 561	does it constitute and admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 4/21/2022 the Unit Manager interviewed the resident regarding his preferences and revised the plan of care for Res #39 to reflect the resident□s preferences. Resident #39 is now receiving showers per his preference. A member of the management team reviewed in-house residents regarding their bathing schedule by 5/11/2022. The residents□ plans of care were updated as indicated. The Director of Nursing (DON)/Licensed Nurse re-educated the nursing staff on honoring the residents' preferences regarding time of day to receive a shower by 5/11/2022. The DON/ Licensed Nurse will interview 5 residents for 4 weeks, then 5 residents monthly for 1 month to ensure resident preferences for the time of day to receive a shower is honored. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		5/12/22

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F 584	Continued From page 4 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain a clean, home like environment for 3 of 3 resident rooms (Room 301, 304 and 307) observed for environment. Findings included: 1a. Observation of room 301 occurred on 4-4-22 at 10:40am. The observation revealed a brown substance spilled on the front of the wall air/heat unit, cobwebs in the lower left corner of the window, brown marks on the ceiling above the bed, bathroom wall had paint chipped off exposing plaster and there was debris in 4 corners of the bathroom floor. A second observation of room 301 was completed on 4-7-22 at 9:20am with the Maintenance Director and the Housekeeping Manager. The observation concluded a brown substance spilled on the front of the wall air/heat unit, cobwebs in the lower left corner of the window, brown marks on the ceiling above the bed, bathroom wall had paint chipped off exposing plaster and there was debris in 4 corners of the bathroom floor. The Housekeeping Manager was interviewed on 4-7-22 at 9:21am who stated she was not aware of the issues found but that she expected her housekeeping staff to maintain a clean room by checking for spills, cobwebs and making sure the floors are clean. 1b Room 304 was observed on 4-4-22 at	F 584	By 5/11/24 the brown substance spilled on the front of the wall air/heat unit room, the cobwebs in the lower left corner of the window, and the debris in the 4 corners of the bathroom floor of room 301, and the black/brown substance on the walls, and the tan substance on the heat air unit in room 304, will be cleaned by the Housekeeping Manager. By 5/11/24 the brown marks on the ceiling above the bed and the chipped paint in the bathroom of room 301, the chipped paint on the wall beside the bed in room 304, and the rubber baseboard in room 307 were repaired by the Maintenance Director. On 4/6/22 the Maintenance treated room 307 for ants and then had the Pest Control Company come out and retreat on 4/8/22. The hole in the window frame was plugged by 5/11/22 The Administrator, Maintenance and Housekeeping Directors completed environmental rounds in every resident room on 4/20/22 to determine if there any other maintenance and/or housekeeping issues that need to be addressed. Any issues found during this resident room assessment will be repaired by maintenance and/or housekeeping by 5/11/22 The housekeeping and maintenance staff were in-serviced by the Administrator on maintaining deep cleaning, stripping, and	

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F 584	Continued From page 5 10:53am. The observation revealed a black/brown substance on the walls, the wall heat/air unit had a tan substance in the vents and there was paint chipped off the wall beside the bed showing the plaster. During a second observation of room 304 on 4-7-22 at 9:23am with the Maintenance Director and the Housekeeping Manager, the observation revealed a black/brown substance on the walls, the wall heat/air unit had a tan substance in the vents and there was paint chipped off the wall beside the bed showing the plaster. The Maintenance Director was interviewed on 4-7-22 at 9:24am. The Maintenance Director stated he was responsible for the walls and cleaning the wall air/heat unit. He stated staff can report any issues through the computer system but that he had not been made aware of the issues discussed. 1c. An observation of room 307 was completed on 4-4-22 at 11:05am. The observation revealed the rubber baseboards were coming off the wall and there were small black ants crawling on the windowsill. On 4-4-22 at 11:15am the Maintenance Director was made aware of the ants located in room 307. He was observed to spray the area and discussed a hole in the frame of the window causing access for the ants to enter the room. The Maintenance Director stated he would plug the hole to block the ant's access. A second observation of room 307 was conducted on 4-7-22 at 9:28am with the Maintenance Director and the Housekeeping	F 584	waxing schedules and timely completion of maintenance issues submitted to TELS, our on-line preventative maintenance repair Facility staff were re-educated by 5/11/22 on how to submit repair requests to TELS (our on-line preventative maintenance repair system) through Point Click Care so maintenance repair requests are completed timely by the Administrator/Maintenance Director. The education will added to the orientation agenda for all new hired staff and will be included as part of the orientation for agency staff going forward. The Administrator and/or Regional Maintenance Director, with the Maintenance and Housekeeping Departments will conduct environmental rounds weekly for 4 weeks then monthly for one month to ensure environmental issues are being addressed as necessary. Outcomes of those rounds will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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F 584	Continued From page 6 Manager. The observation revealed the rubber baseboards were coming off the wall and the hole in the window frame was not plugged. During an interview with the Maintenance Director on 4-7-22 at 9:30am, the Maintenance Director stated he had not been made aware of the baseboards coming off the resident's wall but would correct the issue. He also stated he had called the pest control company to come out and treat for ants. The Administrator was interviewed on 4-8-22 at 12:30pm. The Administrator stated he expected the environment to be maintained in a way where the residents feel comfortable.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility neglected to provide	F 600	Res #217 was assessed by a Registered Nurse (RN) on 4/5/22 by. The resident's	5/12/22

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F 600	Continued From page 7 requested assistance as directed in the resident's plan of care for 1 of 10 residents reviewed for activities of daily living (Resident #217). Findings included: Resident #217 was admitted to the facility 3/30/22. Her active diagnoses included contusion of unspecified forearm, repeated falls, and dependence on renal dialysis. Resident #217 did not have a completed Minimum Data Set assessment. Review of the completed Brief Interview for Mental Status (BIMS) signed 3/31/22 revealed she was assessed as cognitively intact. Resident #217's care plan dated 3/31/22 revealed she was care planned for activities of daily living care. The interventions included to provide one-person guidance and physical assistance with transfers and provide one-person physical extensive assistance for safety with toileting, adjusting clothing, washing hands, and pericare. During an interview on 4/4/22 at 3:06 PM Resident #217 stated early that morning she had to go to the bathroom. She rang the call bell around 6:00 AM. She stated she was previously told not to get out of bed herself by therapy and the staff in the facility. After she had waited thirty minutes, she was able to reach her wheelchair and transferred herself to the wheelchair. She reported she went to the door to the hall in order to turn the light on and a male nurse aide (NA #1) opened the door and said, "What do you need?" The resident told him she needed to use the restroom and she had rung, and no one answered. He told her, "well go." She informed	F 600	physician and representative (RR) were notified on 4/5/22 by the Unit Manager. NA #1 was removed from the schedule by the DON on 4/7/22and is no longer able to work at the facility. The resident and the resident's son were interviewed and stated no abuse occurred, it was a customer service issue. The Patient and the resident representative were satisfied with the investigation and action taken. A member of the facility's management team interviewed current in-house residents regarding abuse by 5/11/2022. The licensed nurses completed body audits of the non-interviewable residents by 4/28/22 to determine signs and symptoms of abuse. No additional concerns were noted. The Director of Nursing (DON)/Licensed Nurse re-educated all facility staff regardless of position or title on Understanding Abuse and Neglect by 5/11/22. Newly hired employees as well as agency staff will be educated on understanding abuse and neglect through the orientation process. The DON/Licensed Nurse will audit the ADL care of 10 residents by observation or interview weekly for 4 weeks then 10 residents monthly for 1 month to ensure requested assistance is provided as directed in the residents' plan of care. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on	

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F 600	Continued From page 8	F 600		

him she was not supposed to transfer alone. She said NA #1 pushed her briskly into the bathroom and left without assisting her on to the toilet. He was gone before she could say anything to him. She transferred herself to the toilet and went to the bathroom but she could not transfer herself back to the wheelchair as the wheelchair was higher than the toilet seat and she was not supposed to transfer herself. She turned on the call light in the bathroom. She sais she pulled the call light three or four times, but no one came. She started yelling from the bathroom for help and banging the wall. After about fifteen minutes of shouting for help she started to cry, and NA #1 came in and asked sharply "What's wrong?" She told him she could not get off the toilet. NA #1 then attempted to assist her by her left arm but her left arm was swollen and painful due to a dialysis shunt issue, so she told him not to use her left arm for transfers. She said NA #1 then took ahold of her nightgown by her right shoulder in his hand and pulled her up by the night gown. It was uncomfortable but enough support to help her transfer to the wheelchair. He pushed her in her wheelchair out of the bathroom into the room and put her beside the bed. Resident #217 stated NA #1 did not transfer her to the bed or assist with her transfer. He left the room quickly before she could ask for assistance back to the bed. She knew at that point she was not going to get help back to bed so she attempted herself. She said she was able to transfer herself to her bed and by that point her legs were shaking. She concluded it made her feel deeply concerned she was not going to get the care and assistance she needed in the facility and it caused her to cry.

Resident #219 resided across the hall from Resident #217 and a review of her Minimum Data

findings.

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F 600	Continued From page 9	F 600		

Set assessment dated 4/3/22 revealed she was assessed as cognitively intact.

During an interview on 4/4/22 at 2:44 PM Resident #219 stated that morning for about 15 minutes a resident was shouting for help across the hall. The resident was shouting for someone to help her, banging on the walls, and crying. Eventually a staff member must have responded because the noise ended after 15 to 20 minutes.

Review of the assignment sheet for the 11 PM to 7 AM shift for 4/3/22 through 4/4/22 revealed NA#1 was assigned Resident #217.

During an interview on 4/7/22 at 4:52 PM NA#1 stated the morning of 4/4/22 Resident #217 had turned her call light on and he went to her room. She asked for assistance to the bathroom. He stated she was still in the bed, and he asked her how she needed assistance as it was his first time working with her. She asked him to guide her by her left arm to her wheelchair and then she could go to the bathroom. NA #1 stated he assisted her by her left arm into the wheelchair and then they entered the bathroom he then assisted her by her left arm to the toilet and told her to ring the call bell when she was done, and he would give her privacy. He stated he then left.NA #1 stated about 5 minutes later the resident rang the call bell from the bathroom and he returned when he saw the light turn on over her room. He stated she had transferred herself back to the wheelchair and was in her room. He stated while trying to transfer the resident back to bed, she indicated she was too weak, so he got assistance from NA#5. Together they were able to transfer the resident to her bed.

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F 600	Continued From page 10 During an interview on 4/7/22 at 5:33 PM NA#5 stated she did work on 4/3/22 through 4/4/22 and never assisted NA #1 with Resident #217. She further stated she did not like working with NA#1 because he would clock in to work and then disappear. NA #5 stated NA #1 did not answer his call lights and would have a bad attitude in order to avoid work. NA #5 concluded she would spend the shift working with NA#1 answering his call lights and providing care in order to assure his residents as well as her own received care. During an interview on 4/8/22 at 7:58 AM Nurse #4 stated NA#1 was always late and always had complaints from his residents about him. Nurse #4 filed grievances about NA#1 on behalf of the residents. NA#1 was fired from the facility a long time ago and came back with an agency staff person. Nurse #4 said NA#1 was then identified as do not return to the facility with his agency but when the Administrator changed, NA#1 would return through an agency. The nurse would inevitably have to file a grievance about NA#1 for a resident and the nurse aide would be labeled as do not return again. This had happened multiple times. During an interview on 4/8/22 at 9:34 AM the Director of Nursing stated nurse aides should assist with transfers and activities of daily care in accordance with their plan of care. Nurse aides were expected to answer and engage with residents to promote dignity and provide the assistance they needed. Based on the information provided she understood this was a concern for Resident #217 and she would follow up with Resident #217 and the nurse aide.	F 600		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg	F 637		5/12/22

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F 637	Continued From page 11 CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to identify and complete a significant change in condition assessment after the resident was admitted to Hospice services for 1 of 2 residents reviewed for Hospice (Resident #21). Findings included: Resident #21 was admitted to the facility on 8-31-18 with multiple diagnoses that included malignant neoplasm. The quarterly Minimum Data Set (MDS) dated 1-21-22 revealed Resident #21 was cognitively intact. A Physician's order dated 2-10-22 revealed Resident #21 was placed on hospice services. Resident #21's care plan dated 2-10-22 revealed a goal that he would not experience pain without appropriate nursing intervention. The	F 637	A significant change assessment was completed for Res #21 on 4/6/22 by the MDS Nurse. By May 11, 2022 current residents receiving hospice services were reviewed by the Minimum Data Set (MDS) nurse to ensure a significant change assessment was completed as indicated. Any issues identified were corrected immediately. The RAI/Reimbursement Auditor re-educated the Minimum Data Set (MDS) nurses on 4/22/22 regarding the Resident Assessment Instrument (RAI) manual □s requirement for significant change assessment. Education regarding the RAI manual's requirement for significant change assessment will be added to the orientation of newly hired MDS nurses going forward.	

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F 637	Continued From page 12 interventions for the goal were in part spiritual care consult, consult with hospice and physician regarding pain management. During an interview with MDS Nurse #1 on 4-6-22 at 2:55pm, MDS Nurse #1 confirmed there was not a significant change MDS completed after Resident #21 was placed on hospice. She also confirmed a significant change MDS should have been completed on 2-10-22 when Resident #21 was placed on hospice. The MDS Nurse stated she had missed completing the significant change assessment. The Administrator was interviewed on 4-8-22 at 12:30pm. The Administrator stated he expected the MDS to be accurately documented when a significant change had occurred.	F 637	The MDS nurse/Reimbursement Auditor will conduct audits of all residents newly admitted to hospice weekly for 4 weeks then monthly for 1 month to ensure identification and completion of a significant change in condition assessment after the resident is admitted to hospice services. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	
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 observations, record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of functional limitation in range of motion (Resident #75), Preadmission Screening and Resident Review (Resident #91), and tobacco use (Resident #97). This was for 3 of 29 resident's MDS assessments reviewed. Findings included: 1. Resident #75 was admitted to the facility on	F 641	Res #91□s assessment was modified by the MDS nurse on 4/6/22. Res #75□s assessment was modified by the MDS nurse on 4/6/22. Res #97□s assessment was modified by the MDS nurse on 4/6/22. The most recent MDS assessment for current in-house residents were reviewed in the areas of functional limitation in range of motion, Preadmission Screening and Resident Review, and tobacco use to	5/12/22

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F 641	Continued From page 13 11/24/2021 with a diagnosis of dementia with behavioral disturbance. A review of the 03/14/2022 quarterly MDS assessment for Resident #75 revealed she had no functional limitation in the range of motion of her lower extremities. It further revealed she received physical therapy (PT) for a total of 169 minutes in the last 7 days beginning on 03/08/2022. A review of the PT Daily Treatment Note for Resident #75 dated 03/08/2022 revealed the treatment diagnosis of contracture (a permanent tightening of the muscles, tendon, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the left knee. On 04/06/2022 at 1:45 PM an interview with Resident #75's Physical Therapist (PT #1) indicated Resident #75's treatment began on 03/08/2022 because of a contracture of her left knee. She stated this meant Resident #75 did not have full functional range of motion in her left knee and could not straighten it all the way. PT #1 went on to say Resident #75 continued to have this knee contracture on 03/29/2022 when Resident #75 was discharged from PT services. On 04/07/2022 at 8:47 AM an interview with MDS Nurse #1 indicated she coded Resident #75's quarterly MDS assessment dated 03/14/2022 to reflect Resident #75 had no functional limitation in the range of motion of her lower extremities. She stated Resident #75 could not follow instructions. She went on to say she had not wanted to touch Resident #75 during the assessment because Resident #75 was easily agitated. She further indicated she observed Resident #75 moving her	F 641	ensure accuracy of the assessment by the MDS nurse. Any issues identified were corrected immediately. The RAI/Reimbursement Auditor re-educated the MDS nurses on completing the assessment accurately according to the RAI manual on 4/22/22. Education regarding completing the areas of functional limitation in range of motion, Preadmission Screening, Resident Review and tobacco use will be included in the orientation process for newly hired MDS nurses going forward. The MDS nurse/Reimbursement Auditor will conduct audits of 5 assessments completed weekly for 4 weeks then 5 assessments completed monthly for 1 month to ensure the MDS assessment is accurately coded in the areas of functional limitation in range of motion, preadmission screening and resident review and tobacco use. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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lower extremities in bed during the look back period for this assessment.

On 04/07/2022 at 9:06 AM an interview with the Director of Nursing (DON) indicated Resident #75's MDS assessment should be an accurate reflection of her status.

2. Resident #91 was admitted to the facility on 3/3/21. His active diagnoses included schizophrenia.

Resident #91's most recent Preadmission Screening and Annual Resident Review (PASARR) Level II determination notification dated 1/26/22 revealed he was assessed to be level II PASARR.

Resident #91's MDS assessment dated 3/3/22 revealed he was assessed to not have a level II PASARR.

During an interview on 4/6/22 at 10:09 AM MDS Nurse #2 stated the MDS dated 3/3/22 was incorrectly coded and was an error. She concluded she would complete a modification immediately.

During an interview on 4/6/22 at 9:52 AM the Administrator stated PASARR status should be accurately reflected in resident MDS assessments.

3. Resident #97 was admitted to the facility on 2/14/20, Her diagnoses included chronic obstructive pulmonary disease and nicotine dependence.

The annual MDS dated 3/10/22 indicated Resident #97 was moderately cognitively impaired and was not a current tobacco user.

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F 641	Continued From page 15 On 4/5/22 at 2:17 PM Resident #97 was observed outside in a designated smoking area with other residents and a staff member. She was observed smoking a cigarette. On 4/5/22 at 2:17 PM Resident #97 stated she had been a smoker since admission to the facility. On 4/8/22 at 12:34 PM an interview with MDS nurse #1 was conducted. She stated Resident #97 was a smoker and tobacco use had been coded incorrectly.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		5/12/22

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F 657	Continued From page 16 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff, resident, and resident representative interviews the facility failed to invite a resident or resident representative to participate in the development or revision of the care plan for 5 of 8 residents reviewed for care plan meetings (Resident #91, Resident #16, Resident #46, Resident #97, and Resident #43). Findings included: 1. Resident #91 was admitted to the facility on 3/3/21. His active diagnoses included schizophrenia, type 2 diabetes mellitus, hyperlipidemia, ischemic cardiomyopathy, stage 4 kidney disease, and heart failure. Resident #91's Minimum Data Set assessment dated 3/3/22 revealed the resident was assessed as cognitively intact. During an interview on 4/4/22 at 11:43 AM Resident #91 stated he had never had a care plan meeting but was not entirely sure what a care plan meeting was. During an interview on 4/6/22 at 8:15 AM Social Worker #1 stated Resident #91 was admitted 3/3/21 and there were two social workers who worked at the facility until early 2/2022. Resident #91 was on Social Worker #2's caseload, and he	F 657	The care plan meeting for Res #43 was held on 4/13/22. On 4/21/2022 Social Services scheduled a care plan meeting for Res #91, #16, #46, and #97. The resident representatives were invited as residents will allow. Current in-house residents were reviewed by a member of the management team to ensure resident or resident□s representative were invited to participate in the development or revision of the care plan by 5/11/2022. The follow up was completed based on the findings. The Interdisciplinary Team (IDT) were re-educated by the Regional Clinical Consultant/Administrator on the regulation F657 by 5/11/2022. Education regarding the regulation F657 will be added to the orientation of newly hired members of the IDT going forward. Social Services updated the care plan meeting schedule by 5/11/2022. The care plan meeting schedule will be discussed 5 days a week in the morning clinical meeting to ensure the meetings are being held and the resident representatives are being invited The Director of Nursing will conduct audits of 5 residents who had MDS assessments	

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F 657	Continued From page 17 was unable to find any documentation of any care plan meetings with the resident. There was also no documentation of the resident being invited to any care plan meetings. He concluded he was unaware of any reason the resident did not have any care plan meetings or invitations to care plan meetings documented and could not speak to if a care plan meeting ever happened for Resident #91 due to lack of documentation. He stated when Social Worker #2 left in 2/2022 the facility began looking for another social worker and in the interim, he was keeping up with the whole building. Social Worker #1 concluded he was unaware the resident had not been having his routine care plan meetings. During an interview on 4/6/22 at 9:52 AM the Administrator stated in early 3/2022 they had identified care plan meetings as an issue due to the loss of a staff member. The facility was hiring for a new social worker and the current social worker had not completed the backlog of care plan meetings that had been missed. He stated currently they have letterheads they had implemented to invite residents and resident representatives to care plan meetings and had implemented a weekly calendar and the letters were sent out on Mondays. The Administrator concluded Resident #91 should have had a care plan meeting and been invited. Social Worker #2 was unavailable for interview. 2. Resident #16 was admitted to the facility on 5/3/21. His active diagnoses included malnutrition, peripheral vascular disease, chronic venous hypertension with ulcer of left and right lower extremity, anemia, adult failure to thrive, dysphagia, personal history of malignant	F 657	completed weekly for 4 weeks then 5 residents monthly for 1 month to ensure the resident or resident's representative is invited to participate in the development or revision of the care plan. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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neoplasm of prostate, and type 2 diabetes.

Resident #16's Minimum Data Set assessment dated 1/15/22 revealed he was assessed as severely cognitively impaired.

During an interview on 4/4/22 at 1:58 PM Resident #16's responsible party stated he was not aware of ever being involved in or invited to a care plan meeting.

During an interview on 4/6/22 at 8:15 AM Social Worker #1 stated Resident #16 was admitted 5/3/21 and there were two social workers who worked at the facility until early 2/2022. Resident #16 was on Social Worker #2's caseload, and he was unable to find any documentation of any care plan meetings with the resident's responsible party as the resident was severely cognitively impaired. There was also no documentation of the resident's responsible party being invited to any care plan meetings. He concluded he was unaware of any reason the resident did not have any care plan meetings documented or invitations of the resident's responsible party to care plan meetings documented. He could not speak to if a care plan meeting ever happened for Resident #16 due to lack of documentation. He stated when Social Worker #2 left in 2/2022 the facility began looking for another social worker and in the interim, he was keeping up with the whole building. Social Worker #1 concluded he was unaware the resident had not been having his routine care plan meetings.

During an interview on 4/6/22 at 9:52 AM the Administrator stated in early 3/2022 they had identified care plan meetings as an issue due to the loss of a staff member. The facility was hiring

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for a new social worker and the current social worker had not completed the backlog of care plan meetings that had been missed. He stated currently they have letterheads they had implemented to invite residents and resident representatives to care plan meetings and had implemented a weekly calendar and the letters were sent out on Mondays. The Administrator concluded Resident #16 should have had a care plan meeting and been invited.

Social Worker #2 was unavailable for interview.
3. Resident #46 was readmitted to the facility on 7/19/21 with diagnoses which included congestive heart failure, atrial fibrillation, and hypertensive heart disease.

The most recent Minimum Data Set (MDS) was a quarterly assessment dated 2/11/22. The MDS indicated Resident #46 was cognitively intact.

During an interview with Resident #46 on 4/5/22 at 10:54 AM she stated she had not attended a care plan meeting and had never heard of a care plan meeting or what it was for.

On 4/6/22 at 8:59 AM Social Worker (SW) #1 stated he reviewed the documentation and there was no record of a care plan meeting for Resident #46. SW #1 said the care plan meeting should be scheduled after each MDS assessment was completed. He said the last MDS for Resident # 46 was dated 2/11/22 so there should have been a care plan meeting within 14 days of that MDS. SW #1 said SW #2 was responsible for this resident prior to 2/2022 when SW #2 was no longer employed by the facility.

On 4/6/22 at 11:30 AM the Administrator reported

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the facility had identified care plan meetings were not being conducted since one of the two social workers left employment. He said the current social worker had not completed the backlog of care plan meeting that had been missed. This included resident #46. The Administrator stated care plan meeting should be scheduled and the residents or their responsible party should be invited to attend.

4. Resident #97 was admitted 2/14/20. Her diagnoses included atrial fibrillation and obstructive pulmonary disease.

The most recent MDS an annual MDS dated 3/10/22 indicated Resident #97 was moderately cognitively impaired. She was able to make herself understood and she was able to understand others with clear comprehension.

On 4/5/22 at 2:03 PM Resident #97 stated she had not attended a care plan meeting.

On 4/6/22 at 8:55 AM SW #1 stated there was no documentation of a care plan meeting for Resident #97. He said he review her medical record back to June 2021 and there were no notes about any care plan meetings. SW #1 stated the other SW left in February 2022 and SW #1 thought SW #2 had completed her assignments. He reported he just started conducting care plan meetings that were previously assigned to SW #2. SW #1 stated Resident # 97 must have been missed.

On 4/6/22 at 11:35 AM the Administrator reported the facility had identified care plan meetings were not being conducted since one of the two social workers left employment. He said the current

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social worker had not completed the backlog of care plan meeting that had been missed. This included resident #97. The Administrator stated care plan meeting should be scheduled and the residents or their responsible party should be invited to attend.
5. Resident #43 was admitted to the facility on 04/29/2021 with a diagnosis of dementia without behavioral disturbance.

A review of the quarterly MDS assessment for Resident #43 dated 02/10/2022 revealed she was severely cognitively impaired. She required the extensive assistance of two people for bed mobility and extensive assistance of one person for dressing. It further revealed Resident #43 required the total assistance of one person for toileting, personal hygiene, and bathing.

A review of her medical record revealed no evidence of care plan meetings or care plan meeting attendance signature sheets.

On 04/04/2022 at 4:41 PM a telephone interview with Resident #43's family member revealed he was her Representative (RP). He stated although the facility kept him informed of any falls or other issues with Resident #43, he had not received any invitation to or participated in any care plan meetings.

On 04/07/2022 at 9:46 AM an interview with SW #1 indicated Resident #43 had not previously been assigned to him. He stated he took over the assignments for all residents in February 2022. He went on to say normally care plan meetings were held based on a calendar the MDS Nurse sent out. SW #1 indicated he would send out the invitation letters to the scheduled care plan

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meetings to residents and their RPs. He went on to say he did not have any record of Resident #43's scheduled care plan meetings and had not sent her RP any invitation letters.

On 04/07/2022 at 10:08 AM an interview with MDS Nurse #1 indicated she sent out the care plan schedule to the SW based the day a resident's MDS assessment was due. She stated Resident #43's 02/10/2022 MDS assessment date would have been on this care plan schedule but she did not keep any records of this.

On 04/7/2022 at 5:43 PM an interview with the facility Corporate Clinical Director indicated the facility had no record of any care plan meetings or care plan meeting attendance sheets for Resident #43. She stated if a care plan meeting was held, there should have been documentation in the progress notes or a care plan meeting signature sheet to indicate who attended the meeting.

On 04/08/2022 at 8:10 AM an interview with the facility's Mobile Administrator indicated she was the facility's previous Administrator and now served as a Mobile Administrator. She stated she thought she recalled a care plan meeting for Resident #43 in December 2021, although she could not recall the exact date. She stated she did not recall the names of the people who attended and there was no documentation of this and no care plan meeting signature sheets in Resident #43's record. She further indicated care plan meetings for residents should be held at least every 3 months and occur after any change in condition. She went on to say she was not aware of any other care plan meetings for Resident #43.

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F 657	Continued From page 23 On 04/08/2022 at 3:19 PM an interview with the Administrator indicated Resident #43 did not have care plan meetings as required. He stated due to the transition of administration and the loss of the social worker who arranged the meetings they had not happened.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed provide assistance with transfers and assistance with toileting (Resident #217), failed to keep dependent residents' fingernails clean (Resident #16, Resident #82, Resident #97, and Resident #88), and failed to provide baths (Resident #77, Resident #21, Resident #114, and Resident #106) for 9 of 10 resident reviewed for activities of daily living (ADL) care. Findings included: 1. Resident #217 was admitted to the facility 3/30/22. Her active diagnoses included contusion of unspecified forearm, repeated falls, and dependence on renal dialysis. Resident #217 did not have a completed Minimum Data Set (MDS) assessment. Review of the completed Brief Interview for Mental Status (BIMS) signed 3/31/22 revealed she was	F 677	The nails were clipped and cleaned on 4/6/22 for Res #217, Res # 16, 82, 97, and #88. The facility staffing guidelines were reviewed with the Staffing Coordinator and the Director of Nursing by the Administrator on 4/7/22 and Residents #106, #77, #21, and #114 are receiving showers as scheduled. A member of the management team reviewed in-house residents regarding their bathing schedule by 5/11/2022. In-house residents were evaluated by a licensed nurse for clean fingernails. Any issues identified were corrected immediately. The Director of Nursing (DON)/ re-educated facility nursing staff regarding the regulation for providing ADL care and the need for nail care. Newly hired employees as well as agency staff will be	5/12/22

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F 677	Continued From page 24 assessed as cognitively intact. Resident #217's care plan dated 3/31/22 revealed she was care planned for activities of daily living care. The interventions included to provide one-person guidance and physical assistance with transfers and provide one-person physical extensive assistance for safety with toileting, adjusting clothing, washing hands, and pericare. During an interview on 4/4/22 at 3:06 PM Resident #217 stated early that morning she had to go to the bathroom. She rang the call bell around 6:00 AM. She was previously told not to get out of bed herself by therapy and the staff in the facility. After she had waited thirty minutes, she was able to reach her wheelchair and transferred herself to the wheelchair. She went to the door to the hall in order to turn the light on and a male nurse aide (NA #1) opened the door and said, "What do you need?" Resident #217 told NA #1 she needed to use the restroom and she had rung, and no one answered. He told her, "well go." She informed him she was not supposed to transfer alone. She stated NA #1 then pushed her briskly into the bathroom and left without assisting her on to the toilet. He was gone before she could say anything to him. REsidnet #217 stated she transferred herslef to the toilet and went to the bathroom but could not transfer herself back to the wheelchair as the wheelchair was higher than the toilet seat and she was not supposed to transfer herself. Resident #217 said she turned on the call light in the bathroom. She pulled the call light three or four times, but no one came. She started yelling from the bathroom for help and banging the wall. After about fifteen minutes of shouting for help she started to cry, and NA#1 came in and asked sharply "What's	F 677	educated on regarding the regulation for providing ADL care and the need for nail care through the orientation process. The DON/Licensed Nurse will audit the ADL care of 10 residents by observation or interview weekly for 4 weeks then 10 residents monthly for 1 month to ensure residents fingernails are clean and baths/showers are provided. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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wrong?" She told him she could not get off the toilet. He then attempted to assist her by her left arm but her left arm was swollen and painful due to a dialysis shunt issue, so she told him not to use her left arm for transfers. NA #1 then took ahold of her nightgown by her right shoulder in his hand and pulled her up by the night gown. Resident #217 said it was uncomfortable but enough support to help her transfer to the wheelchair. He brought her in the room and put her beside the bed and did not transfer her to the bed or assist with her transfer. Resident #217 stated NA #1 left the room quickly before she could ask for assistance back to the bed. She knew at that point she was not going to get help back to bed so she attempted herself. She was able to transfer herself to her bed and by that point her legs were shaking. She concluded it made her feel deeply concerned she was not going to get the care and assistance she needed in the facility and it caused her to cry.

Resident #219 resided across the hall from Resident #217 and a review of her Minimum Data Set assessment dated 4/3/22 revealed she was assessed as cognitively intact.

During an interview on 4/4/22 at 2:44 PM Resident #219 stated that morning for about 15 minutes a resident was shouting for help across the hall. The resident was shouting for someone to help her, banging on the walls, and crying. Eventually a staff member must have responded because the noise ended after 15 to 20 minutes.

Review of the assignment sheet for the 11 PM to 7 AM shift for 4/3/22 through 4/4/22 revealed NA#1 was assigned Resident #217.

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During an interview on 4/7/22 at 4:52 PM NA#1 stated the morning of 4/4/22 Resident #217 had turned her call light on and he went to her room. She asked for assistance to the bathroom. He stated she was still in the bed, and he asked her how she needed assistance as it was his first time working with her. She asked him to guide her by her left arm to her wheelchair and then she could go to the bathroom. He assisted her by her left arm to the wheelchair and then they entered the bathroom he then assisted her by her left arm to the toilet and told her to ring the call bell when she was done, and he would give her privacy. He stated he then left. About 5 minutes later the resident rang the call bell from the bathroom and he returned when he saw the light turn on over her room. He stated she had transferred herself back to the wheelchair and was in her room. He stated while trying to transfer the resident back to bed, she indicated she was too weak, so he got assistance from NA#5. Together they were able to transfer the resident to her bed.

During an interview on 4/7/22 at 5:33 PM NA#5 stated she did work on 4/3/22 through 4/4/22 and never assisted NA #1 with Resident #217. She further stated she did not like working with NA#1 because he would clock in to work and then disappear. She stated he did not answer his call lights and would have a bad attitude in order to avoid work. The nurse aide concluded she would spend the shift working with NA#1 answering his call lights and providing care in order to assure his residents as well as her own received care.

During an interview on 4/8/22 at 7:58 AM Nurse #4 stated NA#1 was always late and always had complaints from his residents about him. Nurse #4 filed grievances about NA#1 on behalf of the

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residents. NA#1 was fired from the facility a long time ago and came back with an Agency. NA#1 was then identified as do not return to the facility with his agency but when the Administrator changed, NA#1 would return through an agency. The nurse would inevitably have to file a grievance about NA#1 for a resident and the nurse aide would be labeled as do not return again. This had happened multiple times.

During an interview on 4/8/22 at 9:34 AM the Director of Nursing stated nurse aides should assist with transfers and activities of daily care in accordance with their plan of care. Based on the information provided she felt this was an activities of daily living concern for Resident #217 and she would follow up with the resident and the nurse aide.

2. Resident #16 was admitted to the facility on 5/3/21. His active diagnoses included malnutrition, peripheral vascular disease, anemia, hypertension, and diabetes mellitus.

Resident #16's quarterly minimum data set assessment dated 1/15/22 revealed he was assessed as severely cognitively impaired. He had no moods and no behaviors. He was totally dependent on one staff member for personal hygiene.

A review of Resident #16's care plan dated 2/16/22 revealed he was care planned for activities of daily living care. The interventions included to provide extensive physical assistance with personal hygiene.

During observation on 4/4/22 at 12:24 PM Resident #16 was observed to have black debris

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caked under his fingernails.

During observation on 4/5/22 at 10:00 AM Resident #16 was observed to still have black debris caked under his fingernails.

During an interview on 4/5/22 at 10:09 AM NA #6 stated Resident #16's fingernails were very dirty and did have black debris caked under the nails and should have been cleaned. She stated she had never known Resident #16 to refuse care and she would clean them that morning when she provided his bed bath.

During observation on 04/05/22 10:10 AM NA #6 was observed to ask Resident #16 if his nails needed to be cleaned and if he would let her. Resident #16 nodded and smiled.

During an interview on 4/5/22 at 10:14 AM Nurse #4 observed Resident #16's fingernails and stated they should have been cleaned before now as they had black debris caked under the nails. He concluded Resident #16 never refused care in his experience.

During an interview on 4/5/22 at 10:15 AM the Director of Nursing, upon observing Resident #16's nails, stated his nails should have been cleaned prior to now as they had black debris caked under the fingernails.

During an interview on 4/5/22 at 10:52 AM the Cooperate Clinical Director stated cooperate staff had rounded this morning on 4/5/22 and identified multiple residents with nail concerns and Resident #16 was one of the residents identified to have not received proper nail care. She concluded staff had not gotten around to cleaning

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his nails yet.
3. Resident #82 was admitted to the facility on 9/14/20 with diagnoses which included diabetes and hemiplegia of the left nondominant side.

The quarterly MDS dated 2/28/22 indicated Resident #82 was cognitively intact. She had no behaviors. She required extensive to total assistance with activities of daily living.

The care plan focus area of bathing last updated 9/15/20 and indicated Resident #82 was totally dependent on staff for bathing.

On 4/4/4/22 at 2:30 PM Resident #82 was observed to have dirty fingernails on both hands. The fingernails were caked with dark brown and black debris.

On 4/4/22 at 2:30 PM Resident #82 stated she did not know when her fingernails were last cleaned. She reported she had received her bed bath this morning and the previous morning.

On 4/5/22 at 11:00 AM Resident #82's fingernails continued to contain dark brown and black debris.

On 4/5/22 at 11:05 AM NA #2 observed Resident #82's fingernails. NA #3 stated the fingernails were dirty and needed to be cleaned.

On 4/5/22 at 11:15 AM Nurse #11 observed Resident #82's fingernails. She stated the Residents' fingernails were dirty and also needed to be trimmed because they had jagged edges. Nurse # 11 then said the NA can clean the fingernails and should report to the nurse if the fingernails need to be trimmed since Resident #82 had a diagnosis of diabetes.

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On 4/5/22 at 2:29 PM the Director of Nursing (DON) said she expected resident's fingernails to be kept clean even if the resident only received a bed bath. She added NAs and nurses should notice if fingernails are dirty or long and clean and trim them as soon as possible.

4. Resident #97 was admitted to the facility on 2/14/20, Her diagnoses included atrial fibrillation, chronic obstructive pulmonary disease and nicotine dependence.

The annual MDS dated 3/10/22 indicated Resident #97 was moderately cognitively impaired. She had rejection of care 1-3 days. She required extensive assistance for dressing, toilet use and personal hygiene. She was totally dependent on staff for bathing.

On 4/5/22 at 10:34 AM Resident #97 was observed to have brown and black debris under her fingernails.

On 4/7/22 at 12:04 PM Resident #97 stated she received a bath last night and her hair was washed. She said her nails were not cleaned during her bath and an observation during the interview revealed her fingernails continued to contain brown and black debris.

On 4/8/22 at 12:06 PM an observation of Resident #97's fingernails revealed they continued to contain brown and black debris. The fingernails were now noted to be jagged.

On 4/8/22 at 12:49 PM NA #15 stated she had enough time to give residents a bath but often did not have time to clean or trim a resident's

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fingernails.

On 4/5/22 at 2:29 PM the Director of Nursing (DON) said she expected residents' fingernails to be kept clean even if the resident only received a bed bath. She added NAs and nurses should notice if fingernails are dirty or long and clean and trim them as soon as possible.

5. Resident #88 was admitted to the facility on 5/11/19 with diagnoses which included diabetes, coronary artery disease, and arthritis.

The annual MDS dated 2/24/22 indicated Resident #88 was moderately cognitively impaired. She required extensive assistance with activities of daily living except she was totally dependent on staff for toileting and bathing.

On 4/4/22 at 12:56 PM Resident #88 was observed to have brown and black debris under the fingernails of both hands. Her fingernails were noted to be more than ¼ inch in length.

On 4/5/22 at 11:08 AM NA #2 observed Resident #88's fingernails. NA #3 stated the fingernails were dirty and needed to be cleaned. She stated Resident #88 had diabetes so she the nurse was responsible to trim her fingernails.

On 4/5/22 at 11:18 AM Nurse #11 observed Resident #88's fingernails. She stated the Residents' fingernails were dirty and also needed to be trimmed because they were long. Nurse #11 then said the NA can clean the fingernails and should report to the nurse if the fingernails need to be trimmed since Resident #88 had a diagnosis of diabetes.

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On 4/5/22 at 2:29 PM the DON said she expected residents' fingernails to be kept clean even if the resident only received a bed bath. She added NAs and nurses should notice if fingernails are dirty or long and clean and trim them as soon as possible.

6. Resident #106 was admitted to the facility on 6-29-17 with multiple diagnoses that included spinal stenosis, chronic pain and diabetes.

Resident #106's care plan dated 2-27-22 revealed a goal that she would be neat, clean and odor free. Maintain good oral hygiene. The interventions for the goal were in part bathing required total dependance with one person, provide intermittent supervision, repetitive cues, aid with set up of oral/dental supplies.

The significant change Minimum Data Set (MDS) dated 3-2-22 revealed Resident #106 was cognitively intact and required extensive assistance with 2 people for bed mobility, total assistance with one person for transfers, bathing and toileting, extensive assistance with one person for personal hygiene.

Review of the March 2022 ADL documentation revealed there was no documentation of baths/showers being provided for the following dates, March 3, 19, 20, 22, 24, 27.

Resident #106 was interviewed on 4-4-22 at 12:00pm. The resident discussed not receiving a bath on a regular basis and stated her baths were not provided mostly on the weekends.

During an interview with NA #10 on 4-7-22 at 1:30pm, the NA confirmed she was assigned to Resident #106 most of the days in March. She

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stated if the missing documentation for a bath/shower was on a weekend (March 19, 20, & 27) she did not provide a bath or shower to Resident #106 due to not having enough staff. NA #10 said on March 3, 22 and 24 she probably had provided a bath/shower and forgot to document.

The Director of Nursing (DON) was interviewed on 4-8-22 at 11:20am. The DON stated ADL care not being provided to the residents was a problem and she was aware the nurses were not assisting the NA's when there were not enough NA's present to complete ADL care. The DON discussed the facility trying to hire more staff to alleviate the care issue.

7. Resident #77 was admitted to the facility on 10-25-21 with multiple diagnoses that included fracture of the upper end of the left humerus (long bone from the shoulder to the elbow).

Resident #77's care plan dated 2-7-22 had a goal of ADL/personal care would be completed with staff support. The interventions for the goal were in part bathing extensive assistance with one person.

The quarterly Minimum Data Set (MDS) dated 2-21-22 revealed Resident #77 was cognitively intact and required extensive assistance with one person for bed mobility, transfers, dressing, toileting and personal hygiene and total assistance with one person for bathing.

Review of Resident #77's ADL documentation for March 2022 revealed no documentation the resident received a bath/shower on the following dates, March 3, 10, 15, 19, 20, 24, 27.

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Resident #77 was interviewed on 4-4-22 at 11:35am. The resident stated she felt the facility was short staffed because there were many days, she did not get a bath or shower and the NA would tell her there were not enough staff to give everyone a bath.

During an interview with NA #3 on 4-6-22 at 8:35am, the NA stated she may have been assigned to Resident #77 on one of the dates in March but could not remember. She said if there was not any documentation of a bath or shower provided, she probably was not able to complete the task because there were not enough staff.

During an interview with NA #10 on 4-7-22 at 1:30pm, the NA confirmed she was assigned to Resident #77 most of the days in March. She stated if the missing documentation for a bath/shower was on a weekend (March 19, 20, 27) she did not provide a bath or shower to Resident #77 due to not having enough staff.

The DON was interviewed on 4-8-22 at 11:20am. The DON stated ADL care not being provided to the residents was a problem and she was aware the nurses were not assisting the NA's when there were not enough NA's present to complete ADL care. The DON discussed the facility trying to hire more staff to alleviate the care issue.

8. Resident #21 was admitted to the facility on 8-31-18 with multiple diagnoses that included muscle weakness and dementia with behavioral disturbance.

The quarterly MDS dated 1-21-22 revealed Resident #21 was cognitively intact and required extensive assistance with one person for toileting

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and personal hygiene and physical help with one person for bathing.

Resident #21's care plan revealed a goal that he would bath safely and appropriately. The interventions for the goal were in part requires set up help provided by staff.

Review of Resident #21's ADL care documentation for March 2022 revealed there was no documentation of Resident #21 had received a bath on the following dates, March 3, 6, 9, 12, 17, 19, 20, 24, 25, 27.

An interview occurred with Resident #21 on 4-4-22 at 12:15pm. Resident #21 discussed being mostly independent with his bathing but required help with set up and washing some parts of his body. He stated he had not received the help necessary to have a bath on a regular basis.

During an interview with NA #3 on 4-6-22 at 8:35am, the NA stated she may have been assigned to Resident #21 on one of the dates in March but could not remember. She said if there was not any documentation of a bath provided on the weekend, she probably was not able to complete the task because there were not enough staff.

During an interview with NA #10 on 4-7-22 at 1:30pm, the NA confirmed she was assigned to Resident #21 most of the days in March. She stated if the missing documentation for a bath/shower was on a weekend (March 12, 19, 20, 27) she did not provide a bath or shower to Resident #21 due to not having enough staff.

The DON was interviewed on 4-8-22 at 11:20am.

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The DON stated ADL care not being provided to the residents was a problem and she was aware the nurses were not assisting the NA's when there were not enough NA's present to complete ADL care. The DON discussed the facility trying to hire more staff to alleviate the care issue.

9. Resident #114 was admitted to the facility on 12-3-18 with multiple diagnoses that included muscle weakness and dementia without behavioral disturbance.

The quarterly MDS dated 3-3-22 revealed Resident #114 was moderately cognitively impaired and required total assistance with one person for dressing, toileting personal hygiene and bathing.

Resident #114's care plan dated 3-22-22 revealed a goal that Activities of ADL/personal care would be completed with staff support. The interventions for the goal were in part bathing total dependance with one person.

Review of Resident #114's ADL documentation for March 2022 revealed there was no documentation Resident #114 received a bath/shower on the following dates, 1, 2, 3, 5, 6, 7, 9, 10, 14, 16, 19, 25, 26, 27, 28.

Resident #114 was interviewed on 4-4-22 at 10:53am. The resident stated she did not receive a bath daily and emphasized especially on the weekends.

During an interview with NA #3 on 4-6-22 at 8:35am, the NA stated she may have been assigned to Resident #114 on one of the dates in March but could not remember. She said if there

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F 677	Continued From page 37 was not any documentation of a bath provided on the weekend, she probably was not able to complete the task because there were not enough staff. During an interview with NA #10 on 4-7-22 at 1:30pm, the NA confirmed she has been assigned to Resident #114 in March 2022. She stated if the missing documentation for a bath/shower was on a weekend she did not provide a bath or shower to Resident #114 due to not having enough staff. NA #1 was interviewed on 4-7-22 at 5:10pm. NA #1 stated he had been assigned to Resident #114 in March 2022 but could not remember which days. He stated if there was not documentation of a bath/shower being provided then he had forgotten to document. The NA also stated if he had worked on a weekend, it was possible, he did not provide a bath or shower due to the number of residents he was assigned. The DON was interviewed on 4-8-22 at 11:20am. The DON stated ADL care not being provided to the residents was a problem and she was aware the nurses were not assisting the NA's when there were not enough NA's present to complete ADL care. The DON discussed the facility trying to hire more staff to alleviate the care issue.	F 677		
F 686 SS=D	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	F 686		5/12/22

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F 686	Continued From page 38 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 record review, observation, resident, staff and Physician interviews, the facility failed to provide wound care treatment as ordered for 1 of 3 residents (Resident #106) reviewed for pressure ulcers. Findings included: Resident #106 was admitted to the facility on 6-29-17 with multiple diagnoses that included pressure ulcer of the left heel stage 3. Resident #106's care plan dated 2-27-22 revealed a goal that her current pressure ulcer would not worsen or show signs/symptoms of infection. The interventions for the goal were in part treatment as ordered by the Physician. The significant change Minimum Data Set (MDS) dated 3-2-22 revealed Resident #106 was cognitively intact and was coded for 1 unstageable pressure ulcer. Physician order dated 3-8-22 read to clean wound with wound cleanser, apply Medi-honey, foam dressing and wrap with gauze. Review of Resident #106's Treatment	F 686	The physician for Resident #106 was notified on 4/7/22 by State Survey Agency (SSA) of no documented wound care on March 12, 13, and 27. The Resident Representative (RR) for Res #106 was notified by a licensed nurse by 5/11/22. The wound was assessed by the licensed nurse on 4/6/22 and there was no deterioration in the wound and showed signs of healing. Treatment Administration Records (TAR) for current in-house residents with a wound were reviewed by a licensed nurse to ensure wound care provided as ordered on 5/3/2022. Follow up completed based on findings. The Director of Nursing (DON)/Licensed Nurse re-educated the licensed nurses on providing wound care treatments as ordered by 5/11/2022. Education regarding providing wound care treatments as ordered will be added to the orientation of newly hired Licensed Nurses and agency Licensed Nurses going forward.	

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F 686	Continued From page 39 Administration Record (TAR) for March 2022 revealed there was no documentation of wound care completed on the following dates, March 12, 13. and 27. During an interview with Resident #106 on 4-4-22 at 12:00pm, the resident stated when the wound care nurses were not working, her dressings to her left heel were not changed. Documentation of Resident 106's heel wound revealed the wound measured 5 centimeters long and 2.6 centimeters wide on 3-30-22. Observation of Resident #106's wound care occurred on 4-6-22 at 9:43am. The wound was noted to be partially covered with eschar (dead tissue) and had moderate bloody drainage. There was no odor or signs and symptoms of an infection. The peri wound was observed to be pink. Resident #106's wound measured 5 centimeters long by 3.5 centimeters wide with no depth. The wound care nurse was observed to provide wound care per the Physician's order maintaining a clean field. A telephone interview was conducted on 4-7-22 at 12:37pm with Nurse #1. The nurse confirmed she worked on 3-12-22 and 3-13-22 with Resident #106. She stated she was aware the resident had a wound, but she did not complete the wound care. Nurse #1 said she thought the wound care nurses would complete the wound care and was not informed there was not a wound care nurse working on 3-12-22 and 3-13-22. Wound Care (WC) Nurse was interviewed on 4-7-22 at 2:43pm. The WC nurse stated she was aware wound treatments were being missed	F 686	The DON/Licensed Nurse Will audit 5 residents with ordered treatments weekly for 4 weeks then 5 residents monthly for 1 month to ensure wound care treatments are provided and documented as ordered. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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F 686	Continued From page 40 when she was not available and explained the floor nurses were responsible for the residents' wound care when there was not a WC nurse available. She also discussed sharing with the facility's Physician the status of Resident #106's wound and had received new treatment orders when necessary. During a telephone interview with Nurse #7 on 4-7-22 at 4:43pm, the nurse confirmed she was assigned to Resident #106 on 3-27-22. The nurse stated she thought she had completed the wound care to Resident #106's heel but said she did not document that the care was completed because the TAR was in a separate binder, and she forgot to look in the TAR binder. The facility Physician was interviewed on 4-7-22 at 1:21pm. The Physician explained he did not perform wound care but spoke with the WC nurses about residents' wounds and would adjust treatment as needed. He stated he was not aware the wound care was not being completed at times and expected staff to complete wound care as ordered.	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		5/12/22

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F 688	Continued From page 41 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and physician interviews the facility failed to apply a left knee brace as recommended by physical therapy (PT) services (Resident #75) and failed to apply a hand roll and elbow brace (Resident #9) for 2 of 2 Residents reviewed for positioning and mobility. This placed Resident #75 and Resident #9 at risk for a decrease in range of motion. Findings included: 1. Resident #75 was admitted to the facility on 11/24/2021 with a diagnosis of dementia with behavioral disturbance. A review of the 03/14/2022 quarterly Minimum Data Set (MDS) assessment for Resident #75 revealed she was severely cognitively impaired. She rejected care on one to three days of the seven day look back period of the assessment. Resident #75 required extensive 2 person assistance for bed mobility. She required the extensive assistance of one person for dressing. She did not walk. She had no functional limitation in the range of motion of her lower extremities. It further revealed Resident #75 received physical therapy (PT) for a total of 169 minutes in the last 7 days beginning on 03/08/2022.	F 688	The nursing staff assigned to the care of resident #75 were educated 4/6/22 by the Physical Therapist regarding donning and doffing the knee brace recommend by Therapy. The nursing staff assigned to the care of resident #9 were educated 4/7/22 by the Physical Therapist regarding donning and doffing elbow splint and the hand roll recommend by Therapy. In-house residents with therapy recommendations for a brace or hand roll were observed by a licensed nurse to ensure application by 5/11/2022. Follow up completed based on findings. The DON/Licensed Nurse re-educated the nursing staff on applying braces and/or hand rolls as recommended by therapy by 5/11/2022. The education will be included in the orientation agenda for newly hired employees and agency staff ongoing. The DON/Licensed Nurse Will audit 5 residents with ordered splints or braces weekly for 4 weeks then 5 residents monthly for 1 month to ensure the splints and braces are applied as ordered. Results of those audits will be reported to	

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F 688	Continued From page 42 A review of the PT Daily Treatment Note for Resident #75 dated 03/08/2022 revealed the treatment diagnosis of contracture (a permanent tightening of the muscles, tendon, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the left knee. She was discharged from therapy services on 03/29/2022. A review of a Functional Maintenance Recommendations form dated 03/29/2022 for Resident #75 revealed recommendations by PT to encourage range of motion (ROM) to bilateral lower extremities during activities of daily living (ADL) care and for Resident #75 to wear her left knee extension brace up to 6 hours. The form was signed by Nurse Aide (NA) #7, NA #8, and the Therapy Director on 03/29/2022 indicating in-service training related to the application of Resident #75's left knee brace was provided to NA #7 and NA #8 on that date. On 04/04/2022 at 2:39 PM Resident #75 was observed in bed. She was not wearing a left knee brace. No brace was observed in Resident #75's room. On 04/06/2022 at 8:53 AM Resident #75 was observed in bed. She was not wearing a left knee brace. No brace was observed in her room. On 04/06/2022 at 1:09 PM an interview with the Therapy Director indicated Resident #75 was discharged from therapy services on 03/29/2022 with the recommendation for her to continue wearing her left knee extension brace for up to 6 hours daily as tolerated. She went on to say she provided training to NA #7 and NA #8 on 03/29/2022 and the Functional Maintenance Recommendation form was provided to Unit	F 688	the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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Manager (UM) #1 either that day or the following day. The Therapy Director indicated she normally would train the NAs and Nurse regularly assigned to Resident #75 but NA #7 and NA #8 were the only people available to train that day. She indicated NA staff were to apply Resident #75's knee brace. She went on to say UM #1 was to place the recommendation on Resident #75's care plan for the NAs to carry out.

On 04/06/2022 at 1:22 PM an observation of Resident #75 revealed she did not have her left knee brace on. An interview with NA #9 indicated she was regularly assigned to Resident #75 at least five days weekly and familiar with her care. She stated Resident #75 did have a left knee brace, but she had not seen it on her lately. She stated therapy staff applied Resident #75's brace. NA #9 went on to say the knee brace was kept in Resident #75's closet. She further indicated she had not been trained or instructed to apply it. She stated if NA staff were to apply a resident's brace it would appear on the resident's care plan which NAs had access to.

On 04/06/2022 at 1:26 PM an interview with Nurse #6 indicated she was regularly assigned to Resident #75 five days weekly. She stated Resident #75 had been receiving therapy services but they had been discontinued. She went on to say Resident #75 had a left knee brace that therapy staff applied. She indicated she had not been instructed to apply Resident #75's left knee brace. Nurse #6 stated it was not on Resident #75's care plan. She stated she had not seen the brace on Resident #75 lately.

On 04/06/2022 at 1:29 PM an interview with Unit Manager (UM) #1 indicated she received the

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Functional Maintenance Recommendation form for Resident #75 but could not recall when. She stated therapy staff normally gave these to her after residents were discharged from therapy and NA staff were trained. She went on to say Resident #75's form had been on her desk. She further indicated she tried to enter the recommendations onto care plans as soon as she got them but she had gotten behind on therapy recommendations and had not entered Resident #75's.

A review of the comprehensive care plan for Resident #75 revealed a focus area initiated on 11/25/2021of activities of daily living (ADL). The goal last updated on 12/15/2021 was for Resident #75 to receive ADL care with staff support as required to maintain or achieve her highest practicable level of function through the next review. A goal initiated on 04/06/2022 was mobility functional maintenance, left knee extension brace up to 6 hours as tolerated.

On 04/06/2022 at 1:36 PM an interview with MDS Nurse #2 indicated the Therapy Manager called her a few minutes ago and told her about Resident #75's left knee brace so she just added it to Resident #75's care plan.

On 04/06/2022 at 1:45 PM an interview with Resident #75's Physical Therapist (PT #1) indicated Resident #75's PT treatment began on 03/08/2022 because of a contracture of her left knee. She stated this meant Resident #75 did not have full functional range of motion in her left knee and could not straighten it all the way. PT #1 went on to say Resident #75 continued to have this knee contracture on 03/29/2022 when Resident #75 was discharged from therapy

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services. She indicated Resident #75 was discharged from therapy with instructions to nursing staff to begin applying Resident #75's left knee extension brace for up to 6 hours a day five days a week as tolerated to prevent Resident #75's contracture from worsening. PT #1 stated she would expect NA staff to begin applying the knee brace as recommended the day they were instructed or the next day. She went on to say she would not expect it to take eight days for this to happen. PT #1 further indicated going that long without the application of her left knee brace put Resident #75 at risk for worsening of the contracture and further decrease in the range of motion of her left knee.

On 04/26/2022 at 2:06 PM an interview with NA #7 revealed she did recall being instructed on the application of Resident #75's left knee brace by therapy staff although she could not recall the exact date. She stated she had not been instructed to pass this information onto anyone and had not done so. She stated she was rarely assigned to Resident #75 and had not applied her knee brace again since being trained.

On 04/06/2022 at 2:21 PM an interview with NA #8 revealed she did recall being instructed on the application of Resident #75's left knee brace by therapy staff although she could not recall the exact date. She stated she was not instructed to pass this information on to anyone and had not done so. She went on to say she had not been assigned to Resident #75 since being instructed and had not applied Resident #75's left knee brace again since being trained.

On 04/06/2022 at 2:47 PM an interview with the Director of Nursing (DON) indicated when

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Resident #75 was discharged from therapy services with the recommendation for nursing staff to continue the application of her left knee brace, UM #1 should have made sure this information was placed on Resident #75's care plan. She stated placing the information on the care plan would ensure NA staff caring for Resident #75 had access to the recommendation. She stated when the information was entered on the care plan it would then be available for the NAs to know they needed to apply the brace. The DON went on to say NA staff who were trained on the application of Resident #75's brace should have passed the information on in report to ensure continuity of care. She further indicated she did not feel eight days was a reasonable amount of time for this to happen.

On 04/06/2022 at 2:56 PM a follow up interview with the Therapy Director indicated she assessed Resident #75's left knee contracture and there had been no decrease in her range of motion. She went on to say she also instructed Nurse #6 in the application of Resident #75's knee brace.
2. Resident #9 was admitted to the facility on 9-1-18 with multiple diagnoses that included hemiplegia affecting right dominant side.

The quarterly MDS dated 1-6-22 revealed Resident #9 was moderately cognitively impaired.

Resident #9's care plan dated 3-24-22 revealed a goal that activities of daily living/personal care will be completed with staff support to maintain or achieve highest level of functioning. The interventions for the goal were in part encourage resident to allow passive range of motion during care and encourage the resident to wear right elbow splint up to 3 hours and right hand roll up to

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8 hours.

A review of the NA care guide revealed instructions to the NA to apply a right elbow extension splint and a hand roll as tolerated.

Resident #9 was interviewed on 4-4-22 at 10:55am. The resident stated she did not have any braces for her arm or anything for her hand. Resident #9 clarified she had not had any brace or hand roll applied.

Observation of Resident #9 on 4-5-22 at 1:00pm revealed she did not have a hand roll or brace applied to her right upper extremity.

On 4-6-22 at 12:50pm, Resident #9 was observed and revealed no brace or hand roll had been applied to her right upper extremity.

During an interview with the Therapy Director on 4-6-22 at 4:05pm, the Therapy Director stated Resident #9 was supposed to have an elbow splint and a hand roll for her right upper extremity that was contracted. She discussed Resident #9 having difficulty wearing the elbow splint and would wear it for 3 hours at a time and the hand roll the resident would wear up to 5 hours. The Therapy director explained Resident #9's therapy ended in January 2022 and the NAs were educated on how to apply the elbow splint and hand roll.

An interview with NA #3 occurred on 4-6-22 at 4:40pm. The NA confirmed she was familiar with Resident #9 but stated she was not aware the resident was supposed to have an elbow splint or hand roll applied. NA #3 stated she did see the instructions on Resident #9's care guide but

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F 688	Continued From page 48 thought therapy was applying the splint and hand roll. NA #4 was interviewed on 4-7-22 at 3:35pm. The NA stated she was familiar with Resident #9 but was unaware the resident was supposed to have an elbow splint or hand roll applied. She stated she had received training by one of the therapists today (4-7-22) on how to apply the elbow splint and hand roll. The facility Physician was interviewed on 4-7-22 at 1:21pm. The Physician stated applying the elbow brace and hand roll to Resident #9 was a low priority and explained due to the length of time the resident had hemiplegia he would not expect to see much improvement.	F 688		
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 observations, interviews with facility staff and the physician and record review the facility failed to prevent a severely cognitively impaired resident (Resident #102) from exiting the facility without supervision for 1 of 2 residents reviewed for accidents. Receptionist #1 let Resident #102 out of the locked front door, without notifying nursing staff and he was left	F 689	Past noncompliance: no plan of correction required.	4/28/22

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outside unattended and out of visual sight of the facility staff. There was a high likelihood of Resident #102 suffering serious harm.

The findings included:

Resident #102 was admitted to the facility on 11/8/21. His diagnoses included vascular dementia without behavioral disturbance, repeated falls, and psychosis.

The Care Plan focus dated 11/8/21 for Resident #102 documented he had chronic progressive decline in intellectual functioning characterized by a decline in memory, judgement, decision making, and thought processes. Another Care Plan focus dated 11/9/21 documented Resident #102 had wandering and was at risk for unsupervised exits from the facility related to new admission. The interventions included to allow him to wander on the unit, to document episodes of wandering per facility protocol.

The Care Plan focus revised on 12/3/21 documented Resident #120 was at risk for falls characterized by a history of actual falls related to impaired mobility, psychoactive medications, and decreased safety awareness. The interventions included to assist him to negotiate barriers as necessary and brake extenders for visual cues to lock wheelchair.

The most recent fall risk assessment dated 1/31/22 indicated Resident #102 was at high risk for falls.

A Wandering Risk Evaluation dated 2/8/22 completed by Nurse #5 indicated Resident #102 was not at risk. He had no known history of

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attempts to leave the facility or wander. He was ambulatory and or self-mobile by wheelchair with mild cognitive loss. Resident #102 had no verbal statements of desire or intent to leave the facility.

The quarterly Minimum Data Set (MDS) dated 3/11/22 indicated Resident #102 was severely cognitively impaired. He was usually understood and usually understands. He had behavioral symptoms not directed towards other for 1-3 days. Resident #102 had no rejection of care or wandering. He required supervision for walking in his room and locomotion on the unit. He required extensive assistance for locomotion off the unit. Resident #102 was not steady but able to stabilize without staff assistance for moving from seated to standing position, walking, turning around and surface to surface transfers. He had no range of motion impairment. He had one fall with no injury since the last MDS assessment.

Nursing notes entered into the electronic medical record by Nurse #10 on 3/25/22 (late entry note) documented on 3/22/22 Resident #102 was noted outside of the building by the sidewalk by the Main Entrance sign by another nurse (Nurse #1) at approximately 7:30 PM. The note revealed the nurse brought Resident #102 back to the unit where the resident's room was located. A head to toe assessment was completed and no injuries were noted. A wander guard (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 placed to resident's left ankle. Resident was assisted to bed and was placed on 1 to 1 observation.

On 4/7/22 at 2:44 PM Receptionist #1 who

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worked the 3:00 PM to 11:00 PM shift on 3/22/22 stated Resident #102 wheeled himself in his wheelchair into the lobby around 6:00 PM where he remained for approximately 1 hour. Receptionist #1 indicated the lobby doors were locked at all times and required a code to open the doors. She said a family member visiting a different resident needed to be signed out so they could leave the building, so she documented the time on the log then put in the code to unlock the front door to let the person out. She said after the door closed Resident #102 asked if he could go outside. Receptionist #1 said she then entered the code to unlock the door a 2nd time and allowed Resident #102 out of the front door at approximately 7:00 PM. She said she saw Resident #102 turn right out of the doorway to remain on the sidewalk then she returned to her desk in the lobby. She said from her desk she could not see Resident #102 and she did not know where he went. Receptionist #1 did not inform the nursing staff she let him outside. Receptionist #1 reported approximately 10 minutes later a staff member (Nurse #1) brought Resident #102 back into the building and asked Receptionist #1 if she allowed the resident out of the building. Receptionist #1 told the staff member no she did not let Resident #102 out of the building because she thought she would get in trouble. Later she received a phone call from the Administrator, and she told the Administrator she did let Resident #102 out of the front door. Receptionist #1 stated she was not aware Resident #102 was cognitively impaired and was not safe to go out of facility without supervision. She said she had not received education prior to the 3/22/22 incident about how to identify residents who were unsafe to go out of the facility without supervision.

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On 3/22/22 at 7:10 PM the temperature was approximately 70 degrees Fahrenheit (www.wunderground.com). Sunset occurred at 7:20 PM (www.sunrisesunset.com).

An observation of the front lobby area on 4/7/22 at 2:10 PM revealed the receptionist desk was located 15 feet from the front door. The desk was facing the front door.

A telephone interview was conducted with Nurse #1 on 4/7/22 at 12:34 PM. Nurse #1 stated she worked on Unit 2 on the 3:00 PM-11:00 PM shift on 3/22/22. She said she was returning to the facility from her break time at approximately 7:10 PM and as she was turning her vehicle into the parking lot, she saw Resident #102 seated in his wheelchair near the blue "Main Entrance" sign. Nurse #1 stated she parked her vehicle then walked up to Resident #102. She said he was facing the street with the sign and the building at this back. She stated Resident #102 had his television remote control up to his left ear as if it was a telephone. Nurse #1 asked Resident #102 why he was outside, and he responded he was waiting for his son. She then told Resident #102 he should wait inside the building. Nurse #1 stated she pushed him in his wheelchair back into the building and then to his assigned unit (Unit #1). Nurse #1 said she did not see Resident #102's nurse but she told someone, although she was unable to recall who she told, he was found outside the building. Nurse #1 said Resident #102 was not safe to be outside unsupervised. She added Resident #102 normally talked like he was coherent, but he was not cognitively intact. Nurse #1 then said she was previously told during a shift report that Resident #102 was a fall risk so

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if he tried to transfer out of the wheelchair he could fall.

A measurement of the exterior of the building on 4/7/22 at 9:00 AM with the Therapy Director revealed the distance of the sidewalk from the lobby exit door to the end of the sidewalk where the "Main Entrance" sign was located measured 119.5 feet in length. The sidewalk was parallel to the building.

An observation on 4/7/22 at 2:00 PM of the left edge of sidewalk which was adjacent to the pavement of the driveway to the front entrance varied from 0 inches closest to the front entrance to 6 inches approximately 6 feet from the blue "Main Entrance" sign where the resident was observed. The sidewalk was 120 feet from the city street. The speed limit for the city street was 35 miles per hour.

During a telephone interview with Nurse #2 on 4/7/22 at 11:00 AM he reported he was working 3:00 PM to 11:00 PM on 3/22/22 and Resident #102 was on his assignment. Nurse #2 stated he saw Resident #102 on the 400 hall, so he gave Resident #102 his medications. (Resident #102's room was on the 100 hall.) Nurse #2 added Resident #102 usually went to bed around 7:30 PM so he was giving the resident his medications prior to going on his break time. Nurse #2 stated the nursing supervisor called him on his telephone while he was on break to tell him Resident #102 had gotten out of the facility. Nurse #2 stated Resident #102 was not safe to be outside alone and if the resident had asked him to go outside, he would not have allowed him to be out of the building unsupervised.

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On 3/22/22, following the incident, Nurse #10 also completed a Wander risk evaluation on 3/22/22 which indicated Resident #102 was at high risk for wandering.

Resident #102's physician was interviewed on 4/7/22 at 1:39 PM. The physician stated Resident #102 was a high risk for falls due to his severe dementia. He stated he was informed by the Director of Nursing that Resident #102 was outside of the facility alone on 3/22/22. The physician stated Resident #102 should not be out of the building without supervision due to his dementia and high risk for falls. He could have gone into the street or could have fallen on the concrete.

On 4/8/22 at 9:30 AM the Administrator stated the facility identified that Receptionist #1 allowed a cognitively impaired resident out of the building on 3/22/22, so they began education with Receptionist #1 and then the other facility staff including the other receptionist. He stated they updated the Wander Identification Book which would be kept at the reception area. He said the book contained pictures of the residents who were consider at risk for wandering and should not be allowed out of the building unsupervised. He said Resident #102 was not listed in the book until it was updated after he was found outside the building.

An observation of Resident #102 on 4/4/22 at 1:11 PM revealed he was in the hall near nursing station #1. He was seated in his wheelchair and was holding a white plastic bag. During the observation Resident #102 stated he needed to go somewhere. Resident #102 was wearing a wander alarm band on his ankle.

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The facility provided the following corrective action plan with a completion date of 3/25/22.

· Resident #102 was in the front lobby around 7:00 pm on 3/22/22 and asked permission to step outside. The resident was allowed to go outside by Receptionist #1. The resident's last wandering assessment on 2/8/22 had identified him as not at risk. The wandering assessment completed on 3/22/22 identified him as at risk, he was placed on 1:1 monitoring, and a wander guard was placed. The Wandering Book was updated to include this resident's picture. The resident was allowed to exit due to a lack in knowledge of the receptionist to check with the nurse prior to letting the resident outside unsupervised. The resident was placed on 1:1 for 24 hours to ensure no more exit seeking behaviors and that the wander guard intervention was effective.
· On 3/22/22 100% head count of all residents were completed by the assigned hall nurses to ensure all residents were present and accounted for. This included wandering risk residents and severely cognitive impaired residents. There were no other concerns.
· On 3/22/22 100% of all residents to include severely cognitive impaired residents wandering assessments were redone by the Nursing Supervisor. This was to ensure assessments were completed accurately and appropriate interventions were put into place for residents with elopement risk. This audit was completed on 3/23/22.
· On 3/22/22 the Nursing Supervisor started staff questionnaires regarding: Do you know of any residents that has verbalized wanting to leave the facility and/or is exit seeking. The questionnaire was completed with 100% of all staff on 3/25/22.

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· On 3/22/22 an Inservice was started by the Administrator with Receptionist #1 regarding: unsupervised exits to include staff should never assist the resident out of the facility unless they have checked with the nurse to ensure the resident is not at risk for wandering and checking the elopement book. The in service was completed on 3/25/22.
· On 3/22/22 an Inservice was started by the Nursing Supervisor with all facility staff on unsupervised exits to include staff should never assist the resident out of the facility unless they have checked with the nurse to ensure the resident is not at risk for wandering. The Inservice was completed on 3/25/22. All newly hired employees will receive the Inservice by the Nursing Supervisor or Director of Nursing during orientation.
· On 3/24/22 100% of wander guards and door alarms were checked by the Maintenance Director as a precaution to ensure alarms were functioning properly and being monitored per facility protocol. There were no issues identified during the audit.
· On 3/25/22 the wander guard book at the receptionist desk was updated by the Administrator to ensure all residents at risk for wandering to include wandering severely cognitively impaired residents are identified.
· The nursing administrative team will interview 10 staff weekly for 4 weeks to identify any residents to include severely cognitively impaired residents that may be at risk for wandering and ensure the elopement book at the receptionist desk is updated and interventions initiated.
· A Quality Assurance meeting was held on 3/22/22 to discuss the plan of correction.
· The Administrator and Director of Nursing are responsible for implementing the plan of

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F 689	Continued From page 57 correction. An onsite validation was completed on 4/8/22 through staff interviews and record review. Staff were interviewed to validate the in-service education was completed on using the Wander Identification Book and communicating with the nurse prior to allowing a resident out of the building without supervision. A record review revealed the facility was interviewing staff to ensure the staff were identifying residents who may have wandering behaviors. The facility's corrective action plan was validated to be completed as of 3/25/22.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation, facility staff and Physician interviews the facility failed to administer medications as ordered by the physician resulting in 7 missed doses of Neurontin (pain medication) for 1of 5 residents (Resident #82) reviewed for unnecessary medication. Findings included: Resident #82 was admitted to the facility on 9-14-20 with multiple diagnoses that included chronic pain.	F 697	The Nurse Practitioner for Res #82 was notified on 4/8/22 and new order to decrease Neurontin to once a day was obtained. The medication administration records (MAR) of in-house residents with an order for pain medication were reviewed by a licensed nurse to ensure medication administered as ordered by the physician by 5/11/2022. The follow up was completed based on the findings.	5/12/22

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F 697	Continued From page 58 The quarterly Minimum Data Set (MDS) dated 2-28-22 revealed Resident #82 was cognitively intact. Resident #82's care plan dated 4-5-22 revealed a goal that she would be pain free. The interventions for the goal were in part administer pain medication as ordered by the Physician and note the effectiveness. A Physician order dated 3-7-22 read Neurontin (pain medication) 300mg (milligram) twice a day for pain. Review of the Pharmacy documentation for March 2022 and April 2022 revealed no documentation for a dose reduction of Resident #82's Neurontin. Resident #82's printed Medication Administration Record (MAR) for April 2022 was reviewed and revealed the order for Neurontin 300mg twice a day had the word "twice" scratched out and the evening dose time scratched out so Resident #82 was receiving her Neurontin once a day from 4-1-22 through 4-8-22. During an interview with Nurse #3 on 4-8-22 at 8:00am, the nurse confirmed on Resident #82's MAR, the medication Neurontin had the word "twice" scratched out and the evening dose time was scratched out. She stated she was not aware of who scratched out the information and thought it had been scratched out due to a transcription error. The nurse reviewed the Physician's orders and confirmed there was no order to decrease Resident #82's Neurontin from twice a day to once a day.	F 697	The DON/Licensed Nurse/Pharmacist re-educated the licensed nurses on transcribing physicians orders by 5/11/22. The education will be included in the orientation agenda for newly hired employees and agency staff ongoing. Physician orders will be reviewed during the morning clinical meeting. The DON/Licensed Nurse will audit 5 residents with ordered pain medication weekly for 4 weeks then 5 residents monthly for 1 month to ensure pain medications are administered as ordered by the physician. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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F 697	Continued From page 59 Observation of Resident #82 occurred on 4-8-22 at 8:50am. The resident was receiving pain medication and was observed not to inquire about what she was taking or how often her medication was prescribed. The facility Physician was interviewed by telephone on 4-8-22 at 9:00am. The Physician confirmed he had not changed Resident #82's Neurontin order from twice a day to once a day. He also stated Resident #82 would not show signs of increased pain from the decreased dose of Neurontin for 3 weeks to a month. An interview with the Director of Nursing (DON) occurred on 4-8-22 at 9:10am. The DON stated she could not comment on the error because she had not known the MAR had been changed. The facility's Nurse Practitioner (NP) was interviewed by telephone on 4-8-22 at 9:16am. The NP confirmed she had not decreased Resident #82's Neurontin from twice a day to once a day. She stated she had given a verbal order today (4-8-22) to decrease the Neurontin dose to once a day due to Resident #82's blood work.	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 725		5/12/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 60 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to provide sufficient staffing to assist with Activities of Daily Living (ADL) care for residents (Resident #106, Resident #77, Resident #21 and Resident #114) who were dependent on facility staff for ADL care. This affected 4 of 42 residents reviewed for staffing. Findings included: Review of the working schedules for March 2022 revealed there were 2 Nursing Assistance (NA) scheduled on the 7:00am to 3:00pm shift for approximately 44 residents on the following dates, March 19 and 27.	F 725	The facility staffing guidelines were reviewed with the Staffing Coordinator and the Director of Nursing by the Administrator on 4/7/22 and Residents #106, #77, #21, and #114 are receiving showers as scheduled. In-house residents have the potential to be affected by this alleged deficient practice. The staffing schedules for the last 2 weeks were reviewed by the Administrator or Director of Nursing to ensure sufficient staffing to assist with Activities of Daily Living (ADL) care for residents by 5/11/22. Follow up completed based on findings.	

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F 725	Continued From page 61 The working schedules for March 2022 also showed there were 3 NAs scheduled for approximately 44 residents on the following dates, March 6 - 7:00am to 3:00pm, March 19 - 3:00pm to 11:00pm and March 25 - 7:00am to 3:00pm. During an interview with NA #10 on 4-7-22 at 1:39pm, the NA stated She had been assigned to Resident #106, Resident #77, Resident #21 and Resident #114 during the month of March. She discussed on the weekends there were usually only 2 NAs for approximately 44 residents, and she was unable to provide baths to all the residents assigned to her. NA #10 also said when there were only 2 NAs present, the nurses were supposed to help with ADL care but that did not occur. NA #1 was interviewed on 4-7-22 at 5:10pm. The NA stated he was unable to document or provide scheduled showers on the weekends due to only 2 NAs scheduled for the shift. He also discussed the 11:00pm to 7:00am shift stating he worked the night shift and there were usually only 2 NAs for approximately 44 residents. An interview with the facility scheduler occurred on 4-8-22 at 10:06am. The scheduler discussed trying to over staff each shift because she was aware there would be staff call outs. She discussed if the call outs occurred before 5:00pm, she would ask staff to stay over to work an extra shift and she would call the agency to see if there were staff available. The scheduler stated if the call outs occurred after 5:00pm, the nurse on call would be responsible for arranging coverage. She confirmed, if the facility was unable to arrange coverage, each staff present would be expected	F 725	The Administrator re-educated the Director of Nursing and the scheduler on the regulation F725 and the facility staffing guidelines by 5/11/22. Any newly hired Directors of Nursing or Schedulers will be in-serviced by the Administrator regarding F725 and the facility staffing guidelines going forth. The nursing staff schedule will be discussed by the IDT during the daily morning staffing meeting Monday through Friday to ensure the facility is meeting staffing requirements. The Regional Nurse Consultant will audit the staffing sheets weekly for 4 weeks then monthly for 1 month to ensure sufficient staffing to assist with ADL care for residents. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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F 725	Continued From page 62 to care for up to 20-22 residents. The scheduler discussed March 19 and 27 and confirmed only 2 NAs were scheduled but stated the floor nurses were expected to assist the NAs in providing ADL care. During an interview with the Director of Nursing (DON) on 4-8-22 at 11:20am, the DON stated the facility was in the process of trying to hire more staff. She discussed care not being completed was a problem and she was aware the floor nurses were not assisting the NAs in providing ADL care. The DON said she was working with staff to work together as a team. The Administrator was interviewed on 4-8-22 at 12:30pm. The Administrator stated financially the facility was over staffed and there were enough staff to provide care to the residents.	F 725		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff and the Registered Dietitian the facility failed to provide resident's food preferences as listed on the meal tray ticket	F 806	Res #26 was immediately offered milk by the Regional Clinical Consultant on 4/5/22 and it was refused by the resident. Resident was interviewed by the Dietary	5/12/22

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F 806	Continued From page 63 for 1 (Resident #26) of 3 residents reviewed for food preferences. The findings included: Resident #26 was admitted to the facility on 7/9/2019. His diagnoses included severe protein calorie malnutrition, diabetes, and adult failure to thrive. The quarterly Minimum Data Set (MDS) assessment dated 1/31/22 indicated Resident #26 was cognitively intact. He had no behaviors. He was independent with eating. The care plan updated 1/27/22 indicated Resident #26 had diabetes and was not compliant with diet and medications. The interventions included obtain resident's likes and dislikes and to incorporate as many likes as possible that are compatible with dietary restrictions. The care plan also revealed he was resistive to care and treatment. The intervention for this focus was to honor resident's choices, preferences and wishes regarding care and services. The diet order dated 3/19/22 was consistent carbohydrate, no added salt diet, regular texture. On 4/5/22 at 8:41 AM Resident #26 stated "They did it again." He said he received 2 individual prepackaged bowls of cereal but no milk for them. He noted there was a sausage patty, grits, toast, and apple juice on the breakfast tray. Resident #26 stated he does not eat those items, and he just wanted his cereal with milk. He then stated "How can I eat cereal with no milk? Who eats cereal with no milk?"	F 806	Manager on 4/5/22 to update his dietary preferences. He is now receiving his preferences as requested Those residents being served from the kitchen have the potential to be affected by this alleged deficient practice. On 4/21/2022 a meal service, meal tray tickets were reviewed for food preferences by the Assistant Dietary Manager. Follow up completed based on findings. Dietary Manager/Registered Dietician (RD) re-educated the dietary staff on the tray line process with emphasis placed on providing residents food preferences as listed on the meal tray ticket by 5/11/22. Education regarding the tray line process with emphasis on providing residents food preferences as listed on the meal tray ticket will be included in the orientation process for newly hired dietary staff going forward. The Dietary Manager/RD will audit 2 trays from each meal twice weekly for 4 weeks, then 2 trays from each meal twice monthly for 1 month to ensure resident food preferences are provided as listed on the meal tray ticket. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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F 806	Continued From page 64 A review of the breakfast meal tray ticket for 4/5/22 revealed a notes section which read; "Send two cheerios ...& two milks only per resident request. In the section titled Standing orders the meal tray ticket read; "4 oz (ounces) assorted juice, 8 oz coffee, hot cereal, 2 X 8 oz milk 2%." An observation of the meal tray line was conducted on 4/6/22 from 12:00 PM - 12:20 PM. It was noted the dietary aide who was putting on the lid did not review the meal tray ticket to make sure the requested foods were on the trays. On 4/7/22 at 2:20 PM the Assistant Dietary Manager stated the dietary aide who put the lid on the tray was also responsible to check the tray for accuracy and food preferences. She said she did not remember which dietary aide was working in the tray checker position at breakfast on 4/5/22. On 4/7/22 at 2:30 PM the Registered Dietitian stated residents should receive foods as written on the meal tray ticket.	F 806		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 835	No residents were identified to be	5/12/22

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F 835	Continued From page 65 facility failed to provide effective oversite to ensure 100% of staff were fully vaccinated or granted medical/non-medical exemptions per Centers for Medicare and Medicaid Services (CMS) requirements. The findings included: This tag is cross-referenced to: CFR 483.80 (F888) - Based on observation, record review, and staff interviews the facility failed to implement an effective process for tracking COVID-19 vaccinations status to achieve 100% vaccination rate which resulted in 8.2% of staff partially vaccinated. This was for 8 of 11 staff reviewed for COVID-19 Vaccination Status (Nurse Aide (NA) #11, NA #12, NA #13, NA #14, Nurse #9, Dietary Aide #1, Housekeeper #1, and Housekeeper #2). The facility was not in outbreak status and had no positive cases for COVID-19 among the residents. During an interview on 4/8/22 at 10:11 AM the Corporate Clinical Director stated Administration should have been monitoring the staff vaccination requirements and enforced the 100% COVID-19 vaccination or approved exemption of staff requirement.	F 835	affected by this alleged deficient practice. NA #11, NA #12, NA #13, NA #14, Nurse #9, Dietary Aide #1, Housekeeper #1 and Housekeeper #2 were removed the schedule by the Administrator on 4/7/22 upon notification of their vaccine status. A member of the facility□s management team reviewed the facility□s Covid-19 vaccinations tracking log to ensure 100% vaccination rate by 5/11/22. The follow up was completed based on the findings. The Regional Vice President re-educated the Administrator on the regulation F835 by 4/6/22. The Human Resource Coordinator (HRC)/Administrator is to verify the COVID-19 vaccination status of newly hired employees or agency staff to ensure no employee works unless they are fully vaccinated or has been granted a medical/non-medical exemption. The DON to will audit 10% of newly hired staff and agency staff weekly for 4 weeks then monthly or 1 month to ensure 100% of staff are fully vaccinated or granted medical/non-medical exemptions per Centers for Medicare and Medicaid Services (CMS) requirements. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i)	F 888		5/12/22

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COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

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

§483.80(i)(3) The policies and procedures must

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include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines

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and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must

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F 888	Continued From page 69 be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to implement an effective process for tracking COVID-19 vaccinations status to achieve 100% vaccination rate which resulted in 8.2% of staff partially vaccinated. This was for 8 of 11 staff reviewed for COVID-19 Vaccination Status (Nurse Aide (NA) #11, NA #12, NA #13, NA #14, Nurse #9, Dietary Aide #1, Housekeeper #1, and Housekeeper #2). The facility was not in outbreak status and had no positive cases for COVID-19 among the residents. Findings included: A review of the "COVID-19 Guideline on Staff Vaccine Requirement" dated 11/9/21 revealed all employees were required to become fully vaccinated with some limited exceptions. Vaccination under this policy is a mandatory condition of employment unless a request for reasonable accommodation was approved. Healthcare workers were to become fully vaccinated for COVID-19 prior to 1/4/22. Applicants for employment were required to be vaccinated at the time of hire. Applicants who had received one dose of a two dose series would be considered for employment contingent on their agreement to receive the second dose at the appropriate time. All documents were to be provided to the Administrator. Review of the COVID-19 Staff Vaccination Status Matrix revealed 8 staff members of 98 total facility	F 888	No residents were identified to be affected by this alleged deficient practice. Nurse Aide (NA) #11, 12, 13, 14, #9, Dietary Aide #1, Housekeeper #1 and Housekeeper #2 were removed from the schedule by the Administrator on 4/7/22 upon notification of their vaccine status. An audit of facility employees and agency staff was completed on 4/7/22 by Administrator to determine if staff are fully vaccinated or have been granted a medical/non-medical exemption. The follow up was completed based on the findings. The Administrator re-educated the Human Resource Coordinator (HRC) on verifying the Covid-19 vaccination status of employees or agency staff to ensure no employee works unless they□re fully vaccinated or have been granted a medical/non-medical exemption by 5/11/22. Education regarding verifying the COVID-19 vaccination status of employees or agency staff will be added t the orientation of newly hired HRCs going forward. The DON will audit 10% of facility and agency staff vaccination status weekly for 4 weeks then monthly for 1 month to ensure implementation of an effective process for tracking Covid-19 vaccination	

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F 888	Continued From page 70 staff were partially vaccinated resulting in 91.8% of staff being fully vaccinated. Review of the vaccination documentation of the 8 staff members provided by the facility revealed NA #11 received the first dose on 12/13/21 and had not received the second dose. NA #12 received the first dose on 12/3/21 and had not received the second dose. NA #13 received the first dose on 1/28/22 and had not received the second dose. NA #14 received the first dose on 12/3/21 and had not received the second dose. Nurse #9 received the first dose on 12/3/21 and had not received the second dose. Dietary Aide #1 received the first dose on 11/21/21 and had not received the second dose. Housekeeper #1 received the first dose on 10/5/21 and had not received the second dose. Housekeeper #2 received the first dose on 1/12/22 and had not received the second dose. NA #12, Nurse #9, Dietary Aide #1, and Housekeeper #1 were unable to be interviewed. During observation on 4/4/22 at 3:39 PM Nurse #9 was observed in the facility working a floater. Nurse #9 was one of the 8 partially vaccinated staff. During an interview on 4/7/22 at 4:23 PM the Scheduler stated Nurse #9 worked as a floater on 4/4/22 which meant she assisted nurses with residents throughout the building where she was needed. During an interview on 4/7/22 at 2:07 PM NA #14 stated she had received only one dose of the COVID-19 vaccine on 12/3/21 and had not received her second dose. She concluded she	F 888	status to achieve a 100% vaccination rate. Results of those audits will be reported to the QAPI Committee monthly for 2 months and the quality monitoring schedule will be modified based on findings.	

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had been working with residents up through 4/2022 while she was partially vaccinated, had been told she needed a second dose, but had forgotten.

During an interview on 4/7/22 at 2:59 PM NA #13 stated she was hired towards the end of 10/2021. At that time, they were told vaccinations would become mandatory for COVID-19 at the facility and she would be required to receive the vaccine. She stated at the beginning of 2022 the facility offered the vaccine to staff but she was sick and unable to get it so she told them she would get it from somewhere else. The nurse aide stated she did not receive the vaccine on 1/28/22 as the facility documentation indicated. The facility did not have anyone following up with staff or enforcing the vaccine requirement and it slipped her mind to get the vaccine and she had not thought about it until she was at her doctor's office on 3/28/22 and received it that date.

During an interview on 4/7/22 at 3:19 PM Housekeeper #2 stated she received her first dose of the COVID-19 vaccine 1/12/22. She further stated she had not thought about getting the second dose and no one from the facility had asked her about the second dose until this week and she had been working through 4/2022.

During an interview on 4/7/22 at 3:28 PM NA #11 stated she had gotten the first vaccine dose on 12/3/21 and had not received a second dose. She had just returned from having an extended leave and had worked a few days at the end of 3/2022 and beginning of 4/2022. She concluded she had not been told by the facility she needed to get the second dose, and no one had been enforcing vaccination requirements at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	C 04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

(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 888	Continued From page 72 During an interview on 4/7/22 at 12:56 PM the Administrator stated he had multiple staff members who had the first vaccine dose of a multi-dose vaccine, were eligible for the second dose, but had not received it. He stated he was aware of the new requirements from the Centers for Medicare and Medicaid Services (CMS) for staff to be either 100% fully vaccinated or granted an exemption. He concluded he had no explanation as to why the staff were not 100% fully vaccinated or granted an exemption.	F 888		