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	345174	A. BUILDING _____ B. WING _____	C 06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA PINES AT ASHEVILLE	91 VICTORIA ROAD ASHEVILLE, NC 28801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 05/09/2022 through 05/13/2022. A new complaint allegation was investigated onsite from 5/31/22 through 6/1/22; therefore the exit date was changed to 06/01/22. The facility was found in compliance with the requirement of CFR 483.73, Emergency Preparedness. Event ID 5PGM11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and complaint survey was conducted on 05/09/2022 through 05/13/2022. A new complaint allegation was investigated onsite from 5/31/22 through 6/1/22; therefore the exit date was changed to 06/01/22. 41 of the 67 complaint allegations were substantiated resulting in deficiencies. Intakes, NC 00176945, NC 00177563, NC 00177565, NC 00178570, NC 00178554, NC 00179525, NC 00179888, NC 00179879, NC 00181555, NC 00182270, NC 00182899, NC 00182988, NC 00183185, NC 00183666, NC 00185816, NC 00185889, NC 00186140, NC 00187713, NC 00188132, NC 00188737, NC 00188846, NC 00188860, NC 00188863, NC 00188878, NC00189435. Event ID #5PGM11.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		6/22/22

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

Electronically Signed 06/13/2022

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F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with resident, resident representative and staff, the facility failed to treat a resident with dignity and respect by not allowing him to come back into the facility after a cancelled dialysis treatment for 1 of 6 residents reviewed for dignity (Resident #84).	F 550	Resident # 84 has been allowed back into facility after his admission to the hospital or following any appointment as of 5/12/2022. Resident #84 grievance was addressed as of 5/12/2022.	

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F 550	Continued From page 2 Resident #84 expressed feelings of being treated like trash that was left outside the facility and felt like the staff did not care about him when he was not allowed to come back into the facility after being sent back from the dialysis clinic. In addition, Resident #84 expressed feelings of being treated like a child and a dog when a staff member yelled at him and threatened to discharge him from the facility. The findings included: Resident #84 was admitted to the facility on 10/11/19 with diagnoses that included end-stage renal failure. 1. A document entitled, "Health Care Power of Attorney," dated 12/12/17 and signed by Resident #84 indicated he chose his RP (responsible party) as his health care agent with no special instructions or any limitations on his agent's authority. Resident #84's care plan revised on 11/16/21 indicated he was at risk for complications related to hemodialysis on Tuesday, Thursday, and Saturday. Hemodialysis is a process of purifying the blood of a person whose kidneys are not working normally. The quarterly Minimum Data Set (MDS) assessment dated 4/22/22 indicated Resident #84 was cognitively intact, had no behaviors and required extensive physical assistance with all activities of daily living including transfer. The MDS further indicated Resident #84 received dialysis while a resident at the facility. A progress note in Resident #84's medical record dated 5/7/22 at 1:06 PM written by Nurse #1 indicated Nurse #1 was informed by dialysis that	F 550	All residents are at risk for this deficient practice. Administrator completed a 100% audit of all appointments as of 6/9/2022 to ensure no other resident has been not allowed in facility. all interview able residents were interviewed and ask if they had ever been abused or yelled at by anyone as of 6/22/2022. Director of Nursing, Staff Development Coordinator/Designee have in-serviced all staff on facility policy for treating residents with Dignity and respect to include allowing residents back in facility following appointments or outside trips as of 6/10/2022. All new staff or Agency staff will be in-serviced on facility policy for treating residents with Dignity and respect to include allowing residents back in facility following appointments or outside trips. All Administrative staff to include Activity Director, Social Worker, Business Office Manager, Director of Nursing, Unit Managers, Maintenance Director, Dietary Manager, Housekeeping Director were in-serviced by the Regional Director of Operations on completing the grievance report and follow up for outcome of grievance as of 6/17/2022. Administrator/Designee will monitor 5 residents daily Monday- Friday for 1 month, then 3 times a week for 1 month, then monthly thereafter to ensure all residents are treated with Dignity and respect as of 6/22/2022. Administrator will report all findings to Quality Assurance Performance Improvement committee monthly for any needed changes in current plan. All concerns will be	

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Resident #84 had a fever of 102.5, shivers, and chills. Resident #84 told staff at dialysis that he did not feel well. DON (Director of Nursing) notified, unit manager notified, and Administrator notified. Resident #84 was then sent back to facility with instructions from Administrator, DON, and unit manager to direct transportation to the hospital. Transportation did not take Resident #84 to the hospital. Instructions per DON, Administrator, and unit manager to leave resident outside until EMS (emergency medical services) arrived and to not let him in the facility. Resident #84 was left outside with nurse aides until the arrival of EMS. Resident waited outside per management of the facility for 30-45 minutes awaiting the arrival of EMS with nurse aides and nurse.

A phone interview with Resident #84's responsible party (RP) on 5/10/22 at 9:22 AM revealed Resident #84 called her from the ER (emergency room) and reported to her that they won't let him inside the facility. Resident #84 sat outside the facility for 45 minutes while waiting for EMS to pick him up to take him to the ER. Resident #84 told her that the wind was blowing, and it was cold outside. Resident #84's RP stated she couldn't understand why they didn't let him in when Resident #84 had been a resident at the facility since 2019. When Resident #84's RP came to the facility on 5/10/22, she spoke with the interim Administrator who told her that the reason why they didn't let Resident #84 inside the facility on 5/7/22 was because they suspected him of having COVID-19 and they did not have any COVID-19 rooms set up at that time.

A phone interview with Resident #84 on 5/12/22 at 3:50 PM revealed he went to dialysis on 5/7/22

addressed immediately.

Date Of Compliance: 6/22/2022

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but when they took his temperature, they said he had a fever, so they sent him back. When he got back to the facility, he asked the staff why they wouldn't let him in, but they didn't tell him why. Resident #84 stated he couldn't understand why they won't let him into the facility. He said it was a little chilly outside, he was shaking, and trembling and he told the staff that he was not feeling good. Resident #84 stated he was worried he might get pneumonia while sitting outside in the cold wind. He further stated they could have placed him in an empty room at that time while he waited for EMS to pick him up. He said he waited for 45 minutes outside because the transporter refused to take him to the hospital, and they had call EMS to come pick him up. Resident #84 stated that it made him angry, and he felt like the staff didn't really care about him. Resident #84 further stated that he felt like trash that was left outside of the facility.

Another interview with Resident #84 on 5/13/22 at 10:55 AM revealed he remembered shaking because it was chilly outside when they won't allow him to come into the facility on 5/7/22. He mentioned about worrying that he might have caught pneumonia from sitting outside in the cold because the last time he had a fever and chills, he had pneumonia. Resident #84 stated that he felt like a piece of trash that was left outside when they restricted him from coming inside the facility. Initially he thought the facility went into lockdown, but he later found out they suspected him of having COVID-19 when he didn't have other symptoms of COVID-19 aside from fever.

An interview with Nurse #1 on 5/10/22 at 10:22 AM revealed on 5/7/22 Resident #84 went to his dialysis appointment and while Nurse #1 was

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attending to another resident, she received a phone call from the dialysis clinic and spoke with the dialysis nurse who reported to her that Resident #84 had a fever of 102.5 and that he was going to be sent back to the facility due to concerns that he might have COVID-19. Unit Manager (UM) #2 gave Nurse #1 directions not to let Resident #84 into the facility and that he was to go to the hospital directly per the Director of Nursing (DON). Nurse #1 told UM #2 that by the time she spoke with her, Resident #84 had already arrived at the facility. UM #2 continued to tell Nurse #1 not to let him into the facility due to concerns that he might have COVID-19. Resident #84 complained of having chills and being cold while he was outside. Nurse #1 stated the wind was blowing at around 1:06 PM. Resident #84 was wearing sweatpants, a t-shirt, and a black jacket. Nurse #1 stated Resident #84 was never alone while he was outside and NA #1, NA #2, NA #3, and Nurse #3 took turns sitting with him. Nurse #1 stated Resident #84 sat outside for 45 minutes waiting to get transported to the ER.

An interview with Nurse Aide (NA) #1 on 5/10/22 at 11:48 AM revealed on 5/7/22 when Resident #84 arrived outside the facility, Nurse #2 went out to request the transportation service to take him to the hospital instead. They refused to take him, so NA #2 stayed with Resident #84 while he was outside. NA #1 also took a turn and replaced NA #2 watching Resident #84 because this happened during lunch time. Resident #84 mentioned to NA #1 that he was cold even though he had a jacket and a blanket over his legs. NA #1 confirmed that it was windy, the sun was not shining and there was an overcast around the time she stayed with Resident #84 outside.

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An interview with Nurse #3 on 5/10/22 at 12:20 PM revealed she was not the nurse assigned to Resident #84 on 5/7/22 but NA #1 reported to her that Resident #84 had been sent back from dialysis because he had a fever of over 102 and he was shivering. The transportation service driver told Nurse #3 that they couldn't take Resident #84 to the ER because they only did non-emergent transportation and they needed to call EMS to take him. Nurse #3 stated they shouldn't have left Resident #84 outside the facility, but they were only following orders and directions from the DON, and they couldn't do anything about it. They didn't want to spread COVID-19 in case he did have COVID-19.

An interview with NA #2 on 5/11/22 at 10:49 AM revealed she sat with Resident #84 for 15 minutes while he was outside the facility, and they wouldn't let him in. Resident #84 asked her why he wasn't allowed to go inside but she couldn't give him a reason and he complained of being cold while sitting outside the facility.

A phone interview with NA #3 on 5/11/22 at 11:23 AM revealed she took a turn watching Resident #84 while he was outside the facility, and he waited outside for 45 minutes before he was transported by EMS to the ER. NA #3 stated it was windy and chilly and Resident #84 complained to her about not letting him inside and said to her that it was crazy why he was not being allowed to come in.

An interview with Nurse #4 on 5/10/22 at 11:05 AM revealed she took a turn watching Resident #84 outside the facility. Nurse #4 stated Resident #84 complained to her of being cold and chilly

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and he wanted to go inside the building. Nurse #4 stated it was windy and Resident #84 sat outside for 45 minutes. Nurse #3 couldn't let him in the building because she received instructions from the DON not to let him inside but instead, to have him sent out to the hospital.

An interview with Unit Manager (UM) #2 on 5/10/22 at 2:59 PM revealed she was notified by Nurse #1 that the dialysis clinic was sending Resident #84 back to the facility because he had a fever of 102.5. UM #2 texted the DON who texted her back with directions not to let Resident #84 into the building and just send him to the ER. UM #2 stated she did not know how long Resident #84 waited outside the facility before EMS arrived to transport him to the hospital.

A phone interview with the Director of Nursing (DON) on 5/13/22 at 4:06 PM revealed he had a text message interaction on 5/7/22 with Nurse #1 who notified him that Resident #84 was being sent back from dialysis because his oral temperature was over 102. The DON stated he gave directions to send Resident #84 to the hospital per protocol because he needed to be seen by a medical provider and the facility did not have a Nurse Practitioner at the facility on the weekends and they only utilized an on-call service for emergencies. The DON stated he jumped into conclusion and thought Resident #84 might be positive for COVID-19 and an exceedingly high temperature met the criteria for being evaluated at the ER. Resident #84 also needed emergency dialysis at that time. The DON also stated he did not know that the transportation service did not do emergency room transports and he thought that they could have transported Resident #84 from either the dialysis clinic or

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from the facility to the ER.

An interview with the Administrator on 5/13/22 at 6:46 AM revealed she didn't see her text messages from the DON and UM #2 until later in the afternoon of 5/7/22. The Administrator stated she called UM #2 and was told of what had happened and that he had already gone to the hospital. She stated the decision not to let him inside the facility was not intentional and was made to protect the other residents in case he turned out to be positive for COVID-19.

2. An interview with Resident #84 on 5/13/22 at 10:55 AM revealed he remembered during a resident council meeting in May of 2021 that the former Administrator had announced that he was going to cut down the shopping for cigarettes for the smokers to once a month. Resident #84 stated he got upset with the announcement and during the meeting, he asked the Activities Director to assist him in going outside to the smoking area which was right next to the day room where the meeting was held. As soon as he got outside with his wheelchair, the door behind him slammed loudly because of the wind. The former Administrator came outside right behind him and started yelling at him and said to him that he would get Resident #84 out of the facility and that he was going to call the cops on him. Resident #84 asked the former Administrator to go back into the day room because he was starting to make him mad. Resident #84 told him to leave him alone, but the former Administrator kept on yelling at him and talking to him like he was a child. Resident #84 said to the former Administrator that he was not a dog and to please not talk to him like that. Resident #84 stated the former Administrator

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might have gotten upset with him because he thought Resident #84 slammed the door behind him which he said he did not do. Resident #84 stated he filed a grievance with therapy staff member #1 but he did not hear anything back about it. Resident #84 stated he felt like the residents did not matter to them and they did not care about them.

An interview with the Activities Director (AD) on 5/13/22 at 8:07 AM revealed the former Administrator held an emergency resident council meeting in May 2021 to announce to the residents that he needed to make a change in the smoking policy. The former Administrator wanted to cut down the shopping by the AD of smoking materials to once a month. Resident #84 got upset during the meeting because he was worried that he might run out of cigarettes, but he did not start to get heated until after the former Administrator started to raise his voice. Resident #84 left the room and went to the smoking area which was right next to the day room and was separated by a glass door and glass wall. The door slammed shut loudly right behind Resident #84 because of the wind and the AD witnessed that Resident #84 did not slam it. The former Administrator thought Resident #84 slammed the door behind him so he went out and told Resident #84 that if he didn't stop, he would put him out on the street. The AD stated he witnessed this verbal altercation between Resident #84 and the former Administrator, along with other residents and staff members at the resident council meeting. The former Administrator also said that he would call the police and have Resident #84 escorted out of the facility.

An interview with Therapy staff member (TSM) #1

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F 550	Continued From page 10 on 5/10/22 at 12:11 PM revealed Resident #84 reported to him about the verbal altercation with the former Administrator in May 2021 a few days after the resident council meeting. TSM #1 stated he filed a grievance about Resident #84's concerns and brought it up at the morning meeting on 5/21/21. Multiple attempts were made to contact the former Administrator, but they were unsuccessful. An interview with the Administrator on 5/13/22 at 6:46 PM revealed he was somewhat aware of Resident #84's concern regarding the former Administrator but he didn't know all the details of what had happened. During the exit conference with the facility on 5/16/22 at 4:12 PM, the Administrator stated he had already addressed with the former Administrator any concerns that Resident #84 had about him.	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		6/22/22

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F 561	Continued From page 11 §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 resident and staff interviews, the facility failed to accommodate a resident's request to be assisted out of bed at their preferred time of day (Resident #20) and provide residents with their preferred number of showers per week (Resident #20, Resident #2, Resident #54, Resident #91, and Resident #23) for 5 of 8 residents reviewed for choices. The findings included: 1. a. Resident #20 was admitted to the facility on 07/31/15 and readmitted on 02/23/22 with diagnoses which included a chronic disease that affects the central nervous system, osteoporosis, and chronic obstructive pulmonary disease (COPD). Resident #20's admission Minimum Data Set (MDS) assessment dated 02/23/22 revealed she was cognitively intact and had no behaviors for	F 561	1) On 6/9/22, the Director of Nursing (DON) Resident #20 care plan and Kardex to reflect resident preference to get out of bed during mealtimes. On 6/9/22, the Nurse Manager updated Resident #2, #20, #23, #54 and #91 shower schedule to reflect resident bathing preference. 2) On 6/9/22, the Administrator and Social Worker completed an audit via questionnaire of residents preferred time of getting out of bed and preference for bathing type and frequency. On 6/17/2022, the DON and Administrator discussed preferences with the resident Representatives for non-interviewable residents. The Director of Nursing (DON) completed updates to shower schedules, care plans and Kardex as indicated.	

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F 561	Continued From page 12 refusal of care. The MDS assessment also revealed Resident #20 required total assistance of 2 staff with transfers into a Geri chair. Resident #20's care plan revised on 02/24/22 revealed a plan of care for activities of daily living and required total care related to muscle insufficiency/coordination/sensory deficits and tremors secondary to MS with chronic pain and limited range of motion of the left upper extremity. The interventions included feed all meals with HOB in fully upright position, elevate entire bed to eye level to promote chin down position, full body mechanical lift for transfers, and appointments in Geri chair. Observation and interview on 05/09/22 at 10:41 AM revealed Resident #20 lying in bed with the head of bed (HOB) slightly elevated. Resident #20 stated she would prefer to be up in the chair by now but had been unable to get staff to get her up in the chair. Resident #20 stated she was supposed to be up in the chair at mealtime but said they were elevating the head of her bed and leaving her in bed for her meals. Observation on 05/10/22 at 2:54 PM revealed Resident #20 lying in bed with HOB slightly elevated. Resident #20 stated she would have liked to have been up in the chair for breakfast and lunch today but stated she didn't want to get up now because it was so late in the afternoon. She further stated she had asked to get up in the chair and was told there was not enough staff to get her up in the chair. Observation on 05/11/22 at 9:55 AM revealed Resident #20 lying in bed and stated she would prefer to be up in the chair instead of in the bed	F 561	3) Effective 6/22/22, the Staff Development Coordinator (SDC) completed education with current facility and agency direct care nursing staff on honoring resident rights related to preferred times of getting out of bed and bathing preferences. Resident preferences will be assessed and updated during admission, quarterly and upon request to ensure residents are getting out of bed and bathed as desired. Education included the process of the nurse aide notifying the nurse supervisor when a shower/bedbath is refused or not completed so that the nurse can provide assistance when needed to meet the residents need. Newly hired facility and agency direct care nursing staff will receive education upon hire and prior to first shift worked. Point-of-Care (POC) compliance reports will be reviewed during morning clinical meetings for oversight. 4) The DON/Designee will monitor five (5) residents for preferred time of getting out of bed and bathing preferences. Monitoring will be completed at a frequency of five (5) weekly for four (4) weeks then, once weekly for eight (8) weeks. The DON will present the results of monitoring to the QAPI Committee monthly and changes to the plan will be made as necessary to maintain compliance with resident rights to self-determination. Completion Date: 6/22/22	

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but stated staff had not been in to get her up. She stated staff had been in and elevated her HOB and fed her breakfast but had not offered to get her out of bed even when she had asked to get up in the chair.

Telephone interview on 05/11/22 at 11:54 AM with Resident #20's responsible party (RP) revealed she was frustrated because staff were not getting Resident #20 up in her chair for meals as recommended by the Speech Therapist. Resident #20's RP stated she would like for the resident to be up in her chair for meals and to be up in her chair and out of her room and living the fullest life possible while in the facility.

Interview on 05/12/22 at 2:51 PM with Nurse Aide (NA) #8 revealed she frequently cared for Resident #20 and stated she was assigned to her today and had not gotten her out of bed. NA #8 stated they were usually short staffed and unable to get residents that were total lifts out of bed due to staffing.

Interview on 05/13/22 at 8:42 PM with NA #14 revealed she frequently cared for Resident #20 and stated it was not possible to get her up every day because there was not always enough help to get total lift residents out of bed. NA #15 stated she always put her head of bed up if she was unable to get Resident #20 up in the chair for her meals.

Interview of 05/13/22 at 9:35 AM with NA #18 revealed she had taken care of Resident #20 and stated it was not always possible to get total lift residents up due to staffing. NA #18 stated she worked at the facility about 75 to 80 hours a pay period and they were still short staffed on most

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shifts.

Interview on 05/13/22 at 9:40 AM with NA #15 revealed she had taken care of Resident #20 and said she was able to get incontinence care done and turning and positioning done but was not always able to get Resident #20 out of bed in the chair. She stated the facility was often understaffed and there were not enough staff to get total lift residents out of bed.

Interview on 05/13/22 at 5:04 PM with the Director of Nursing (DON) revealed he would have expected staff to get Resident #20 out of bed into the chair for meals as recommended by Speech Therapy. The DON stated all residents that desired to be up should be out of bed in their prospective chairs.

Interview on 05/13/22 at 7:08 PM with the Administrator revealed he expected all residents to be out of bed as desired by the resident.

b. Resident #20 was admitted to the facility 07/31/15 and readmitted on 02/23/22 with diagnoses which included a chronic disease that affects the central nervous system, osteoporosis, and chronic obstructive pulmonary disease (COPD).

Resident #20's admission Minimum Data Set (MDS) assessment dated 02/23/22 revealed she was cognitively intact and had no behaviors for refusal of care. The MDS assessment also revealed Resident #20 required total assistance of 1 staff with bathing and personal hygiene.

Resident #20's care plan revised on 02/24/22 revealed a plan of care for activities of daily living

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and required total care related to muscle insufficiency/coordination/sensory deficits and tremors secondary to MS with chronic pain and limited range of motion of the left upper extremity. The interventions included provide with showers/bed baths as per resident's choice - prefers showers, provide AM/PM oral care, facial hygiene and combing/brushing hair, encourage to choose clothing as able and dress daily in appropriate clothing for the season.

Observation and interview on 05/09/22 at 10:41 AM revealed Resident #20 lying in bed with the head of bed (HOB) slightly elevated. Resident #20 was observed to have greasy hair and stated she had not had her shower today and had not had a shower in a couple of weeks. She stated she had not refused any showers and stated staff had not been giving her showers as scheduled.

Observation and interview on 05/10/22 at 2:54 PM revealed Resident #20 lying in bed with HOB slightly elevated. She stated she had received her shower yesterday as scheduled and stated, "it felt good to be clean." Resident #20 said she preferred showers but was told by staff they didn't have time to shower her because she was total care and total lift, and they didn't have enough staff to get her up and shower her.

Review of Resident #20's bathing report from the electronic medical record (EMR) revealed the following from March 2022 to present:

March 2022 - 6 of 9 showers scheduled for the month were not documented as completed and there were no bed baths given on the days showers were missed.
April 2022 - 4 of 8 showers scheduled for the

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month were not documented as completed and there were no bed baths given on the days showers were missed.

May 2022 - 2 of 4 showers scheduled thus far for the month were not documented as completed and there were no bed baths given on days showers were missed.

Interview on 05/12/22 at 2:51 PM with Nurse Aide (NA) #8 revealed she frequently cared for Resident #20 and stated she was assigned to her today and had not given her shower yet but was working till 7:00 PM and would try to get it done before she left. NA #8 stated they were usually short staffed and unable to give residents their showers on scheduled days because they were short staffed. NA #8 further stated it was especially hard when the residents were total lift and total care to get showers done.

Interview on 05/13/22 at 8:42 PM with NA #14 revealed she frequently cared for Resident #20 and stated it was not possible to get her up for her shower because there was not usually enough staff to get a total care and total lift resident up for a shower. NA #14 stated they were usually not fully staffed and that made it difficult to get all their showers done as scheduled.

Interview of 05/13/22 at 9:35 AM with NA #18 revealed she had taken care of Resident #20 and stated it was not always possible to get total lift residents up for showers due to staffing. NA #18 stated she worked at the facility about 75 to 80 hours a pay period and they were still short staffed on most shifts.

Interview on 05/13/22 at 9:40 AM with NA #15

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revealed she had taken care of Resident #20 and said she was able to get incontinence care done and turning and positioning done but was not always able to get Resident #20 up for showers. She stated the facility was often understaffed and there were not enough staff to get total lift residents up for their showers.

Interview on 05/13/22 at 5:04 PM with the Director of Nursing (DON) revealed he would have expected staff to get Resident #20 up for her showers as scheduled. The DON stated all residents should be bathed or showered as scheduled and staff should have asked for assistance in getting showers done.

Interview on 05/13/22 at 7:08 PM with the Administrator revealed he expected all residents to receive their showers or bed baths as scheduled.

2. Resident #2 was admitted to the facility on 10/19/17 and readmitted on 03/10/21 with diagnoses which included cerebral vascular accident (CVA) or stroke. Hemiplegia and anxiety disorder.

Resident #2's quarterly Minimum Data Set (MDS) assessment dated 02/25/22 revealed the resident was cognitively intact and had no behaviors for refusal of care. The MDS assessment also revealed Resident #2 required extensive assistance of 1 staff for bathing and personal hygiene.

Resident #2's care plan revised on 04/06/22 revealed a plan of care for activities of daily living (ADL) required assistance related to right hemiparesis due to history of stroke. The

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interventions included provide choice of scheduling time of day for ADL completion, provide assistance with showers/bed baths as per resident' s choice - prefers showers, provide set up for oral care, facial hygiene and combing/brushing hair, encourage to choose clothing and provide assistance with dressing.

Observation and interview on 05/09/22 at 10:25 AM revealed Resident #2 up and dressed and in her room sitting in her wheelchair. Resident #2 stated she was scheduled for showers on Monday and Thursday but stated she had not been getting showers as scheduled and said she had to ask staff to give her a shower.

Observation and interview on 05/10/22 at 3:34 PM revealed Resident #2 received her shower yesterday but said she had to keep asking staff to get her shower. Resident #2 stated she didn't think she should have to ask the staff for her shower and said if it was her shower day, they should be asking her about getting her shower. Resident #2 further stated she had never refused her shower if asked about it by staff.

Review of Resident #2's bathing report from the electronic medical record (EMR) revealed the following from March 2022 to present:

March 2022 - 6 of 9 showers scheduled for the month were not documented as completed and there were no bed baths given on the days showers were missed.

April 2022 - 4 of 8 showers scheduled for the month were not documented as completed and there were nobed baths given on the days showers were missed.

May 2022 - 2 of 4 showers scheduled thus far

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for the month were not documented as completed and there were no bed baths given on the days showers were missed.

Interview on 05/12/22 at 2:51 PM with Nurse Aide (NA) #8 revealed she frequently cared for Resident #2 and stated she was assigned to her today and had not given her shower yet but was working till 7:00 PM and would try to get it done before she left. NA #8 stated they were usually short staffed and unable to give residents their showers on scheduled days. NA #8 further stated it was especially hard when the residents required extensive assistance with their shower.

Interview on 05/13/22 at 8:42 PM with NA #14 revealed she frequently cared for Resident #2 and stated there was usually not enough staff to get all the residents' showers done as scheduled. NA #14 stated staffing made it difficult to get all their showers done.

Interview of 05/13/22 at 9:35 AM with NA #18 revealed she had taken care of Resident #2 and stated it was not always possible to get showers done due to staffing. NA #18 stated she worked at the facility about 75 to 80 hours a pay period and they were still short staffed on most shifts.

Interview on 05/13/22 at 9:40 AM with NA #15 revealed she had taken care of Resident #2 and said she was able to get incontinence care done and turning and positioning done but was not always able to get Resident #2's shower done. She stated the facility was often understaffed and there were not enough staff to get all the showers done as scheduled.

Interview on 05/11/22 at 4:13 PM with NA #16

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revealed she had taken care of Resident #2 and stated it depended on staffing as to whether showers were done. She stated it was difficult to do any showers on 2nd shift because they were usually short staffed. She further stated residents complained about not getting showers and they had more falls when they were understaffed.

Interview on 05/13/22 at 5:04 PM with the Director of Nursing (DON) revealed he would have expected staff to give Resident #2 her showers as scheduled. The DON stated all residents should be bathed or showered as scheduled and staff should have asked for assistance in getting showers done.

Interview on 05/13/22 at 7:08 PM with the Administrator revealed he expected all residents to receive their showers or bed baths as scheduled.

3. Resident #54 was admitted to the facility on 6/19/21 with diagnoses that included cerebral infarction and muscle weakness.

Resident #54's care plan revised on 8/26/21 indicated Resident #54 required set up to extensive/total assistance with dressing, toileting, and hygiene due to continued poor strength, balance, and activity tolerance. Interventions included to provide assistance with showers/bed baths as per resident's choice, Resident #54 will refuse showers at times when offered, reoffer when she refuses or offer a bed bath.

The quarterly Minimum Data Set (MDS) assessment dated 4/1/22 indicated Resident #54

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was cognitively intact, had no rejection of care behaviors and required extensive physical assistance with all activities of daily living including toilet use, personal hygiene, and bathing. The MDS further indicated she was occasionally incontinent of urine and frequently incontinent of bowel. She also had impairment on one side for both upper and lower extremities.

A review of the Shower schedule revealed Resident #54 was scheduled for a shower on Tuesday and Friday on the 7:00 AM to 3:00 PM shift.

A review of the Bathing Record for Resident #54 from 4/1/22 to 5/9/22 indicated the following information:
Resident #58 received a shower on 4/19/22 and 4/29/22. She received a bed bath on 4/1/22, 4/5/22, 4/15/22, 5/3/22 and 5/4/22. No refusals were recorded.

A review of the Progress Notes in Resident #54's medical record from 4/1/22 to 5/9/22 indicated no progress note that she refused to receive a shower or a bed bath.

An interview with Resident #54 on 5/9/22 at 10:14 AM revealed she only received a shower once a week and she wanted to have at least two showers per week because she didn't feel clean especially when she had her menstrual period.

An interview with Nurse Aide (NA) #4 on 5/11/22 at 11:56 AM revealed she was usually assigned to Resident #54 on the day shift from 7:00 AM to 3:00 PM but she only worked with her every other Tuesday and Friday. NA #4 stated Resident #54 sometimes refused to take a shower, but she

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gave her a bed bath whenever she refused to take a scheduled shower.

A phone interview with NA #5 on 5/11/22 at 2:37 PM revealed she worked with Resident #54 on 4/12/22, 4/22/22 and 4/26/22 but was unable to give her scheduled shower because there wasn't enough staff at the facility on those days. NA #5 stated she often had to work with only one other nurse aide on the day shift for the whole hall and this happened at least once or twice a week. During those days when there were only two nurse aides for the day shift on the hall, NA #5 stated they didn't have time to complete any of the showers that were scheduled.

An interview with NA #2 on 5/11/22 at 10:49 AM revealed she worked with Resident #54 on 4/8/22 on the day shift but she didn't give her a shower because they were short-staffed at that time. There were only three nurse aides who worked that day on the hall, and she didn't have enough time to go back and give Resident #54 her shower.

A follow-up interview with Resident #54 on 5/11/22 at 11:00 AM revealed she did not get a shower on 5/10/22. Resident #54 stated NA #6 told her that she was going to give her shower after she was finished with all her tasks, but she never came back to her room. Resident #54 stated she did not refuse to take a shower on 5/10/22. She said staff usually came and asked her if she wanted a shower or a bed bath and she sometimes picked to have a bed bath, but NA #6 didn't even ask her on 5/10/22. Resident #54 stated she wanted to take a shower on 5/10/22.

An interview with NA #6 on 5/11/22 at 11:39 AM

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revealed she worked with Resident #54 on 5/10/22 for the first time but she was not assigned to do Resident #54's shower. NA #6 stated NA #3 was supposed to give Resident #54 her shower and she remembered Nurse #3 talking to NA #3 about it. NA #6 stated the shower assignments did not correspond to the resident assignments. She said the unit manager usually listed the scheduled showers for the day and the nurse aides divided them up among themselves.

An interview with NA #3 on 5/12/22 at 10:09 AM revealed she had the bottom section of the hall on 5/10/22 and was not assigned to do Resident #54's shower. NA #3 stated she did all her scheduled showers and at the end of the shift, only one resident did not receive a shower and it was Resident #54. NA #3 stated she wasn't sure what had happened and that there was probably some kind of misunderstanding as to who was supposed to give Resident #54 a shower.

An interview with Nurse #3 on 5/12/22 at 11:53 AM revealed the nurse aides told her towards the end of the day shift on 5/10/22 that NA #3 had not given Resident #54 a shower. Nurse #3 stated she did not request NA #3 to give Resident #54 a shower because she wasn't part of her assignment. NA #6 should have given Resident #54 a shower. Nurse #3 stated that staffing was a problem at the facility and not getting showers was a big concern and they were often not getting done as scheduled.

A phone interview with the Director of Nursing (DON) on 5/13/22 at 6:04 PM revealed he heard about shower concerns on a day-to-day basis, and it was usually reported when there were only

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three nurse aides on the halls. The DON stated he should not be the daily shower monitor and the residents should get their scheduled showers at least two times a week.

4. Resident #91 was admitted to the facility on 10/20/21 with diagnoses that included fracture of the right lower leg and generalized muscle weakness.

Resident #91's care plan revised on 11/10/21 indicated Resident #91 required set up to total assistance with dressing, toileting, and hygiene due to new onset of decreased strength, balance, and activity tolerance. Interventions included to provide assistance with showers/bed baths as per resident's choice and Resident #91 preferred showers.

The quarterly Minimum Data Set (MDS) assessment dated 4/29/22 indicated Resident #91 was cognitively intact, had no rejection of care behaviors and required extensive physical assistance with toilet use, personal hygiene, and bathing. She had impairment to one side of her lower extremities. The MDS further revealed Resident #91 was always incontinent of both urine and bowel.

A review of the Shower schedule revealed Resident #91 was scheduled for a shower on Tuesday and Friday on the 3:00 PM to 11:00 PM shift.

A review of the Bathing Record for Resident #91 from 10/20/21 to 5/9/22 indicated the following information:
Resident #91 received a shower on 11/3/21,

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11/16/21 and 3/1/22. She received a bed bath on 10/29/21, 12/23/21, 1/5/22, 1/24/22, 2/14/22 and 5/4/22. No refusals were recorded.

An interview with Resident #91 on 5/9/22 at 10:32 AM revealed she was admitted to the facility on 10/20/21 and had only received 3 showers. Resident #91 stated she was supposed to receive a shower on Tuesdays and Fridays on the afternoon shift from 3:00 PM to 11:00 PM. Resident #91 stated the facility did not have enough staff. She stated she had mentioned this concern to the Social Services Director and then he passed the concern to Unit Manager #1, but she had not heard anything about it. Resident #91 stated she would never refuse to get a shower because she liked to get her hair washed. She further stated she last received a shower about 2 months ago.

A phone interview with Nurse Aide (NA) #7 on 5/11/22 at 5:28 PM revealed he usually worked on the night shift from 11:00 PM to 7:00 AM but he sometimes came in at 7:00 PM to help on the afternoon shift. NA #7 stated he had come in at 7:00 PM on 4/1/22, 4/12/22 and 4/19/22 but did not give Resident #91 her shower. NA #7 further stated they often only had two nurse aides on the evening shift for the hall which usually had 47 residents. He said they didn't have time to do the scheduled showers because they were busy answering call lights and getting incontinence care rounds done.

An interview with NA #8 on 5/11/22 at 11:43 AM revealed she worked with Resident #91 on 4/19/22 and 4/26/22 but did not give Resident #91 a shower or a bed bath on those days. NA #8 stated there were usually 2 to 3 nurse aides on

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the evening shift on each hall but that was not enough to adequately take care of all the residents. NA #8 stated they usually didn't have enough time to get the scheduled showers completed.

An interview with NA #9 on 5/11/22 at 3:45 PM revealed he had worked with Resident #91 on 4/5/22, 4/8/22 and 4/22/22 but he was unable to give her scheduled shower because there were only two nurse aides who worked on the hall. NA #9 stated it was tough to get showers done when they had to serve supper, feed residents who needed assistance and care rounds to do. He stated there was no excuse for Resident #91 not getting her shower because she got up every day and worked with therapy.

A phone interview with NA #11 on 5/11/22 at 2:52 PM revealed she worked with Resident #91 on 4/15/22 and 4/29/22 but did not give her a shower because there were only two nurse aides for the evening shift for the hall. NA #11 stated the facility had been short-staffed especially during the past two weeks.

A phone interview with NA #10 on 5/11/22 at 2:18 PM revealed she worked with Resident #91 on 5/3/22 on the evening shift but didn't give her a shower that day and she couldn't remember if Resident #91 had refused to take one. NA #10 stated she was not sure why Resident #91 did not receive a shower on 5/3/22.

An interview with the Rehabilitation Director on 5/11/22 at 10:20 AM revealed there had been some residents who had voiced their concerns to him and his staff about not receiving their scheduled showers and one of them had been

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Resident #91. Resident #91 had complained to him about not receiving her showers, but he had informed the nursing staff about it. The Rehabilitation Director stated he had also brought it up at the morning meeting. He also stated that there had been an ongoing issue with resident showers not getting done.

A phone interview with the Director of Nursing (DON) on 5/13/22 at 6:04 PM revealed he heard about shower concerns on a day-to-day basis, and it was usually reported when there were only three nurse aides on the halls. The DON stated he should not be the daily shower monitor and the residents should get their scheduled showers at least two times a week.

5. Resident #23 was admitted to the facility on 07/29/21 with diagnoses which included atrial fibrillation, muscle weakness and cardiomyopathy.

Resident #23's quarterly Minimum Data Set (MDS) assessment dated 03/04/22 revealed resident was cognitively intact and had no behaviors with refusals. The MDS assessment also revealed Resident #23 required physical help in part with one-person physical assistance of staff for bathing.

Resident #23's revised care plan dated 04/04/22 revealed a plan of care for activities of daily living (ADL) that required assistance related to bathing. The interventions included provide choice of scheduling, provide assistance with showers/ bed baths as per resident's choice and resident prefers showers.

Observation and interview on 05/09/22 at 10:12

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AM revealed Resident #23 was up and dressed and in her room sitting in a chair. Resident #23 stated she was scheduled for showers during second shift on Wednesday and Saturday and has not been receiving her showers as scheduled.

Observation and interview on 05/10/22 at 10:15 AM revealed Resident #23 was up and dressed and in her room sitting in a chair. Resident #23 was observed with greasy hair and stated she did not receive a shower last night and her hair gets sweaty from her physical therapy and night sweats. She revealed no one had told her why she was not receiving her scheduled showers other than they were short staffed. She stated that she would like to have her showers as scheduled.

Review of Resident #23's bathing report from electronic medical record (EMR) revealed the following from April 2022 to present:

April 2022- 9 of 9 showers scheduled for the month were not documented as completed and there were no bed baths given on the day's showers were missed.

May 2022- 3 of 3 showers scheduled for the month were not documented as completed and there were no bed baths given on the day's showers were missed.

Interview conducted with Unit Manager #1 on 05/10/22 at 3:17 PM revealed resident's have their scheduled shower days and times. She stated the NAs were responsible for completing a shower sheet which was signed off on by hall nurse and placed into the shower notebook at the nurse's station. She revealed residents had the right to be showered at their request whether that

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was daily or weekly and this request should be accommodated. She stated if a resident refuses a shower, the NA informs the hall nurse. She stated the hall nurse would speak with the resident about the refusal and document the reason for the refusal. She revealed there were no reasons to her knowledge as to why residents shouldn't be receiving showers as scheduled.

Interview conducted with NA #16 on 05/11/22 at 3:55 PM revealed she frequently provided care for Resident #23 and stated being able to get showers completed depended on how many staff were working. She revealed on most occasions second shift was not able to complete their showers due to being short staffed. She stated on days when there was enough staff on first shift, they had been asked to complete showers for residents who missed their showers on second shift. She revealed first shift staff tried to give bed baths if not able to give resident shower. She stated she had given Resident #23 a shower on first shift about two months ago but primarily she was supposed to receive her showers on second shift.

Observation and interview on 05/12/22 at 2:13 PM revealed Resident #23 up and dressed and in her room sitting in a chair. Resident #23 was observed with greasy hair and stated she did not receive her scheduled shower last night, 5/11/22, because there was only one staff on the hall. She revealed staff told her they would give her a shower tonight. She revealed her last shower to her knowledge, was in April before she attended a medical appointment. She stated she would prefer to have her showers as scheduled.

Interview conducted with NA #11 on 05/12/22 at

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2:18 PM revealed she frequently provided care for Resident #23 and was assigned to her last night, 5/11/22. She stated she was not able to assist Resident #23 with her scheduled shower last night due to low staffing and being the only NA on the hall. She revealed the facility was often understaffed and that made it difficult to get all their showers done as scheduled.

A telephone interview was conducted with Nurse #9 on 05/13/22 at 11:05 AM and revealed she had not seen Resident #23 receive a bath or shower. She stated she had never seen any of the NAs give showers and when she has asked about why showers have not been completed, she was told there was low staffing, or the resident refused. She revealed resident's not receiving showers is a concern and one of the biggest personal care areas that did not get completed. She stated staffing was an issue with personal care not being completed, especially on the weekends when staffing was very low.

Observation and interview on 05/13/22 at 8:40 AM revealed Resident #23 up and dressed and in her room sitting in a chair finishing breakfast. She stated she did not receive a shower last night, 5/12/22. She revealed she preferred to have a shower and she has never refused a shower when offered because she wants to have them.

Interview conducted with the Director of Nursing (DON) on 05/13/22 at 6:15 PM revealed he would have expected staff to give Resident #23 her showers as scheduled. The DON stated all residents should be bathed or showered as scheduled and staff should have asked for assistance in getting showers done.

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F 561	Continued From page 31 Interview was conducted with Administrator on 05/13/22 at 7:11 PM revealed he expected all residents to receive their showers or bed baths as scheduled.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		6/22/22

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F 580	Continued From page 32 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff and Medical Director interviews, the agency failed to notify the physician of missed injections of Capoxone (for multiple sclerosis) for 1 of 8 residents reviewed for medications (Resident #17) and failed to notify the resident representative (RP) and the physician of transfer to the hospital for 1 of 1 resident reviewed for hospitalization (Resident #84). The findings included: 1. Resident #17 was admitted to the facility on 5/5/21 with a diagnosis of multiple sclerosis (MS). Review of the quarterly minimum data set (MDS) assessment dated 2/22/22 revealed Resident #17 was cognitively intact and could make her needs known. An interview was conducted on 5/9/22 with	F 580	1) On 5/11/22, the Medical Director (MD) was notified of missed medications for Resident #17. On 5/11/22, the Medical Director was notified of Resident #84 hospital transfer on 5/7/22. Resident Representative (RR) was notified on 5/7/22. 2) On 6/8/22, the Director of Nursing (DON) reviewed Medication Administration Records (MARs) from 6/1-6/7/22 for current facility residents to identify additional missed medications. On 6/9/22, the MD was notified of omissions and medications were ordered to ensure availability. On 6/8/22, the DON reviewed hospital transfers from 5/1-5/31/22 to ensure MD/RR notifications. 3) Effective 6/22/22, the Staff Development Coordinator (SDC) provided education to current facility and agency Licensed Nurses on notification to MD/RR	

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F 580	Continued From page 33 Resident #17. She stated she missed 5 shots of the Capoxone 20 milligrams in May, which she was getting for MS. Review of the physician order dated 2/14/22 stated to inject Capoxone 20 milligrams (mg) subcutaneously at bedtime for MS. Review of the Medication Administration Record (MAR) for May 2022 revealed the Capoxone injections were documented as not given on 5/2, 5/3, 5/4, 5/5 and 5/6/22 with the reason stated as waiting to receive from the pharmacy. This writer was unable to interview the Med Tech who was assigned to Resident #17 on 5/2/22. An interview with Nurse #2 on 5/12/22 at 8:52 AM revealed she was assigned to Resident #17 on 4/30/22, 5/1/22 and 5/3/22. She stated she should have reordered the medication when she cared for Resident #17 on 4/30/22. She stated she was not sure why she didn't reorder. She stated she did not administer the Capoxone injection on 5/3/22 because there was none in the med cart. She stated she did not notify the physician that the injection was not given. She was unable to state why she failed to notify the physician. An interview was conducted with Nurse #4 on 5/10/22 at 1:42 PM. She acknowledged that Resident #17 did not receive Capoxone 20mg injections at bedtime on 5/4/22 and 5/6/22. Nurse #4 was assigned to Resident #17 on 5/4/22 and 5/6/22. She stated she was off a couple days and when she returned on 5/4/22, there were no more doses in the med cart. She reordered the medication on 5/4/22. Nurse #4 stated she did	F 580	with changes in resident condition. Education included the importance of notifying the MD of missed medications and of notifying the MD/RR promptly with all hospital transfers. Newly hired facility and agency Licensed Nurses will receive education upon hire and prior to first shift worked. Electronic Medication Administration Records (MARs) and transfer reports will be reviewed during morning clinical meetings for oversight. 4) The DON/Designee will monitor five (5) resident MARs for MD notification of missed medications and recent hospital transfers for timely MD/RR notifications. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, once weekly for eight (8) weeks. The DON will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with notification of changes. Compliance date: 6/22/22	

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not notify the physician on 5/4/22 or on 5/6/22 that Resident #17 had missed the injections of Capoxone. She was unable to state why she failed to notify the physician.

An interview with Unit Manager #2 was conducted on 5/12/22 at 4:03 PM. She stated she was assigned to Resident #17 on 5/5/22. She was unable to administer the Capoxone because there was none in the med cart. She stated the medication should have been reordered by 4/29/22 so that it would have been delivered to the facility by 5/2/22, when the first dose was missed. She did not notify the physician that the Capoxone was not administered. She was unable to state why she failed to notify the physician.

An interview with the Medical Director was conducted on 5/12/22 at 11:19 AM. He stated he should have been notified that Resident #17 had missed injections of Capoxone 20mg. He stated he was not aware of any harm from the missed injections although the Capoxone was a significant medication for her.

An interview with the Director of Nursing (DON) on 5/13/22 at 05:10 PM. He stated he was not aware that Resident #17 had missed 5 injections of Capoxone. He stated the physician should have been notified by the nurse with each missed dose.

An interview with the Administrator was conducted on 5/13/22 at 7:12 PM. He stated he expected the staff to notify the physician when a medication was not administered.

2. Resident #84 was admitted to the facility on

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10/11/19.

A document entitled, "Health Care Power of Attorney," dated 12/12/17 and signed by Resident #84 indicated he chose his RP (responsible party) as his health care agent with no special instructions or any limitations on his agent's authority.

The quarterly Minimum Data Set (MDS) assessment dated 4/22/22 indicated Resident #84 was cognitively intact.

A progress note in Resident #84's medical record dated 5/7/22 at 1:06 PM written by Nurse #1 indicated Nurse #1 was informed by dialysis that Resident #84 had a fever of 102.5, shivers, and chills. Resident #84 told staff at dialysis that he did not feel well. DON (Director of Nursing) notified, unit manager notified, and Administrator notified. Resident #84 was then sent back to facility with instructions from Administrator, DON, and unit manager to direct transportation to the hospital. Transportation did not take Resident #84 to the hospital. Instructions per DON, Administrator, and unit manager to leave resident outside until EMS (emergency medical services) arrived and to not let him in the facility. Resident #84 was left outside with nurse aides until the arrival of EMS. Resident waited outside per management of the facility for 30-45 minutes awaiting the arrival of EMS with nurse aides and nurse.

An interview with Nurse #1 on 5/11/22 at 10:30 AM revealed there was too much going on that day when Resident #84 came back from dialysis and ended up being sent to the hospital. She didn't think about calling Resident #84's

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responsible party (RP) because he wasn't supposed to come back to the facility. Resident #84's RP came to the facility later in the afternoon on 5/7/22 when she found out Resident #84 had been outside before he was sent out to the hospital, but Nurse #1 did not talk to her. Nurse #1 also didn't know she needed to notify the physician because the call had already been made to send Resident #84 out to the hospital. Nurse #1 stated she thought the DON might have already talked to the physician about it.

An interview with Resident #84 on 5/13/22 at 10:55 AM revealed he called his responsible party on 5/7/22 from the ER to report that the facility wouldn't let him inside. He told her that he had a fever when they checked his temperature at dialysis so he was sent back to the facility but when he arrived back, they would not let him in. The EMS transported him from the facility to the hospital.

A phone interview with Resident #84's RP (responsible party) on 5/10/22 at 9:22 AM revealed Resident #84 called her from the ER (emergency room) on 5/7/22 and reported to her that the facility wouldn't let him go inside the facility after being sent back by the dialysis clinic. Resident #84's RP stated she did not receive a phone call from the facility to notify her of Resident #84 being sent to the hospital. She went by the facility on the afternoon of 5/7/22 and talked to some of the staff members she was given conflicting stories about why Resident #84 was not allowed to come inside the facility and whether he was left alone by himself while he was outside. She went to the facility on 5/9/22 and talked to the Administrator and the Social Services Director who told her that Resident #84

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F 580	Continued From page 37 was not allowed inside the facility because they did not have any COVID-19 rooms set up on 5/7/22 and they had suspected that Resident #84 might have had COVID-19. An interview with the Medical Director on 5/12/22 at 10:22 AM revealed the facility used an on-call service on the weekends and he was not sure if they had called it on 5/7/22. He stated he was not aware that Resident #84 had to be sent to the hospital on 5/7/22 but he expected to be notified of any transfer to the ER. A phone interview with the Director of Nursing (DON) on 5/13/22 at 4:06 PM revealed he had a text message interaction on 5/7/22 with Nurse #1 who notified him that Resident #84 was being sent back from dialysis because his oral temperature was over 102. The DON stated he gave directions to send Resident #84 to the hospital per protocol because he needed to be seen by a medical provider and the facility did not have a Nurse Practitioner at the facility on the weekends and they only utilized an on-call service for emergencies. The DON stated he had assumed that Nurse #1 had already called Resident #84's RP and notified the on-call provider that Resident #84 was being sent to the hospital because that was the facility protocol.	F 580		
F 584 SS=E	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.	F 584		6/22/22

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F 584	Continued From page 38 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to replace stained ceiling tiles on 1 of 4 halls (kitchen/service hall); failed to maintain walls in good repair (resident rooms 109, 118 and 212,	F 584	All stained ceiling tiles on kitchen service hall have been replaced as of 6/10/2022. Rooms 109, 118 and 212, hallway across from tub room near 211 and hallway	

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F 584	Continued From page 39 hallway across from tub room near room 211 and hallway outside of room 116) on 3 of 4 halls; failed to maintain floors in good condition (rooms 101, 107, 108, 109) on 1 of 4 halls; failed to maintain room entry doors and bathroom doors in good condition (room 107); failed to maintain sanitary bathing rooms on 2 of 4 halls (Shower room 5 and tub room by room 211); failed to replace missing closet doors (rooms 109, 110) and drawer fronts (room 118) on 2 of 4 halls; and failed to replace a leaking toilet (room 219) on 1 of 4 halls. The findings included: Observations made of the facility's environment during the annual recertification survey revealed the following: a. Observation of the kitchen/service hall on 5/12/2022 at 3:56 PM revealed several brown, bulging ceiling tiles. A subsequent observation of the kitchen/service hall on 5/13/2022 at 3:05 PM revealed the brown, bulging ceiling tiles were still in place. b. Observation of room 109 on 5/9/2022 at 1:58 PM revealed sticky residue from picture hangers on the wall. c. Observation of room 118 on 5/11/2022 at 8:52 AM revealed large areas of spackling on the wall beside the resident's bed. d. Observation of room 212 on 5/10/2022 at 2:59 PM revealed a light-colored wall panel with 2 attached light sconces and a decorative print were not attached to the wall but were leaning against the headboard of the bed. A square hole	F 584	outside of room 116 wall have been repaired as of 6/17/2022. Floors for rooms 101, 107, 108, 109 have been repaired as of 6/17/2022. Room 107-bathroom door has been repaired as of 6/17/2022. Shower room #5 and tub room near 211 have been cleaned and repaired and in sanitary condition as of 6/17/2022. Closet doors for 109 and 110 replaced as of 6/17/2022. Drawer for room 118 has been replaced and leaking toilet repaired in room 219 as of 6/17/2022. All resident rooms have the potential to be affected by this deficient practice. Complete audit of facility has been completed by the maintenance supervisor as of 6/10/2022 for any needed repairs. Maintenance department has been in-serviced on maintaining a safe homelike environment and maintenance rounds and repairs for all resident rooms and nonresident rooms of the facility as of 6/10/2022. All new maintenance staff will be in-serviced on safe homelike environment and maintenance rounds and repairs for all resident rooms and nonresident rooms arears of the facility prior to starting first shift. Maintenance Director will complete weekly rounds as of 6/17/2022 of entire facility weekly for 3 months to ensure that facility is safe, clean and in good repair. Maintenance Director will report all findings to Quality Assurance Performance Improvement committee monthly for any needed changes in current plan. All concerns will be addressed immediately.	

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approximately 4 to 5 inches across was noted to be cut into the sheetrock between the beds at a height of approximately 5 feet from the floor. A silver corrugated tube was protruding from the hole.

Subsequent observation of room 212 on 5/11/2022 at 8:39 AM, 5/12/2022 at 12:29 PM and 2:16 PM and 5/13/2022 at 8:33 AM and 3:05 PM revealed no change in the panels leaning against the bed and the hole in the wall remained uncovered with the silver tube protruding.

e. Observation of hallways on 5/11/2022 at 8:39 AM revealed torn wall covering across from the tub room near room 211 and ripped wall covering in the hall beside room 116 across from the nurses' station.

f. Observation of room 101 on 5/9/2022 at 12:50 PM revealed the floor was sticky causing surveyor's shoes to stick to the surface.

Subsequent observation of the floor in room 101 on 5/10/2022 at 10:04 AM revealed the floor continued to be sticky.
During the observation, an interview with Resident #58 revealed the floor had been mopped that morning by housekeeping.

Interview with Housekeeper #1 on 5/10/2022 at 10:07 AM revealed resident rooms were cleaned daily. The Housekeeper acknowledged the floor was still sticky. The Housekeeper re-mopped the floor with a natural floor cleaner.

An interview with the Environmental Services Director (ESD) on 5/11/2022 at 8:36 AM revealed housekeepers utilized a premixed chemical to

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mop the floors. He further stated each housekeeper was assigned to deep clean one room per day. The ESD stated he checked behind the housekeepers.

A third observation of the floor in room 101 on 5/11/2022 at 8:50 AM revealed the floor remained sticky.

g. Observation of room 107 (Resident #2) on 5/9/2022 at 10:18 AM revealed base boards peeling from the wall in the resident's bedroom. Base boards were also peeling from the wall and linoleum was detached from the floor in the resident's bathroom.

Interview with Resident #2 on 5/9/2022 at 10:07 AM revealed she had been asking to have her bathroom floors and walls fixed. Resident #2 stated the facility Administrator had told her that her door would be painted months ago, and it still was not done.

Observation of Resident #2's entry door to room 107 on 5/9/2022 at 10:18 AM revealed a blue color of paint on it unlike the remainder of the door or other doors in the facility. During the same observation, the bathroom door was noted to have spackling on the door and required painting.

h. Observation of room 108 on 5/11/2022 at 9:18 AM revealed a portion of tile missing in the doorway of the room.

i. Observation of room 109 on 5/11/2022 at 9:18 AM revealed a section of 6 tiles (approximately 12 inches by 12 inches each) missing from the floor near the bathroom at the end of the B bed.

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The area where the tiles were missing was black and the remainder of the floor was white tile. Black scuff marks (approximately 4 to 5) were noted on the white tiles around the A bed.

Subsequent observation on 5/12/2022 at 10:29 AM revealed the tiles remained absent. The scuff marks were still in place.

j. Observation of shower room 5 (as labeled on the door) near room 101 on 5/11/2022 at 8:42 AM revealed a soiled incontinence garment and a pair of non-skid socks hanging on the toilet pipes. The top of the toilet base had a rusty brownish-orange substance on the surface. The discolored area was approximately 7 inches by 4 inches in size.

k. Observation of the tub room near room 211 on 5/11/2022 at 8:39 AM revealed what appeared to be brown dust on the floor near the tub and shower stretcher. Tracks in the brown substance looked as if they were made by the shower stretcher wheels. A wall cabinet facing the door had a rusted hinge connecting the two cabinet doors. A pink substance was observed on the walls and floor tiles in the shower area. The pink substance was in place from the floor of the shower up the wall approximately 12 inches.

l. Observation of room 109 on 5/9/2022 at 1:58 PM revealed no closet doors for Resident #17.

Interview with Resident #17 during the observation revealed she wanted doors on her closet.

m. Observation of room 110 on 5/9/2022 at 10:39 AM revealed no closet doors for Resident #20.

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n. Observation of room 118 on 5/13/2022 at 3:05 PM revealed no drawer front for one of Resident #56 drawers.

o. Observation of room 219 (Resident #71) on 5/9/2022 at 9:59 AM revealed a leaking toilet.

Interview with Resident #71 revealed he had told maintenance about the leak, and it had not been fixed. Resident #71 did not recall when or the name of the person he spoke to. Resident #71 stated the leak made his room stink.

Interview on 5/11/2022 at 4:33 PM with Administrator #13 revealed the Maintenance Director would be in the facility on 5/12/2022. Administrator #13 stated there was lots for him to do. Administrator #13 indicated there were wall panels on the renovated side of the building (200 hall side) that were falling off the wall when the beds were pushed up against them.

Interview with the Maintenance Director on 5/12/2022 at 2:16 PM revealed his primary responsibility was at a sister facility. He stated he had been splitting his duties between this building and his regularly assigned building for 4 to 5 months. The Maintenance Director stated he thought the position had been advertised, but no one had been hired. The Maintenance Director revealed employees were supposed to utilize TELS (a maintenance software utilized by the company) to report work orders. The Maintenance Director disclosed with previous management changes in the building, use of the software had fallen by the wayside. The Maintenance Director stated he was trying to get employees back to using the system. At present,

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F 584	Continued From page 44 he stated Administrator #13 and the Director of Nursing (DON) were keeping a list for him between his visits to the building. He stated he currently had only 1 work order for a bed repair. The Maintenance Director indicated he was waiting on delivery of tiles to replace broken tiles in the floor. An interview and walking tour of the facility on 5/12/2022 at 2:48 PM with the Maintenance Director revealed he was not aware of any specific plan in place for repairs in the building. Interview on 5/13/2022 at 7:23 PM with the facility Administrator, the Vice President of Risk Management, and Administrator #13 revealed the Administrator was aware of the brown ceiling tiles. The Administrator stated the air conditioning unit on the roof had leaked causing the roof to need repair. The repair was completed, but after a hard rain, the roof leaked again. The Administrator indicated the tiles were on-site ready to be placed, but they needed to verify the roof leak repair before the tiles were replaced again.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC	F 585		6/22/22

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facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their

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conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the

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F 585	Continued From page 47 result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents, family member and staff, the facility failed to thoroughly investigate concerns brought up at a resident council meeting and grievances filed by 4 of 4 residents (Resident #91, Resident #84, Resident #447, and Resident #2). The facility also failed to provide a written summary of corrective action to be taken by the facility for 1 of 1 resident (Resident #2) reviewed for grievances. The findings included: 1. A review of the Resident Council Meeting minutes dated 11/18/21 indicated the following concerns were brought up by the residents who attended the meeting: a. The council stated snacks were not being given on first or second shifts and they were concerned about diabetic residents. b. The council stated staff was very disrespectful. Nursing staff members did not knock before entering rooms. The nurse aides were rude and nasty with earbuds in their ears, talking on the phone or talking over residents while giving care to other nurse aides about their personal lives. c. The council stated residents felt they were being treated as though everyone had dementia and they felt like they had no choices. d. Residents stated they were afraid to complain or file a grievance due to being afraid of retaliation. A review of the Grievance Log from January 2021	F 585	Administrator interviewed residents number 91, 84, 447, 2 for any current concerns as of 6/17/2022. Social Service Director reviewed resident council minutes for April and May 2022 for any concerns, grievance form completed for any noted concerns as of 6/10/2022. All resident rooms have the potential to be affected by this deficient practice. Complete audit of all current residents has been completed by the Social Servce Director as of 6/10/2022. All Administrative staff to include Activity Director, Social Worker, Business Office Manager, Director of Nursing, Unit Managers, Maintenance Director, Dietary Manager, Housekeeping Director were in-serviced by the Regional Director of Operations on completing the grievance report and follow up for outcome of grievance as of 6/17/2022. Social Worker will monitor 5 residents daily as of 6/17/2022 for grievances for 1 month then 5 residents weekly for 2 months. Social worker will monitor resident council minutes monthly for 6 months as of June 2022. Social worker will ensure all grievances are completed and resolved as per facility policy for grievances. Social Worker will report all findings to Quality Assurance Performance Improvement committee monthly for any needed changes in current plan. All	

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to May 2022 revealed no grievances related to the concerns brought up by the residents at the 11/18/21 resident council meeting.

An interview with the Activities Director (AD) on 5/13/22 at 8:07 AM revealed he was present at the 11/18/21 resident council meeting and he was the one who recorded the minutes for that meeting. The AD stated he wrote a grievance on each complaint that was brought up at the meeting and submitted them to the former Administrator who was in charge of grievances at that time. The AD stated he didn't know what the former Administrator did with the written grievances, but the former Administrator mentioned to him that if he had already written grievances for the concerns, then he needed to remove the concerns from the resident council minutes. The AD stated he didn't agree with what the former Administrator said but most of the time, the former Administrator took care of writing the minutes for each of the resident council meeting except the one on 11/18/21. The AD stated most of the concerns brought up at the 11/18/21 resident council meeting continued to be an issue, and these included the snacks not being offered to the residents, the staff being disrespectful and the residents being afraid of retaliation.

Multiple attempts were made to contact the former Administrator, but they were unsuccessful.

An interview with the Administrator on 5/13/22 at 6:46 PM revealed he was not aware of any of the concerns that were brought up at the November resident council meeting.

2. Resident #91 was admitted to the facility on

concerns will be addressed immediately.
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10/20/21. Her most recent Minimum Data Set (MDS) assessment which was a quarterly MDS dated 4/29/22 indicated Resident #91 was cognitively intact.

An interview with Resident #91 on 5/9/22 at 10:32 AM revealed she had only received 3 showers since admission to the facility and she was supposed to receive a shower twice a week. Resident #91 stated she had mentioned this concern to the Social Services Director who then passed it on to Unit Manager #1. Resident #91 stated she had not heard anything more about her concern regarding her showers.

A review of the Grievance Log from January 2021 to May 2022 revealed no grievances related to Resident #91 and her concern about not receiving showers as scheduled.

An interview with the Social Services Director (SSD) on 5/13/22 at 11:51 AM revealed Resident #91 told him 2-3 weeks ago that she had been in the facility for a long time and had only gotten 1-2 showers. The SSD stated he discussed Resident #91's concern with Unit Manager (UM) #1 and she was supposed to follow up on the concern. He heard from UM #1 that she followed up with Resident #91 and she received a shower on either the same day or the next day she voiced her concern to the SSD. The SSD stated he typically would file a written grievance if a concern was brought up to him, but he did not in this case and he was not sure why.

A written statement signed by the SSD dated 5/16/22 indicated: He was aware of the grievance related to Resident #91's lack of showers and discussed the issue with the

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interdisciplinary team during morning meeting the following day after hearing of the complaint. Unit Manager #1 took charge of the follow up and discussed the issue with Resident #91 that day. The same day, Resident #91 was given a shower. Also, in review of the task documentation for bathing in the electronic medical record, there were multiple instances of partial baths and bed baths given on top of the showers that were given. There had not been any more complaints since, and the SSD felt that he responded appropriately by taking it to the team to be resolved immediately.

An interview with Unit Manager (UM) #1 on 5/12/22 at 3:18 PM revealed Resident #91 had discussed her concern about not receiving her scheduled showers to her at least a month ago but she couldn't remember the exact date. Resident #91 stated to her that she was having a hard time getting the staff to get her up and into the shower room whenever she was scheduled to have a shower. UM #1 stated Resident #91 ended up getting a shower that day, so she assumed that her concern had been resolved. UM #1 also stated she spoke with Resident #91 at least every day and Resident #91 had not voiced any more concerns regarding her showers. UM #1 stated she didn't specifically ask her if she had been getting her showers as scheduled and she had thought the staff had gotten into a routine and had been following the shower schedule.

An interview with the Administrator on 5/13/22 at 6:54 PM revealed he did not remember any resident complaining about showers or not getting their showers as scheduled. He did not remember hearing about Resident #91's

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concerns regarding her showers but he stated the SSD should have filled out a grievance so the concern could have been appropriately addressed with the team. He stated he encouraged his staff to fill out a grievance for any concern voiced by the residents to them.

3. Resident #84 was admitted to the facility on 10/11/19. His most recent Minimum Data Set (MDS) assessment which was a quarterly MDS dated 4/22/22 indicated Resident #84 was cognitively intact.

An interview with Resident #84 on 5/13/22 at 10:55 AM revealed he remembered during a resident council meeting in May of 2021 that the former Administrator had announced that he was going to cut down the shopping for cigarettes for the smokers to once a month. Resident #84 stated he got upset with the announcement and during the meeting, he asked the Activities Director to assist him in going outside to the smoking area which was right next to the day room where the meeting was held. As soon as he got outside with his wheelchair, the door behind him slammed loudly because of the wind. The former Administrator came outside right behind him and started yelling at him and said to him that he would get Resident #84 out of the facility and that he was going to call the cops on him. Resident #84 asked the former Administrator to go back into the day room because he was starting to make him mad. Resident #84 told him to leave him alone, but the former Administrator kept on yelling at him and talking to him like he was a child. Resident #84 said to the former Administrator that he was not a dog and to please not talk to him like that. Resident #84 stated the former Administrator

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might have gotten upset with him because he thought Resident #84 slammed the door behind him which he said he did not do. Resident #84 stated he filed a grievance with therapy staff member #1 but he did not hear anything back about it. Resident #84 stated he felt like the residents did not matter to them and they did not care about them.

An interview with the Activities Director (AD) on 5/13/22 at 8:07 AM revealed the former Administrator held an emergency resident council meeting in May 2021 to announce to the residents that he needed to make a change in the smoking policy. The former Administrator wanted to cut down the shopping by the AD of smoking materials to once a month. Resident #84 got upset during the meeting because he was worried that he might run out of cigarettes, but he did not start to get heated until after the former Administrator started to raise his voice. Resident #84 left the room and went to the smoking area which was right next to the day room and was separated by a glass door and glass wall. The door slammed shut loudly right behind Resident #84 because of the wind and the AD witnessed that Resident #84 did not slam it. The former Administrator thought Resident #84 slammed the door behind him so he went out and told Resident #84 that if he didn't stop, he would put him out on the street. The AD stated he witnessed this verbal altercation between Resident #84 and the former Administrator, along with other residents and staff members at the resident council meeting. The former Administrator also said that he would call the police and have Resident #84 escorted out of the facility. The AD stated he was also present at the morning meeting when therapy staff member #1 had brought up a

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grievance related to this incident that involved Resident #84. The AD heard the former Administrator say that he was going to take care of the grievance, but the AD said he felt like it was just swept under the rug and was not investigated.

An interview with Therapy staff member (TSM) #1 on 5/10/22 at 12:11 PM revealed Resident #84 reported to him about the verbal altercation with the former Administrator in May 2021 a few days after the resident council meeting. TSM #1 stated he filed a grievance about Resident #84's concerns and brought it up at the morning meeting on 5/21/21. The former Administrator commented to give him the concern and that he would investigate it. TSM #1 thought there was a conflict of interest because Resident #84's concern was regarding the way the former Administrator had treated him and TSM #1 did not know what else he could have done at that point.

A phone interview with the former Director of Nursing (DON) on 5/12/22 at 5:50 PM revealed she was at the morning meeting when therapy staff member #1 had brought to their attention regarding the grievance by Resident #84. Resident #84 had not voiced his concerns about the former Administrator to her and she didn't talk to him about it, but she remembered the former Administrator saying that he was going to take care of the grievance. The former DON could not remember any other details about what happened to the grievance filed by therapy staff member #1.

A review of the Grievance Log from January 2021 to May 2022 revealed no grievance related to Resident #84's altercation with the former

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Administrator in May 2021.

Multiple attempts were made to contact the former Administrator, but they were unsuccessful.

An interview with the Administrator on 5/13/22 at 6:46 PM revealed he didn't know all the details of what had happened between Resident #84 and the former Administrator. He also stated the former Administrator should not have investigated the grievance about himself and it should have been submitted to corporate who was over the former Administrator.

4. Resident #447 was admitted to the facility on 4/5/21 and left against medical advice on 7/8/21. The quarterly Minimum Data Set (MDS) assessment dated 5/6/21 indicated Resident #447 was cognitively intact.

An interview with Therapy staff member (TSM) #1 on 5/10/22 at 12:11 PM revealed he brought up a grievance concerning Resident #447 at the morning meeting on 5/21/21. A couple of days before, Resident #447 approached him and explained the conversation he had with the former Administrator. Resident #447 was visibly upset and stated that the former Administrator threatened him and told him that he was going to be discharged to a homeless shelter. Resident #447 stated he was scared that the former Administrator would retaliate against him. TSM #1 stated he wrote a grievance about Resident #447 and presented it at the morning meeting. The former Administrator commented to give him the concern and he would investigate it. TSM #1 stated he thought there was conflict of interest because Resident #447's grievance was about the former Administrator.

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An interview with the Activities Director (AD) on 5/13/22 at 8:07 AM revealed Resident #447 told him about a verbal altercation with the former Administrator that ended with the former Administrator threatening Resident #447 that he would put him on the street. The AD also attended a morning meeting where therapy staff member #1 had brought up a grievance regarding Resident #447 about the same situation. The AD heard the former Administrator say that he was going to take care of the grievance, but the AD said he felt like it was just swept under the rug and was not investigated.

A phone interview with the former Director of Nursing (DON) on 5/12/22 at 5:50 PM revealed she was at the morning meeting when therapy staff member #1 had brought to their attention regarding the grievance by Resident #447. She couldn't remember if she had talked to Resident #447 about his concern regarding the former Administrator, but she remembered the former Administrator saying that he was going to take care of the grievance. The former DON could not remember any other details about what happened to the grievance filed by therapy staff member #1.

A review of the Grievance Log from January 2021 to May 2022 revealed no grievance related to Resident #84's altercation with the former Administrator in May 2021.

Multiple attempts were made to contact the former Administrator, but they were unsuccessful.

An interview with the Administrator on 5/13/22 at 6:46 PM revealed he was not aware of Resident #447's grievance regarding the former

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Administrator. The Administrator stated the former Administrator should not have investigated the grievance about himself and it should have been submitted to corporate who was over the former Administrator.

5. Resident #2 was admitted to the facility on 10/19/17 and readmitted on 03/10/21.

Review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated 02/25/22 revealed she was cognitively intact with no behaviors.

Observation and interview on 05/09/22 at 10:18 AM with Resident #2 revealed her up and dressed and sitting in her wheelchair. Resident #2 stated she had been trying for over a year to get the facility to do something about her bathroom. She further stated she was not used to luxurious surroundings but would like for them to be pleasant. Resident #2 opened her bathroom door, and the tile was separating from the floor along the baseboard. The caulking around the base of the commode was chipped off in places and there was a dark brown ring in the areas where the caulking was chipped. The door to the bathroom had several dents along the bottom half of the door and needed to be painted. Resident #2 pointed out that the door leading into her room was 3 different colors and needed to be painted. Resident #2 indicated she had completed a grievance about the repairs that needed to be done to her bathroom but stated nothing had been done.

Review of a grievance filed by Resident #2 dated 03/29/22 and completed by the Social Services Director (SSD) revealed she had requested the facility replace the linoleum flooring in the

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bathroom, cover the gouge in the bathroom door and paint the back of the bathroom door. Under "Investigation," the staff member assigned to the investigation was the Administrator and Maintenance. Under the section, "Departments impacted by complaint/Grievance was Maintenance. Under the section "Findings of investigation" was written: "Condition of bathroom in 107 noted." Under the section "Plan to resolve complaint/grievance was written: "Noted plan to replace flooring and paint in bathroom. Under the section Complaint/Grievance is it resolved? Describe ...": The block was empty; however, the SSD had signed off on the grievance on the same day as being completed with the complainant being satisfied.

Interview with the Maintenance Director on 05/12/22 at 2:16 PM revealed he was only at the building when he was contacted for repairs. The Maintenance Director stated he was at the facility today to check on a bed that needed repairs. He further stated he was not aware of any other requests for repairs. The Maintenance Director indicated to his knowledge there were no formal plans in place to do repairs at the facility. He further indicated he had not received any requests from the facility other than for the bed that he was there to repair. According to the Maintenance Director, no one had contacted him or consulted with him about repairs needing to bed done in Resident #2's room.

Interview with the Social Services Director (SSD) on 05/13/22 at 11:51 AM revealed he had completed the grievance for Resident #2 about her bathroom. The SSD stated he had discussed the resident's issues with the former Administrator and had been told by the former Administrator

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F 585	Continued From page 58 there was a plan in place to repair Resident #2's bathroom and other repairs throughout the building. The SSD stated once he had discussed it with the former Administrator, he had informed Resident #2 there was a plan in place to repair her bathroom and he assumed the former Administrator had taken care of the resident's request with the Maintenance Director. Multiple attempts were made to contact the former Administrator, but they were unsuccessful. Interview on 05/13/22 at 6:54 PM with the Administrator revealed he was not aware of the grievance filed by Resident #2 regarding the condition of her bathroom. He stated the grievance should have been appropriately addressed to the resident's satisfaction and corrective action taken to resolve the grievance.	F 585		
F 600 SS=G	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	F 600		6/22/22

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F 600	Continued From page 59 by: Based on record review, and interviews with resident, resident representative, staff, dialysis clinic personnel, transportation service personnel and the Medical Director, the facility neglected to assess a resident who had voiced complaints of burning up during the night, failed to obtain vital signs before sending the resident to dialysis, and failed to assess the resident and give him any medication for fever on return to the facility. Resident #84 was sent back to the facility without having dialysis due to a fever on arrival at the dialysis clinic. In addition, the facility mistreated Resident #84 when he returned to the facility when they refused to allow him to come inside while waiting on transport to the hospital without notifying the physician or giving Resident #84 an explanation why. Resident #84 complained to staff that he was shaking; he was cold because it had been chilly outside and that he was not feeling good, but they would not let him inside the facility. The findings included: Resident #84 was admitted to the facility on 10/11/19 with diagnoses that included end-stage renal disease. Resident #84's care plan revised on 11/16/21 indicated he was at risk for complications related to hemodialysis on Tuesday, Thursday, and Saturday. Hemodialysis is a process of purifying the blood of a person whose kidneys are not working normally. The quarterly Minimum Data Set (MDS) assessment dated 4/22/22 indicated Resident #84 was cognitively intact, had no behaviors and	F 600	Resident # 84 has been allowed back into facility after his admission to the hospital or following any appointment as of 5/12/2022. Resident #84 grievance was addressed as of 5/12/2022. All residents are at risk for this deficient practice. Administrator completed a 100% audit of all appointments as of 6/9/2022 to ensure no other resident has been not allowed in facility. Director of Nursing, Staff Development Coordinator/Designee have in-serviced all staff on facility policy for treating residents with Dignity and respect to include allowing residents back in facility following appointments or outside trips as of 6/10/2022. In-serviced included Abuse types for verbal, physical, neglect, misappropriation of resident property of facility property, Diversion against resident or facility. All new staff or Agency staff will be in-serviced on facility policy for treating residents with Dignity and respect to include allowing residents back in facility following appointments or outside trips. All Administrative staff to include Activity Director, Social Worker, Business Office Manager, Director of Nursing, Unit Managers, Maintenance Director, Dietary Manager, Housekeeping Director were in-serviced by the Regional Director of Operations on completing the grievance report and follow up for outcome of grievance as of 6/17/2022. Administrator/Designee will monitor 5 residents daily Monday- Friday for 1 month, then 3 times a week for 1 month,	

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F 600	Continued From page 60 required extensive physical assistance with all activities of daily living including transfer. The MDS further indicated Resident #84 received dialysis while a resident at the facility. A progress note in Resident #84's medical record dated 5/7/22 at 1:06 PM written by Nurse #1 indicated Nurse #1 was informed by dialysis that Resident #84 had a fever of 102.5, shivers, and chills. Resident #84 told staff at dialysis that he did not feel well. DON (Director of Nursing) notified, unit manager notified, and Administrator notified. Resident #84 was then sent back to facility with instructions from Administrator, DON, and unit manager to direct transportation to the hospital. Transportation did not take Resident #84 to the hospital. Instructions per DON, Administrator, and unit manager to leave resident outside until EMS (emergency medical services) arrived and to not let him in the facility. Resident #84 was left outside with nurse aides until the arrival of EMS. When EMS was called they refused to come pick up resident due to their consideration of non-emergent transport. EMS was called again for emergent transportation. Resident waited outside per management of the facility for 30-45 minutes awaiting the arrival of EMS with nurse aides and nurse. An interview with Nurse #1 on 5/10/22 at 10:22 AM revealed on 5/7/22 while she was giving Resident #84's morning medications, Resident #84 stated he was burning up the night before and he felt a little cold today, but he felt fine now. Nurse #1 stated she did not check his vital signs prior to him leaving for his dialysis appointment at 12:00 PM. Nurse #1 stated even though Resident #84 complained of being cold, it didn't raise a red flag to her because Resident #84 sometimes	F 600	then monthly thereafter to ensure all residents are treated with Dignity and respect as of 6/22/2022. Administrator will report all findings to Quality Assurance Performance Improvement committee monthly for any needed changes in current plan. All concerns will be addressed immediately. Date Of Compliance: 6/22/2022	

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complained of being hot and sometimes he complained of being cold. Resident #84 went on to his dialysis appointment and while Nurse #1 was attending to another resident, she received a phone call from the dialysis clinic and spoke with the dialysis nurse who reported to her that Resident #84 had a fever of 102.5 and that he was going to be sent back to the facility due to concerns that he might have COVID-19. The dialysis nurse told her that they could not test him for COVID-19 at the dialysis clinic so he was sent back to the facility so they could test him. Nurse #1 immediately tried to call the Director of Nursing (DON) and Unit Manager (UM) #1 around 11:50 AM to let them know that Resident #84 might be positive for COVID-19, but she received no response. Nurse #1 did not call the on-call Nurse Practitioner. Nurse Aide (NA) #1 was able to contact Unit Manager #2 who gave Nurse #1 directions not to let Resident #84 into the facility and that he was to go to the hospital directly. Nurse #1 told UM #2 that by the time she spoke with her, Resident #84 had already arrived at the facility. UM #2 continued to tell Nurse #1 not to let him into the facility due to concerns that he might have COVID-19. Nurse #1 received a forwarded text message at 12:40 PM coming from the DON to send Resident #84 directly to the ER because he had a temperature of over 102. The text message further read: don't test him, just send him, he meets criteria whether he had a test or not, let the hospital test him.

The interview with Nurse #1 on 5/10/22 at 10:22 AM further revealed she had to call EMS twice because when she called non-emergent EMS transport, she was told they did not have trucks at that time, and she would need to call emergent

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EMS. When she called emergent EMS, they told her they did not know how long it would take them to get to the facility. Resident #84 complained of having chills and being cold while he was outside. Nurse #1 said she was wearing a jacket and she thought it had been cold outside. Nurse #1 stated the wind was blowing at around 1:06 PM. Resident #84 was wearing sweatpants, a t-shirt, and a black jacket. Nurse #1 stated Resident #84 was never alone while he was outside and NA #1, NA #2, NA #3, and Nurse #4 took turns sitting with him. At some point, while waiting for EMS to arrive, Nurse #3 did a rapid test for COVID-19 on Resident #84 and his roommate and both residents tested negative. Nurse #1 stated Resident #84 sat outside for 45 minutes waiting to get transported to the ER. Nurse #1 stated she did not assess Resident #84 and obtain his vital signs when he came back from the dialysis clinic because she really did not know what to do at that point and she was directed not to let him inside the facility and to send him to the hospital. She also did not think of administering any anti-pyretic medication (substance that reduces fever) to Resident #84 for his fever. She couldn't remember if she had made the DON aware that Resident #84 tested negative for COVID-19 because she wasn't even supposed to test him per his directions. When the EMT (emergency medical technicians) arrived, they were very upset about finding Resident #84 outside and upon learning that he was not allowed to come inside the facility. Nurse #1 stated the EMT told them that refusing to let Resident #84 was highly illegal.

A phone interview with the supervisor at the dialysis clinic on 5/11/22 at 9:18 AM revealed Resident #84 was screened as soon as he

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arrived at the clinic on 5/7/22 and his temperature was 102.5. The dialysis nurse called the facility to let them know they couldn't treat him because he had a fever and he needed to get tested for COVID-19. The dialysis supervisor stated the facility should have known not to send any resident to dialysis with a fever and that the nursing home was responsible for testing their residents for COVID-19.

A phone interview with the transportation service personnel on 5/11/22 at 9:26 AM revealed Resident was transported back to the facility at 12:00 PM after the dialysis clinic called to send him back because he had a fever of 102.5. They did not do emergency transport and could not transfer Resident #84 to the hospital which was what they told the facility staff after returning Resident #84 to the facility.

A phone interview with Resident #84 on 5/12/22 at 3:50 PM revealed he went to dialysis on 5/7/22 but when they took his temperature, they said he had a fever, so they sent him back. When he got back to the facility, he asked the staff why they wouldn't let him in, but they didn't tell him why. Resident #84 stated he couldn't understand why they wouldn't let him into the facility. He said it was a little chilly outside, he was shaking, and trembling and he told the staff that he was not feeling good. Resident #84 stated he was worried he might get pneumonia while sitting outside in the cold wind. He further stated he eventually found out that they wouldn't let him in because they thought he might have had COVID-19 but they could have placed him in an empty room at that time while he waited for EMS to pick him up. He said he waited for 45 minutes outside because the transporter refused to take

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him to the hospital, and they had to call EMS to come pick him up. Resident #84 stated he didn't have cough or other symptoms of COVID-19.

A phone interview with Resident #84's RP (responsible party) on 5/10/22 at 9:22 AM revealed Resident #84 called her from the ER (emergency room) on 5/7/22 and reported to her that the facility wouldn't let him go inside the facility after being sent back by the dialysis clinic. Resident #84's RP stated she did not receive a phone call from the facility to notify her of Resident #84 being sent to the hospital. Resident #84 sat outside the facility for 45 minutes while waiting for EMS to pick him up to take him to the ER. Resident #84 told her that the wind was blowing, and it was cold outside. Resident #84's RP stated she couldn't understand why they didn't let him in when Resident #84 had been a resident at the facility since 2019. She went by the facility on the afternoon of 5/7/22 and talked to some of the staff members but she was given conflicting stories about why Resident #84 was not allowed to come inside the facility and whether he was left alone by himself while he was outside. She came to the facility on 5/9/22 and talked to the Administrator and the Social Services Director who told her that Resident #84 was not allowed inside the facility because they did not have any COVID-19 rooms set up on 5/7/22 and they had suspected that Resident #84 might have had COVID-19.

An interview with Nurse Aide (NA) #1 on 5/10/22 at 11:48 AM revealed on 5/7/22 after Nurse #1 received a phone call from the dialysis clinic, she came over to the 200-hall side and asked her and Nurse #3 what she needed to do because dialysis was sending Resident #84 back to the facility and

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she couldn't get ahold of the DON and UM #1. NA #1 stated she called UM #2 who told her and Nurse #1 not to let Resident #84 enter the building and send him to the hospital right away because he had a fever of 102.5. NA #1 stated she didn't ask UM #2 why they couldn't let Resident #84 come inside the facility, but she later found out that the reason was because the facility was not prepared for a COVID-19 unit at that time. NA #1 further stated there were 2 empty rooms at the end of 200 hall at that time. When Resident #84 arrived outside the facility, Nurse #3 went out to request the transportation service to take him to the hospital instead. They refused to take him, so NA #2 stayed with Resident #84 while he was outside. NA #1 also took a turn and replaced NA #2 watching Resident #84 because this happened during lunch time. Resident #84 mentioned to NA #1 that he was cold even though he had a jacket and a blanket over his legs. NA #1 confirmed that it was windy, the sun was not shining and there was an overcast around the time she stayed with Resident #84 outside. When EMT arrived, they were upset upon learning that they did not let Resident #84 inside the facility.

An interview with Nurse #3 on 5/10/22 at 12:20 PM revealed the transportation service driver told her they couldn't take Resident #84 to the ER because they only did non-emergent transportation and they needed to call EMS to take him. While Nurse #1 called EMS, Nurse #3 came out to do a rapid test on Resident #84 and it was negative even though they were told not to even test him. She couldn't remember if she had relayed to the DON that Resident #84 tested negative for COVID-19. Nurse #3 stated they shouldn't have left Resident #84 outside the

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facility, but they were only following orders and directions from the DON, and they couldn't do anything about it. They didn't want to spread COVID-19 in case he did have COVID-19. Nurse #3 further stated they were supposed to obtain vital signs before sending a resident for dialysis and after a resident receives his dialysis treatment. She was not sure if Resident #84 was given any medication for his fever because she was not assigned to him.

An interview with Nurse #4 on 5/10/22 at 11:05 AM revealed she worked on the day shift on 5/7/22 and was not assigned to Resident #84 but she alternated with the nurse aides in checking on Resident #84 when he was outside the facility. Nurse #4 stated Resident #84 was outside for 45 minutes before he was picked up by EMS. She said it was windy and he was complaining to her that he was cold. Resident #84 had a jacket and a blanket over his legs. Nurse #4 also stated that they were supposed to get pre-dialysis vital signs prior to sending a resident to the dialysis clinic, make sure the resident was not in distress and take care of the dialysis site by applying topical lidocaine to the access site. When the resident comes back from his treatment, they were again supposed to obtain post-dialysis vital signs. Around the time EMS got to the facility, they decided to let Resident #84 in, but it was too late. EMS had already arrived.

An interview with Unit Manager (UM) #2 on 5/10/22 at 2:59 PM revealed she received a phone call from Nurse #1 on 5/7/22 after NA #1 called her. She was notified by Nurse #1 that the dialysis clinic was sending Resident #84 back to the facility because he had a fever of 102.5. UM #2 tried to explain to Nurse #1 that Resident #84

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just had urine collected on 5/6/22 for urinalysis because he had been complaining of pain while voiding. UM #2 texted the DON who texted her back with directions not to let Resident #84 into the building and just send him to the ER. UM #2 shared the text message she received from the DON which read: test him outside, go ahead and send to ER, we don't have a COVID-19 unit set up. UM #2 stated she did not know whether Resident #84 was tested for COVID-19 and no one from the facility contacted her anymore after she talked to Nurse #1.

A review of the weather conditions per Weather Underground website revealed the following data for Asheville, North Carolina on 5/7/22 at 11:54 AM: 62 degrees Fahrenheit (F) with no precipitation, wind gust of 20 miles per hour (mph) and North wind speed at 13 mph. The conditions at 12:54 PM were 64 degrees F with no precipitation, wind gust of 22 mph and North wind speed of 15 mph.

A review of the local EMS patient care record for Resident #84 dated 5/7/22 indicated a call was received by EMS at 12:36 PM for a request to transport Resident #84 from the nursing home facility to the hospital and they arrived on scene at 1:04 PM. The record further indicated the following information: dispatched routine traffic in reference to subject (Resident #84) having fever and chills. On arrival, Resident #84 was sitting in a reclining type of chair outside the facility. Resident #84 was alert and oriented x 4. The staff advised the EMT (emergency medical technician) that the Administrator told them not to allow the resident back into the facility due to him having a fever. Resident #84 complained of being cold. The staff on scene were standing

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outside with the resident on EMS arrival. Resident #84 complained of having chills, and that he needed dialysis. Resident #84's vital signs taken by EMT at 1:20 PM indicated the following: temperature of 99, blood pressure of 146/80, pulse of 102, respiratory rate of 20 and oxygen saturation of 100%. Resident #84 was transported routine to the ER (emergency room) for treatment.

The Emergency Room hospital record for Resident #84 dated 5/7/22 indicated Resident #84 had a temperature when he arrived at the dialysis clinic. He could not be dialyzed because of the fever and was sent back to the nursing home who would not let him in the building because of fever, hence he was sent to the hospital. On arrival to the hospital, he had a temperature of 99.9 and a white count of 14,500. Chest x-ray unremarkable. He reported the skilled nursing facility did a rapid COVID-19 test and it was negative. His only symptoms were urinary. He described feeling like fire when he urinated. No other voiding issues. He voided at least once a day and periodically needed catheterization. He reported no sore throat, earache, cough, shortness of breath, nausea, vomiting, diarrhea, or abdominal pain. He has had no COVID-19 contacts and PCR (polymerase chain reaction) is pending. The ER physician further noted that Resident #84's only symptoms were urinary, and he suspected he had a urinary tract infection. They will try to obtain urine for urinalysis and culture and will also start him on empiric antibiotics. Resident #84 will have a COVID-19 study but he had no symptoms to suggest COVID-19.

An interview with the Medical Director on 5/12/22

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at 10:22 AM revealed he would not have advised for Resident #84 to miss a dialysis treatment just because he had a fever because it would make it worse for him if he did not receive dialysis. He stated he had been providing education to facility staff about the importance of taking vital signs and he was not sure if it could have prevented the whole situation of Resident #84 being sent back to the facility due to fever, but the facility should have assessed him prior to sending him to dialysis and after he came back to the facility. The Medical Director stated he wasn't aware of Resident #84 being left outside and not allowed to come in on 5/7/22 and he didn't know the reason behind it so he couldn't comment on what the facility had done.

A phone interview with the Director of Nursing (DON) on 5/13/22 at 4:06 PM revealed he had a text message interaction on 5/7/22 with Nurse #1 who notified him that Resident #84 was being sent back from dialysis because his oral temperature was over 102. The DON stated he gave directions to send Resident #84 to the hospital per protocol because he needed to be seen by a medical provider and the facility did not have a Nurse Practitioner at the facility on the weekends and they only utilized an on-call service for emergencies. The DON stated he jumped to conclusion and thought Resident #84 might be positive for COVID-19 and an exceedingly high temperature met the criteria for being evaluated at the ER. Resident #84 also needed emergency dialysis at that time. The DON also stated he did not know that the transportation service did not do emergency room transports and he thought that they could have transported Resident #84 from either the dialysis clinic or from the facility to the ER. The DON further stated Nurse #1 should

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have followed the facility's policy for care of dialysis residents and obtained a set of vital signs for Resident #84 prior to sending him to the dialysis clinic and after receiving him back. The DON stated he knew Resident #84 had been complaining that he had not been feeling good, but it was different from having a temperature of over 102. He gave directions to staff to keep Resident #84 outside and not let him in the building because he thought he might have been positive for COVID-19, and he didn't want to spread COVID-19 to the other residents.

An interview with the Administrator on 5/13/22 at 6:46 PM revealed she didn't see her text messages from the DON and UM #2 until later in the afternoon of 5/7/22. The Administrator stated when she called UM #2, Resident #84 had already gone to the hospital, but UM #2 told her that the facility staff let him wait outside the facility for EMS to pick him up. The Administrator stated he did not know that Resident #84 was not allowed to come inside the facility until 5/9/22 when his responsible party (RP) talked to him and the Social Services Director. He stated that he asked Resident #84's RP to let him investigate what happened to Resident #84 on 5/7/22. He also stated they could have placed Resident #84 in an empty room while waiting for EMS to pick him up instead of not allowing him to come inside the facility. The Administrator stated the decision not to let him inside the facility was made to protect the other residents in case he turned out to be positive for COVID-19. She also said Resident #84 should have been assessed by Nurse #1 when he got back to the facility, but it wasn't right not to let him inside the facility. She said the reason to send him to the hospital was because he had fever and they thought he might

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F 600	Continued From page 71 have COVID-19. Resident #84 needed to be seen by a physician and he needed to have dialysis.	F 600		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide care according to professional standards when a medication aide (MA#3) administered a medication used to control and relieve symptoms of acute diarrhea without a physician's order for 1 of 2 residents (Resident #294) reviewed for dialysis. The findings included: Facility standing orders dated 12/7/2020 were reviewed and revealed there was not a standing order to administer Loperamide (an antidiarrhea medication) for diarrhea. Resident #294 was admitted to the facility on 5/5/2022 with diagnoses including malignant neoplasm of the colon and end stage renal disease on dialysis. Resident #294 discharged from the facility on 5/10/2022. An interview with the nurse aide (NA) #20 on 5/10/2022 at 8:42 AM revealed Resident #294 had been experiencing diarrhea on the morning of 5/9/2022 while staff were assisting him with	F 658	1) Resident #294 discharged from the facility on 5/10/22, therefore no corrective action is applicable. 2) On 6/10/22, the Director of Nursing (DON) completed medication pass observations of 5 residents to ensure administered as needed medications were only given with a current physician order. No concerns identified. On 6/9/22, the Medical Director (MD) updated the facility standing orders to include commonly used as needed medications. 3) Effective 6/22/22, the Staff Development Coordinator (SDC) provided education to current facility and agency licensed nurses and medication aides on the process of administering as needed medications. Education included the requirement of a licensed nurse assessment for residents with changes in condition and administration of as needed medications by licensed nurses and	6/22/22

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F 658	Continued From page 72 getting dressed for his dialysis appointment. NA #20 indicated MA #3, who was on the hall that morning, had given Resident #294 a medication to stop the diarrhea. Resident #294's Physician's orders were reviewed and did not reveal an order for an antidiarrheal medication. Resident #294's Medication Administration Record (MAR) was reviewed and did not reveal any antidiarrheal medication had been signed as given on 5/9/2022. Interviews conducted with MA #3 on 5/10/2022 at 11:47 AM and 5/10/2022 at 3:58 PM revealed MA #3 had been assigned to Resident #294 on 5/9/2022 and had administered Loperamide 2mg to Resident #294 the morning of 5/9/2022 for diarrhea. MA #3 indicated there was a standing order for the medication and she had told the Unit Manager (UM) #1 that she had given the Loperamide after administration. MA #3 further indicated she did not have access to input orders into resident charts and that UM #1 was supposed to input the order. MA #3 reported that she had not documented the administration of the Loperamide because the order had not been put in Resident #294's orders. An interview and observation of the facility's standing orders with MA #3 on 5/10/2022 at 3:58 PM revealed there was not a standing order for the Loperamide. MA #3 further revealed she had not checked the facility standing orders or reported the diarrhea to UM #1 prior to administration of the Loperamide. An interview with UM #1 on 5/10/2022 at 2:53 PM revealed standing orders had to be inputted into	F 658	medication aides only with an active physician order including standing orders. Newly hired licensed nurses and medication aides will receive education upon hire and prior to first shift worked. 4) The DON/Designee will complete medication pass observations of five (5) residents to ensure as needed medications are only administered with a current physician order. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, once weekly for eight (8) weeks. The DON will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with professional standards. completion date; 6/22/2022	

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F 658	Continued From page 73 the residents' charts by a nurse. UM #1 indicated the physician was supposed to be called to receive an order for Loperamide because it was not on the standing orders. UM #1 reported she had not been notified of Resident #294 having diarrhea or receiving the Loperamide by MA #3 on 5/9/2022. An interview with the Medical Director (MD) on 5/12/2022 at 4:16 PM revealed that although it was reasonable to give Loperamide for the diarrhea, there should have been an order for it prior to administration.	F 658		
F 677 SS=D	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 to provide nail care, oral care, and facial hygiene to 2 of 7 dependent sampled residents reviewed for activities of daily living (ADL) (Resident #79 and Resident #20). The finding included: 1. Resident #79 was admitted to the facility on 03/31/15 with diagnoses which included heart failure, atrial fibrillation, and diabetes mellitus (DM). Review of the care plan that was revised on 01/18/19 described Resident #79 with ADLs self-care performance deficit related to general	F 677	1) On 6/11/22, Resident #79 and #20 was provided oral care, nail care and facial hygiene/shaving. Activities of Daily Living (ADL) care will continue to be provided to meet resident needs. 2) On 6/8-6/9/22, the Department Heads completed interviews and observational monitoring of current facility residents to ensure oral care, nail care and facial hygiene is provided to meet resident needs. Care needs provided as identified. 3) Effective 6/22/22, the Staff Development Coordinator (SDC) provided	6/22/22

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F 677	Continued From page 74 deconditioning, weakness, gait instability, and poor activity tolerance secondary to heart failure, DM, and atrial fibrillation. The goal was to reach the highest level of self-participation daily through the next review date. Interventions included extensive assist of staff for bathing and personal hygiene. Provided set up and assistance for oral care and facial hygiene. A quarterly Minimum Data Set (MDS) dated 04/15/22 assessed Resident #79 with intact cognition. He required extensive staff assistance for most of his ADLs included bathing and personal hygiene and had not demonstrated refusal of care during the 7-day assessment. An observation on 05/09/22 at 11:37 AM revealed Resident #79's left fingernails extended approximately 7.5 millimeter (MM) beyond his fingertips and his beard were approximately 75 MM in length. Interview conducted with Resident #79 during the initial observation revealed he was a diabetic and able to trim his right fingernails. However, he could not trim his left fingernails due to right-side weakness. He recalled his beard had not been trimmed for at least 6 months and stated he had to ask the staff to trim his beard and fingernails each time. Subsequent observations conducted on 05/10/22 at 03:02 PM and 05/11/22 at 09:32 AM revealed Resident #79's fingernails and beard remained unchanged. During a joint observation conducted with Nurse #8 and Unit Manager (UM) #1 on 05/11/22 at 11:28 AM, Resident #79's beard and fingernails remained unchanged. Resident #79 stated he wanted his beard to be trimmed but not	F 677	education to current facility and agency licensed nurses and nurse aides on providing ADL care for dependent residents. Education included providing oral care and facial hygiene during routine morning and evening care. Nails should be clean, trimmed and free of jagged edges and facial hair should be shaved as needed to maintain quality resident care. Newly hired facility and agency licensed nurses and nurse aide will receive education upon hire and prior to first shift worked. 4) The Administrator/Designee will make observations of five (5) residents to ensure oral care, nail care and facial hygiene/shaving is provided. Monitoring will be completed at a frequency of five (5) times weekly for four (4) weeks then, once weekly for eight (8) weeks. The Administrator will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with ADL care for dependent residents. Compliance date: 6/22/22	

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completely shaved. He also wanted his left fingernails to be trimmed.

A joint interview was conducted with Nurse #8 and UM #1 on 05/11/22 at 11:30 AM. Both facility staff agreed Resident #79 needed nail care and facial hygiene and the staff should offer to trim his beard during the shower day. Since Resident #79 was a diabetic, UM #1 stated Resident #79's fingernails should be trimmed by a nurse, and she would make arrangement to have a staff to trim his beard immediately.

A phone interview conducted with the Director of Nursing (DON) on 05/13/22 at 4:08 PM indicated it was his expectation for all the residents to receive proper nail care and facial hygiene as indicated in a timely manner.

During an interview conducted on 05/13/22 at 7:08 PM, the Administrator stated residents should not have to ask for ADL care and it should be offered. It was his expectation for all the residents to receive ADL care as indicated in a timely manner.

2. Resident #20 was admitted to the facility 07/31/15 and readmitted on 02/23/22 with diagnoses which included osteoporosis, and chronic obstructive pulmonary disease (COPD).

Resident #20's admission Minimum Data Set (MDS) assessment dated 02/23/22 revealed she was cognitively intact and had no behaviors for refusal of care. The MDS assessment also revealed Resident #20 required total assistance of 1 staff with bathing and personal hygiene.

Resident #20's care plan revised on 02/24/22

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revealed a plan of care for activities of daily living and required total care related to muscle insufficiency/coordination/sensory deficits and tremors secondary to MS with chronic pain and limited range of motion of the left upper extremity. The interventions included provide with showers/bed baths as per resident's choice - prefers showers, provide AM/PM oral care, facial hygiene, and combing/brushing hair, encourage to choose clothing as able and dress daily in appropriate clothing for the season.

Observation and interview on 05/09/22 at 10:41 AM revealed Resident #20 lying in bed with the head of bed (HOB) slightly elevated. Resident #20 was observed to have several chin hairs that were approximately ¼ to ½ inches beyond her chin and gray in color. Resident #20 when asked about the chin hairs stated she "wanted them gone." Resident #20 was also observed to have a film over her teeth and white food particles in her upper and lower teeth in front. She was asked when the last time her teeth had been brushed and she stated she "couldn't remember the last time staff brushed her teeth." She stated she had received her morning care already and the Nurse Aide (NA) had not brushed her teeth or shaved her chin. Resident #20 further stated she would like to have her teeth brushed twice a day but at least once a day.

Observation and interview on 05/10/22 at 2:54 PM revealed Resident #20 lying in bed with HOB slightly elevated. Resident #20 was observed to have several chin hairs that were approximately ¼ to ½ inches beyond her chin and gray in color. Resident #20 was also observed to have a film over her teeth and white food particles in her upper and lower teeth in front. She stated that

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she still had not had her teeth brushed by staff.

Observation and interview on 05/11/22 at 9:55 AM revealed Resident #20 lying in bed and stated she still had not had her teeth brushed and she was observed to still have chin hairs that were approximately ¼ to ½ inch beyond her chin and gray in color. Resident #20 was also observed to have a film over her teeth and white food particles in her upper and lower teeth in front.

Interview on 05/12/22 at 2:51 PM with Nurse Aide (NA) #8 revealed she had been assigned to Resident #20 on 05/12/22 . She stated she had shaved the resident's face and removed her chin hairs. NA #8 stated she had shaved Resident #20 because she had been instructed to do so by Unit Manager #2. NA #8 further stated she had not brushed Resident #20's teeth today while taking care of her.

Interview on 05/13/22 at 8:42 AM with NA #14 revealed she had frequently taken care of Resident #20. NA #14 stated they usually did not have time to shave residents or brush their teeth because they were usually short staffed on all shifts.

Interview on 05/13/22 at 9:35 AM with NA #18 revealed shaving of residents, brushing their teeth and nail care were not getting done because they were usually short staffed and didn't have time to do personal hygiene. She stated it was all they could do to keep people dry and turned and fed their meals because of staffing.

Interview on 05/13/22 at 9:40 AM with NA #15 revealed residents were not being shaved and getting their teeth brushed and hair combed and

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F 677	Continued From page 78 brushed because they usually worked short staffed. NA #15 stated it was all they could do to keep people dry and turned. Interview on 05/13/22 at 5:04 PM with the Director of Nursing (DON) revealed all residents should have their teeth brushed during AM care and PM care or at the very least once daily. The DON stated he expected shaving, nail care and brushing of teeth to be a part of the care provided when residents are given a bath or shower. Interview on 05/13/22 at 7:08 PM with the Administrator revealed he expected all residents to be provided mouth care and facial hygiene including shaving as the resident requested and needed. The Administrator stated residents should not have to ask for ADL care but should have it provided to them.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Medical Director interviews and record review, the facility failed to prevent a resident who was at risk for aspiration from using straws for 1 of 1 resident reviewed for nutrition (Resident #27).	F 684	1) Effective 6/2/22, Resident #27 was reevaluated by speech therapy and determined to be appropriate for straws. Physician notified, orders clarified and care plan revised as appropriate.	6/22/22

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F 684	Continued From page 79 The findings included: Resident #27 was admitted to the facility 8/3/2016 with diagnoses including dysphagia (difficulty swallowing), chronic respiratory failure and chronic obstructive pulmonary disease. Review of the quarterly minimum data set (MDS) assessment dated 3/8/22 revealed Resident #27 could make her needs known but was dependent on the staff for activities of daily living. She required set up only for eating and drinking. Review of the care plan, initiated on 8/16/2016 and revised on 4/23/2019, revealed a focus area for nutrition with an intervention including "no straws." Review of the speech therapy discharge summary revealed Resident #27 received speech therapy services for swallowing difficulties and increased risk of aspiration fro 3/4/21 through 4/9/21. The discharge recommendations included "no straws." During the mealtime observation on 5/9/22 at 12:35pm, Resident #27's meal tray card stated, "no straws." A large styrofoam cup with clear liquids was noticed on the bedside table with a straw in it. The resident was not observed to drink from the cup during the observation. Review of a physician order dated 5/10/2021 revealed the order included "no straws" On 5/11/22 at 10:23am a styrofoam cup with a straw and a glass of tea with a straw was observed on Resident #27's overbed table. The	F 684	2) On 6/8/22, the Director of Nursing (DON) completed an audit to identify residents with orders for no straws. On 6/13/22, the speech therapist reevaluated residents per 6/8/22 audit and provided updated recommendations relevant to use of straws. Physician notified, orders clarified and care plans revised as appropriate. A list of residents with no straw orders posted on hydration and medication carts for quick reference. 3) Effective 6/22/22, the Staff Development Coordinator (SDC) provided education to current facility and agency licensed nurses, medication aide, nurse aides and department heads on ensuring physician orders are followed for residents with no straw orders. The licensed nurse will obtain physician orders and update care plans and Kardex's when no straw orders are indicated. The DON/Unit Managers will update and maintain master list on hydration and medication carts for residents with no straw orders for quick reference. Newly hired facility and agency licensed nurses, medication aide, nurse aides and department heads will receive education upon hire and prior to first shift worked. 4) The DON/Designee will monitor five (5) residents at risk for aspiration to ensure straws are not provided per care plan and physician orders. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, once weekly for eight (8) weeks. The	

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F 684	Continued From page 80 resident was not observed to drink from the cup during the observation. An interview with Nurse Aide (NA) #9 who cared for Resident #27 was conducted on 5/11/22 at 11:48am. He stated the therapist or the nurse notifies the NAs when there were restrictions with straws. He stated he was not aware that Resident #27 was not supposed to have a straw. He stated he did not hand out the meal trays today. He stated when he does hand out the meal trays, he usually does not pay any attention to the comments on the meal tray cards. An interview was conducted with the NA #14 who cared for Resident #27 on 5/11/22 at 1:06pm. She stated she never knew that Resident #27 was not to have a straw. She stated she had not checked the Kardex and had not paid any attention to the meal card. She stated she gave Resident #27 a straw this morning when was passing out ice water, not realizing she should not have a straw. Review of the Kardex dated 5/12/2022 revealed "no straws." An interview with Nurse #4 who cared for Resident #27 was conducted on 5/12/22 at 10:07am. She stated she was not aware of any restrictions. She stated she may look at care plan if she is looking for something specific. The nurse states she was not aware Resident #27 was not to have straws. She stated therapy should have let them know. An interview with Unit Manager #2 was conducted on 5/12/22 at 3:54 PM. She stated she has been employed by the facility for 6 weeks. She stated	F 684	Administrator will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with ADL care for dependent residents. Compliance date: 6/22/22	

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staff should read the meal tray card and a sign in Resident #27's room might help prevent the staff from giving her straws.

An interview with the Director of Rehab was conducted on 5/11/2022 at 9:42am. He stated Resident #27 was evaluated for difficulty swallowing on 3/4/21. She received speech therapy services until 4/9/21. Goals included self-awareness, increase orientation, maintain hydration through thin liquids. On 4/9/21, the speech therapy discharge summary stated resident was to have no straws, be in an upright posture when eating and drinking. He stated that speech therapy gave a copy to the MDS nurse and one to the dietary manager.

An interview with the Speech Therapist (ST) was conducted on 5/11/22 at 11:02am. She stated Resident #27 was to have no straws because of her difficulty swallowing and increased risk for aspiration and pneumonia. She stated when she made modifications to the diet, she gave a copy to the MDS nurse so that it could be care planned. At the time of discharge, she was on the 200 hall. She instructed staff on the 200 hall to not give her straws. Resident #27 currently resides on the 100 hall. She stated she talked with dietary staff and they were willing to add "no straws" to the meal tray card. The ST stated she would go to Resident #27's room and remove the straws from the cups.

An interview with the Director of Nursing (DON) was conducted on 5/13/22 at 5:04pm. He stated if the meal tray card stated no straws staff should be checking the meal tray cards. Staff should be checking the kardex and the care plan. It is quite clear she should not have had a straw due to the

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F 684	Continued From page 82 risks of aspiration. An interview with the Medical Director was conducted on 5/12/22 at 10:40am. He stated that staff need to follow the recommendations of the speech therapist. A sign above the bed might be a solution to assuring the staff do not give Resident #27 a straw. An interview with the Administrator was conducted on 5/13/22 at 7:04pm. He stated he expected staff to follow the recommendations of the speech therapist and the physician's orders.	F 684		
F 697 SS=E	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, resident, staff and Medical Director interviews the facility failed to respond to and administer as needed pain medication 1 of 4 residents reviewed with pain (Resident #69). Resident #69 was admitted to the facility on 04/11/22 with a diagnosis of unspecified fracture of lower end of right radius and fracture with routine healing. Review of admission Minimum Data Set (MDS) dated 04/18/22 revealed Resident #69 was cognitively intact.	F 697	1) Resident #69 discharged from the facility on 6/1/22, therefore no corrective action is applicable. 2) On 6/9/22, the Director of Nursing (DON) completed medical record reviews and interviews for residents with physician orders for as needed pain medication to ensure pain responded to and medication provided if necessary. Physician notified and new orders obtained where appropriate to ensure appropriate pain management plan of care in place.	6/22/22

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F 697	Continued From page 83 Review of Physician order dated 04/26/22 stated to give Oxycodone HCl 5 MG by mouth every 12 hours as needed for moderate to severe pain. (Narcotic analgesic that relieves pain for 4 to 6 hours) Review of the Medication Administration Record (MAR) for Resident #69 dated April 2022 revealed Oxycodone HCl 5 MG was administered on the evening of 04/29/22 with a pain level of 9. Review of the MAR for Resident #69 dated May 2022 revealed Oxycodone HCl 5 MG was administered on the evenings of 05/03/22, 05/06/22 and 05/12/22 with a pain level of 9. Review of care plan on 05/10/22 revealed goal for Resident #69 to be free of signs of pain or complaints of pain daily and will state relief of pain daily. Interventions include administer pain medication for pain and observe for effectiveness/ side effects and report ineffectiveness to physician. An interview with Resident #69 on 05/09/22 at 10:36 AM revealed resident was at the facility for rehab services after suffering a fall at home that resulted in a fractured wrist and shoulder. He stated he suffers from pain in the evenings due to receiving his physical therapy and using his wrist and shoulder throughout the day. He stated he was supposed to be receiving Oxycodone every 12 hours for pain at his request and he has only been receiving it every 24 hours. Resident #69 revealed he received his pain medication as scheduled at his request in the mornings but did not receive it in the evenings when he has requested it. Resident #69 indicated he has	F 697	3) Effective 6/22/22, the Staff Development Coordinator (SDC) provided education to current facility and agency licensed nurses and medication aides on pain management and responding to and administering as needed pain medications. Education included the process of license nursing assessing resident for indications of pain and the licensed nurse or medication aide administering as needed pain medication per physician orders. The licensed nurse will evaluate the effectiveness of the medication and report ineffective pain relief to the physician for follow-up intervention. Newly hired facility and agency licensed nurses and medication aides will receive education upon hire and prior to first shirt worked. 4) The DON/Designee will complete ongoing monitoring via medical record review and interview of five (5) residents with orders for as needed pain medication to ensure pain is properly responded to and medication provided if necessary. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, once weekly for eight (8) weeks. The Administrator will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with ADL care for dependent residents.	

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F 697	Continued From page 84	F 697	Compliance date: 6/22/22	

requested his pain medication every morning and every night since his admission to the facility. He stated when he requests his pain medication in the evenings, staff have not responded or have told him it is not time for him to receive his medication and do not come back to give it to him. Resident #69 revealed he has complained to nursing staff about not getting his pain medication at his request, but it continues to happen. Resident #69 also revealed not receiving his pain medication when requested causes him to be in pain throughout the night and makes it difficult for him to be able to rest.

An interview was conducted with Medication Aide #3 on 05/10/22 at 12:04 PM. She revealed she administers medication on first shift and has administered medications to Resident #69. She stated Resident #69 always requested his Oxycodone medication for pain. She revealed Resident #69 has complained about not receiving his medication on second shift when he requested it.

An interview was conducted with Resident #69 on 05/10/22 at 3:05 PM. He stated he did not receive his pain medication last night and when he requested it, the nursing staff told him it was not time for him to receive his medication. Resident #69 revealed he requested nursing staff to come back to administer his medication when it was time and nursing staff never returned. He stated he was in pain through the night and received his pain medication this morning at 8:30 AM.

A telephone interview was conducted with Nurse #9 on 05/13/22 at 10:57 AM. She revealed she worked the evening shifts at the facility and was working on the evening of 05/08/22 and 05/09/22.

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She stated she was familiar with Resident #69 and he has requested pain medication from her before and she believes he received it but does not recall. She stated if it was not time for Resident #69 to receive his pain medication then she would inform him he would have to wait, and she believed that she would go back into the room and check to see if he was still in pain and wanted his pain medication. She was not aware of Resident #69 not receiving his requested pain medication on 05/08/22 and 05/09/22.

An interview was conducted with Unit Manager #1 on 05/10/22 at 3:21 PM. She revealed no knowledge of Resident #69 not receiving pain medication when requested on second shift. She stated resident pain medications should be administered at the correct times as ordered and when requested by a resident. She stated if a resident requests a pain medication and it is not time for that medication to be administered per the order, nursing staff should revisit resident to see if they are in pain and still need to be administered their pain medication.

An interview was conducted with Resident #69 on 05/11/22 at 10:00 AM. He stated he did not receive his Oxycodone medication for pain last night. He revealed he used his call light to request his medication and nursing staff did not respond. He stated he was in pain through the night.

A telephone interview was conducted with Medication Aide #4 on 05/13/22 at 7:25 AM. She revealed she worked the evening shift at the facility as a Med Aide and worked on the evening of 05/10/22. She did not recall Resident #69 or if he asked to be administered pain medication.

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F 697	Continued From page 86 An interview was conducted with Resident #69 on 05/13/22 at 8:44 AM. He revealed he was administered his Oxycodone pain medication last night when he requested it. He stated this was the first night in he doesn't know how long that he received his pain medication even though he requests it every night. An interview with the Medical Director was conducted on 05/12/22 at 11:16 AM. He stated he was not made aware of Resident #69 not receiving pain medication when requested. He revealed medications should be given as ordered and at the request of resident. A telephone interview was conducted with the Director of Nursing (DON) on 05/13/22 at 6:21 PM. He stated it was never brought to his attention that Resident #69 not receiving pain medication when requested. He revealed if a resident asked for pain medications, he should receive it. He stated his expectation would be that if resident is requesting pain medications, he would receive the medications and if it is not time for that medication to be administered staff would go back to resident at the correct time and assess for pain and administer the medication. An interview with the Administrator was conducted on 05/13/22 at 7:20 PM. He stated he expected the staff to follow physician's orders and resident to be free from pain.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		6/22/22

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F 698	Continued From page 87 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, and interviews with staff, dialysis clinic personnel and the Medical Director, the facility failed to transport a resident for his dialysis treatment which resulted in him missing one dialysis treatment for 1 of 2 residents reviewed for dialysis (Resident #294). The findings included: Resident #294 was admitted to the facility on 5/5/2022 with diagnoses including end stage renal disease on dialysis and unspecified dementia with behavioral disturbance. Resident #294 discharged from the facility on 5/10/2022. A hospital discharge summary dated 5/5/2022 revealed Resident #295 had a discharge diagnosis of end stage renal disease on dialysis with no follow up dialysis appointment listed. Resident #294's care plan dated 5/6/2022 revealed a focus area for dialysis with interventions which included to coordinate transportation to the dialysis center as scheduled. An interview with the Unit Manager (UM) #1 on 5/10/2022 at 2:53 PM revealed Resident #294 had arrived at the facility at about 8:00 PM on 5/5/2022 and the UM had conducted the admission. UM #1 further revealed she typically reviewed the discharge summary for any follow up appointments and did not see any follow up appointments scheduled for dialysis for Resident #294. UM #1 indicated she found out Resident	F 698	Resident #294 is no longer a resident of the facility. All residents who receive Dialysis have the potential to be affected by this deficient practice for missing Dialysis. Administrator audited 100% of residents for receiving Dialysis and schedule for dialysis days on 6/9/2022. Director of Nursing/Designee in-serviced all nursing staff on dialysis appointments as of 6/172022. All new staff or Agency staff will be in-serviced on dialysis appointments prior to starting their first shift. Director of Nursing/Designee will monitor transportation Schedule daily Monday through Friday for 3 months to ensure transportation is arranged for all residents receiving dialysis as of 6/17/2022. Director of Nursing will report Findings to Quality Assurance Performance Improvement committee monthly for any needed changes in current plan. All concerns will be addressed immediately. Completion Date: 6/22/2022	

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#294 had a dialysis appointment on 5/6/2022 at 11:00 AM the day of his appointment when the dialysis center had called the facility. UM #1 stated by that time she was not able to get transportation services due to the facility's transportation aide was off on Fridays and the backup transportation service did not have any openings. UM #1 reported she did try to get him a Saturday appointment for 5/7/2022 with the dialysis center but the dialysis center did not have any available appointment times that day.

An interview with the transportation aide on 5/10/2022 at 12:00 PM revealed she typically reviewed the discharge summary for any follow up appointments to ensure transportation was provided. The transportation aide further revealed she was not working on 5/6/2022 because she did not work on Fridays. The transportation aide indicated the process for getting transportation for newly admitted residents on dialysis when the transportation aide was not available was the floor nurses who admitted the residents were supposed to review the discharge summary for appointments that were scheduled and call the backup transportation company to set up transport.

An interview with Resident #294's family on 5/10/2022 at 10:25 AM revealed Resident #294 had missed a dialysis appointment on 5/6/2022 that was scheduled at 12:00 PM and she was not sure exactly why he had missed the appointment. Resident #294's family indicated she had called the facility on 5/6/2022 at about 7:50 AM and told a staff member she was bringing in clothes for Resident #294 because he had a dialysis appointment that day. Resident #294 was not able to recall the name of the staff member she

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F 698	Continued From page 89	F 698		

had spoken with that morning.

An interview with the dialysis center Administrator on 5/11/2022 at 9:35 AM revealed one of the nurses at the dialysis center had called the facility and spoken to a staff member on 5/6/2022 around 9:30 AM to make the facility aware of the time of Resident #294's appointment that day, but the nurse could not recall the staff members' name.

A follow up interview with UM #1 on 5/13/2022 at 6:25 PM revealed the Admissions Director did send emails with information on new admissions, but there were also texts that were sent to her cell phone with pertinent information on new admissions. UM #1 did find the email that was sent on 5/5/2022 at 11:31 AM but UM #1 stated she did not typically look at the emails to obtain information on new admissions but instead reviewed the text messages that were sent out. UM #1 reported she did not look at the email sent on 5/5/2022 for Resident #294 and instead reviewed the text message that was sent but did not have any details regarding dialysis. UM #1 further reported that even if she had seen the email, she would have assumed the Admissions Director would have already set up the appointment because this is the typical process.

A telephone interview with the Admissions Director on 5/13/2022 at 6:41 PM revealed she had never set up transportation for any follow appointments for new admissions. The admissions Coordinator stated for residents who were on dialysis, she just verified what facility the residents went to and the dates and times of the dialysis appointments.

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F 698	Continued From page 90 A telephone interview with the Director of Nursing (DON) on 5/13/2022 at 4:07 PM revealed an email was sent out by the Admissions Director on 5/5/2022 at 11:31 AM to staff that included the DON and UM #1. The DON further revealed the email stated Resident #294 had dialysis on Monday, Wednesday, and Friday at 12:00 PM. The DON indicated he was not at work on 5/5/2022 or 5/6/2022 and would not have seen the email however the appointment on Friday should not have been missed. The DON further indicated he was not sure why the appointment was missed but it may have been due to transportation not being available. An interview with the Medical Director (MD) on 5/12/2022 at 10:34 AM revealed the MD did not advise any resident to miss a dialysis appointment.	F 698		
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 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	F 725		6/22/22

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F 725	Continued From page 91 nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews the facility failed to provide sufficient nursing staff to accommodate a resident's request to be assisted out of bed; failed to provide showers / hair washing; failed to provide nail care, oral care, and facial hygiene. This affected 6 residents (Resident #20, #2, #54, #91, #23 and #79). The findings included: This tag is cross-referenced to: 1. F561: Based on record review, observations, resident and staff interviews, the facility failed to accommodate a resident's request to be assisted out of bed at their preferred time of day (Resident #20) and provide residents with their preferred number of showers per week (Resident #20, #2, #54, #91, and #23) for 5 of 8 residents reviewed for choices. 2. F677: Based on observations, record review, staff interviews the facility failed to provide nail care, oral care, and facial hygiene to 2 of 7 dependent residents reviewed for activities of	F 725	1) On 6/9/22, the Nurse Manager updated Resident #20 care plan and Kardex to reflect resident preference to get out of bed during mealtimes. On 6/9/22, the Nurse Manager updated Resident #2, #20, #23, #54 and #91 shower schedule to reflect resident bathing preference. On 5/11/22, Resident #79 and #20 was provided oral care, nail care and facial hygiene/shaving. Activities of Daily Living (ADL) care will continue to be provided to meet resident needs. 2) On 6/8/22, the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), Scheduler and Medical Director conducted an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss current nurse staffing and sufficient levels needed to ensure Activities of Daily Living (ADLs) and Resident preferences are being honored and provided. Open	

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F 725	Continued From page 92 daily living (ADL) (Resident #79 and #20). Interview with NA #19 on 5/13/2022 at 9:35 AM revealed she was agency staff who had worked at the facility for 6 years. NA #19 indicated showers, shaving, nail care, and oral care were not getting done at the facility due to staffing. The NA stated the workload was too much and there was not enough time to get everything done. Interview with Nurse #9 on 5/13/2022 at 11:05 AM revealed she had been hesitant to accept her assignment the first weekend in May 2022 because she was going to be the only nurse in the building. Nurse #9 was scheduled to work with Medication Aides (MA) and NAs. Telephone interview with the Director of Nursing (DON) on 5/13/2022 at 5:04 PM revealed he was aware of staffing challenges. He stated he expected staff to complete showers / bed baths, hair washing, nail care, facial hygiene, and oral care daily. The DON indicated the facility was actively seeking to hire permanent staff. He revealed for every permanent staff member hired, they could eliminate use of one agency staff. Interview with the facility Administrator, Administrator #13, and the Vice President of Risk on 5/13/2022 at 7:08 PM revealed they expected residents to be out of bed per their preference, showers provided / hair washed, nail care, oral care, and facial hygiene completed daily or as care planned. The Administrator stated hiring permanent staff was an active pursuit for the facility.	F 725	positions discussed with ongoing recruitment and retention plans in place. 3) On 6/14/22, the Regional Director of Nursing provided education to the Administrator and Director of Nursing on providing sufficient nurse staffing levels to meet resident ADL care preferences and needs. Education included process of daily and weekly staffing meetings. Staffing will be reviewed weekly for weekend staffing and schedule to ensure proper staffing for census and resident needs. Effective 6/22/22, the staffing committee (DON, Administrator, SDC and Scheduler) will meet daily to discuss daily nurse staffing schedules to ensure sufficient staffing levels to meet resident care needs. Schedules will be adjusted accordingly for call-outs, changes in census and changes in resident acuity. Weekly staff meetings will be held to discuss ongoing recruitment and retention. 5) The Administrator/DON will monitor for sufficient staffing levels by review of ongoing monitoring tools per F561 (Self-Determination) and F677 (ADL Care for Dependent Residents) for effectiveness of implemented corrective action plan. Monitoring will be completed weekly for twelve(12) weeks. Results of monitoring will be presented to the Quality Assurance Process Improvement (QAPI) committee monthly and changes to the plan will be made as necessary to maintain compliance with sufficient nurse	

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F 725	Continued From page 93	F 725	staffing. Completion Date: 6/22/22	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention	F 732		6/22/22

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	345174	A. BUILDING _____ B. WING _____	C 06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA PINES AT ASHEVILLE	91 VICTORIA ROAD ASHEVILLE, NC 28801

(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 732	Continued From page 94 requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post nurse staffing information on 5 of 5 days during the survey and failed to maintain the daily nursing staff records since December 2021. The findings included: A tour of the facility was made on 5/9/2022 at 9:33 AM. No nurse staffing information was observed in the lobby of the facility or in any prominent location. Subsequent observations were made in the facility on 5/10/2022, 5/11/2022, 5/12/2022 and 5/13/2022 with no posted nurse staffing information in view. An interview with the facility Scheduler on 5/12/2022 at 2:47 PM revealed she was responsible for scheduling staff. The Scheduler stated she used to complete a daily staff posting and place it in a plastic frame on the wall in the lobby. The Scheduler informed the frame was taken down during renovations and she did not know where to put the posting. The Scheduler stated she had not completed the staff posting sheet since before Christmas when the facility renovations started. An interview with the facility Administrator on 5/13/2022 at 7:23 PM revealed he was aware staff posting was a regulatory requirement. The	F 732	No residents affected. Facility Staffing has been posted as of 6/10/2022. No residents are at risk for staff posting not being posted. Staffing coordinator was in-serviced as of 6/10/2022 on facility policy for posting and maintaining staff posting daily by the Staff Development Coordinator. Staffing coordinator will post staffing daily Monday - Friday, weekend receptionist will post for weekends. Administrator will monitor staff posting daily Monday Friday for 3 months to ensure daily posted is up. Staff sheet will be completed on Friday for weekend per schedule. weekend staffing will be reviewed on Monday's for any needed correction. receptionist will post staffing on weekend as of 6/22/2022. Administrator will report all findings to Quality Assurance Performance Improvement committee monthly for any needed changes in current plan. All concerns will be addressed immediately. Correction Date: 6/22/2022	

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F 732	Continued From page 95 Administrator stated staff posting was previously posted in the front lobby but following facility renovations, he had not realized it was not being completed or posted.	F 732		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		6/22/22

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F 755	Continued From page 96 This REQUIREMENT is not met as evidenced by: Based on record review and staff, Medical Director and Pharmacy Manager interviews the facility failed to acquire Capoxone pre-filled syringes (used to treat multiple sclerosis) and as a result Resident #17 missed 5 doses. This affected 1 of 8 residents reviewed for medications (Resident #17). The findings included: Resident #17 was admitted to the facility on 5/5/21 with a diagnosis of multiple sclerosis (MS). Review of the quarterly minimum data set (MDS) assessment dated 2/22/22 revealed Resident #17 was cognitively intact and could make her needs known. Review of the physician order dated 2/14/22 stated to inject Capoxone 20 milligrams (mg) subcutaneously at bedtime for MS. An interview was conducted on 5/9/22 at 1:46 PM with Resident #17. She stated she did not get 5 Capoxone shots in May, which she was getting for multiple sclerosis. Review of the Medication Administration Record (MAR) for May 2022 revealed the Capoxone injections were documented as not given on 5/2/22, 5/3/22, 5/4/22, 5/5/22 and 5/6/22 with the reason stated as waiting to receive from the pharmacy. On 5/12/22 at 5:05 PM, an interview was conducted with Nurse #1. She stated medications should be reordered 3 days before running out.	F 755	1) Medications will continue to be made available and administered as ordered for Resident #17. 2) On 6/10/22, the Director of Nursing (DON) and Unit Manager (UM) completed a Medication Administration Record (MAR) to cart audit of current residents to ensure medications are available for administration per physician orders. Refill orders were processed if within the 3 to 5-day reordering window. 3) Effective 6/22/22, the Staff Development Coordinator (SDC) provided education to facility and agency licensed nurses and medication aides on ensuring medications are available for administration as ordered by the physician. Education included the process for ordering, reordering within 3 to 5-days of last available dose and obtaining medications from Pharmacy to ensure availability for administration. The licensed nurse or medication aide will submit medication refill requests to the Pharmacy within 3 to 5 days of last available dose as noticed during routine medication passes. The DON/UM will monitor for timely Pharmacy deliveries at least weekly. 4) The DON/UM will complete a MAR to cart audit of 5 residents to ensure medications are available for administration per physician orders. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, weekly for eight (8) weeks. The DON will present the results of monitoring to the QAPI Committee	

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F 755	Continued From page 97 She confirmed she worked at the facility and cared for Resident #17 on 4/29/22 and she should have reordered the medication then. She stated she was not sure why she didn't reorder. An interview with Nurse #2 on 5/13/22 at 8:52 AM. She confirmed she cared for Resident #17 on 4/30/22 and 5/1/22. She stated the medication should have been ordered 7 days before it ran out. She stated that she should have reordered the medication when she cared for Resident #17 on 4/30/22. She stated she was not sure why she didn't reorder. The Med Tech who was assigned to Resident #17 on 5/2/22 was not available for interview. An interview with Nurse #2 on 5/12/22 at 8:52am revealed she was assigned to Resident #17 on 4/30/22, 5/1/22 and 5/3/22. She stated she should have reordered the medication when she cared for Resident #17 on 4/30/22. She stated she did not administer the Capoxone injection on 5/3/22 because there was none in the med cart. She stated she was not sure why she didn't reorder. An interview was conducted with Nurse #4 on 5/10/22 at 1:42 PM. She confirmed she was assigned to Resident #17 on 5/4/22 and 5/6/22 acknowledged that Resident #17 did not receive the Capoxone 20mg injections at bedtime on 5/4 and 5/6/22. Nurse #4 stated she was off a couple days and when she returned on 5/4/22, there were no more doses of Capoxone in the med cart to give to Resident #17. She reordered the medication on 5/4/22 but did not notify the physician. She stated when a resident's medication was low she reordered using the	F 755	monthly and makes changes to the plan as necessary to maintain compliance with Pharmacy Services and medication availability. Completion Date: 6/22/22	

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F 755	Continued From page 98	F 755		

electronic medical record. The Capoxone should have been reordered 2-3 days before it ran out.

An interview with the Unit Manager #2 was conducted on 5/12/22 at 4:03 PM. She stated she was assigned to Resident #17 on 5/5/22 and was unable to administer the Capoxone injection because there was none in the med cart. She stated the medication should have been reordered by 4/29/22 so that it would have been delivered to the facility by 5/2/22, when the first dose was missed.

On 5/10/22 at 1:55 PM, an interview was conducted with the Pharmacy Manager. She stated a 30-day supply of Capoxone 20mg injections were ordered on 3/24/22 and delivered to the facility on 3/26/22. The next order was made on 5/4/22 and delivered to the facility on 5/7/22. She stated the pharmacy had 72 hours to refill medication orders. The pharmacy has asked the facility to reorder 3-5 days before the doses ran out. She stated the facility could have run a report that told them when refills were due.

An interview with the Director of Nursing (DON) on 5/13/22 at 05:10 PM revealed the nurses have control of the medication carts and the medication record and they should reorder medication at least 48 hours before the last dose is to be given.

An interview with the Administrator was conducted on 5/13/22 at 7:12 PM. He stated he expected the staff to follow the pharmacy protocol for ordering medications so that doses were not missed.

An interview with the Medical Director was

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F 755	Continued From page 99 conducted on 5/12/22 at 11:19 AM. He stated he thought it was a pharmacy problem across the board and there are plans to provide education to the staff to start using an app to reorder medications.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		6/22/22

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F 756	Continued From page 100 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist (CP), and Medical Director (MD), the CP failed to identify drug irregularities and provide recommendations for 1 of 6 residents reviewed for unnecessary medications (Residents #90). The findings included: Resident #90 was admitted to the facility on 10/08/19 with diagnoses that included low back pain, stage 4 sacral pressure ulcer, migraine, and anxiety. Review of physician's orders revealed Resident #90 had obtained orders to receive 1 tablet of Oxycontin extended release (ER) 10 milligrams (mg) 2 times daily for pain since 10/22/21, and 1 tablet of oxycodone 5 mg once every 6 hours as needed for pain since 10/29/21. The quarterly Minimum Data Set (MDS) dated 04/28/22 assessed Resident #90 with intact cognition. She reported having pain level of 6 out of 10 frequently and was receiving scheduled and "as needed" pain medications daily during the 7-day assessment period. A review of medication administration records (MARs) indicated Resident #90 had received the	F 756	1) On 6/13/22, the Consultant Pharmacist completed a pharmacy review for Resident #90 to identify drug irregularities and provided recommendations to the facility Medical Director. Physician orders obtained as appropriate. 2) On 6/8/22, the Director of Nursing completed an audit of June 2022 Pharmacy recommendations and of residents with physician orders for opioid analgesic. Residents identified with opioid analgesic orders without pharmacy reviews for irregularities were reviewed by the Consultant Pharmacist on 6/13/22. Physician orders obtained where appropriate. 3) On 6/13/22, the Director of Nursing provided education to the Consultant Pharmacist on the regulatory requirements related to F756 (Drug Regime Review, Report Irregular, Act On). Education included process of resident drug regime reviews by the Pharmacist to identify irregularities and to provide recommendations for Physician consideration and follow-up. The DON will	

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F 756	Continued From page 101 "as needed" oxycodone 36 times in November 2021, 31 times in December 2021, 37 times in January 2022, 27 times in February 2022, 42 times in March 2022, 52 times in April 2022, and 16 times in May 2022 by 05/11/22. Review of Resident #90's medical records revealed the CP had conducted medication regimen reviews monthly from January through May 2022 and no recommendations had been made to the physician in the past 6 months. During an interview conducted on 05/12/22 at 12:21 PM, the MD stated he had to assess the resident to determine the effectiveness of the current pain regimen before making any changes or adjustments. An interview was conducted with Resident #90 on 05/12/22 at 1:28 PM. She stated the scheduled pain medication was not sufficient to cover her pain. She had to ask the "as needed" pain medication frequently for her breakthrough pain and she was tired of doing this repeatedly. During a phone interview conducted on 05/12/22 at 3:13 PM, the CP explained she did not notice that Resident #90 had requested the "as needed" pain medication frequently in the past 5 months. Otherwise, she would have recommended the physician to consider increasing the scheduled pain medication or make other adjustments. A phone interview was conducted with the Director of Nursing (DON) on 05/13/22 at 4:08 PM. He expected the consultant pharmacist to alert the physician to re-evaluate the effectiveness of the pain medication regimen and provide recommendations to minimize Resident	F 756	review monthly Pharmacy reports to verify reviews are completed, recommendations received and Physician response obtained. Newly designated Pharmacy Consultants will be educated as appropriate. 4) The DON/Designee will monitor 5 residents for proper Pharmacy Consultant review and recommendations. Monitoring will be completed at a frequency of once weekly for twelve (12) weeks. The DON will present the results of monitoring to the QAPI Committee monthly and makes changes to the plan as necessary to maintain compliance with drug regime review. Completion Date: 6/22/22	

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F 756	Continued From page 102 #90's breakthrough pain. During a phone interview conducted on 05/13/22 at 7:08 PM, the Administrator stated it was his expectation for the consultant pharmacist to identify drug irregularities related to the frequent requests of the "as needed" pain medications and provide recommendations in timely manner.	F 756		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and Physician interviews, the facility failed to prevent significant medication errors whey they failed to acquire and administer Capoxone pre-filled syringes (used to treat multiple sclerosis) and as a result Resident #17 missed 5 doses and when pain medications were not administered as ordered by the physician to Resident #345 for 2 of 8 sampled residents whose medications were reviewed. The findings included: 1. Resident #17 was admitted to the facility on 5/5/21 with a diagnosis of multiple sclerosis (MS). Review of the quarterly minimum data set (MDS) assessment dated 2/22/22 revealed Resident #17 was cognitively intact and could make her needs known. An interview was conducted on 5/9/22 at 1:46pm	F 760	1) On 5/11/22, the Regional Director of Nursing notified the Medical Director and completed a medication error report for Resident #17. Medications will continue to be available and administered as ordered by the physician. Resident #345 discharged on 5/10/22. 2) On 6/10/22, the Director of Nursing (DON) and Unit Manager (UM) reviewed the Medication Administration Records (MARs) from 6/1-6/7/22 of active residents for medication errors. Medication errors were reported to the Medical Director and no new orders required. 3) Effective 6/22/22, the Staff Development Coordinator (SDC) provided education to facility and agency Licensed Nurses and Medication Aides (MA) on ensuring residents are free from significant medication errors. Education included medication ordering/reordering	6/22/22

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F 760	Continued From page 103 with Resident #17. She stated she did not get 5 Capoxone shots in May, which she was getting for multiple sclerosis. Review of the Physician order dated 2/14/22 stated to inject Capoxone 20 milligrams (mg) subcutaneously at bedtime for MS. Review of the Medication Administration Record (MAR) for May 2022 revealed the Capoxone injections were documented as not given on 5/2/22, 5/3/22, 5/4/22, 5/5/22 and 5/6/22 with the reason stated as waiting to receive from the pharmacy. This writer was unable to interview the Med Tech who was assigned to Resident #17 on 5/2/22. An interview was conducted with Nurse #2 on 5/12/22 at 8:52 AM. She stated she cared for Resident #17 on 5/3/22 and was not able to administer the Capoxone injection because there was none in the med cart. She stated when she cared for her on 4/30/22, she should have reordered the medication. She was not sure why she did not reorder the medication. An interview was conducted with Nurse #4 on 5/10/22 at 1:42 PM. She acknowledged that Resident #17 did not receive the Capoxone 20mg injections at bedtime on 5/4/22 and 5/6/22. She stated she administered Capoxone 20mg injections to Resident #17 on 4/25/22, 4/26/22, 4/27/22, and 4/28/22. When she returned to the facility on 5/4/22, there were no more doses of Capoxone in the med cart to give to Resident #17. She stated she reordered the medication on 5/4/22.	F 760	process to ensure availability and review of the five rights of medication administration to ensure the right medication is administered as ordered. Newly hired facility and agency Licensed Nurses and MAs will receive education upon hire and prior to first shift worked. 4) The DON and/or UM will complete a MAR to cart audit and med pass observation of five (5) residents to ensure residents are administered medications as ordered. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) Committee monthly and changes will be made to the plan as necessary to maintain compliance with ensuring residents are free from significant medication errors. Completion Date: 6/22/22	

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F 760	Continued From page 104	F 760		

An interview with Unit Manager #2 was conducted on 5/12/22 at 4:03 PM. She stated she was assigned to Resident #17 on 5/5/22 and there were no doses of the Capoxone in the med cart. She stated she confirmed that Nurse #4 had reordered the medication using the electronic medical record on 5/4/22. She stated the medication should have been ordered by 4/29/22 in order to have been delivered to the facility by 5/2/22, when the first dose was missed.

An interview with the Medical Director was conducted on 5/12/22 at 11:19 PM. He stated he was not aware of any harm from the missed doses although the Capoxone injections were necessary to prevent a flare up of the MS.

An interview with the Director of Nursing (DON) on 5/13/22 at 05:10 PM. He stated he was not aware that Resident #17 had missed 5 injections of Capoxone for her MS. The Capoxone injections should have been administered as ordered by the physician.

An interview with the Administrator was conducted on 5/13/22 at 7:12 PM. He stated he expected the staff to follow physician's orders.

2. Resident #345 was admitted to the facility on 05/02/22 with a diagnosis of malignant neoplasm of rectum, secondary neoplasm of liver and intrahepatic bile duct and secondary malignant neoplasm unspecified lung.

Review of the nursing skills assessment dated 05/02/22 revealed Resident #345 was cognitively intact.

Review of initial care plan 05/04/22 revealed goal

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for Resident #345 to be free of signs of pain or complaints of pain and will state relief of pain daily. Interventions include administer pain medication for pain and observe for effectiveness/side effects and report ineffectiveness to physician.

Review of the Physician order dated 05/03/22 stated to give Oxycontin Tablet ER 10 MG by mouth every 12 hours for pain. (Narcotic analgesic that releases slowly over 12 hours)

Review of Physician order dated 05/06/22 stated to give Oxycodone HCl 10 MG by mouth every 3 hours as needed for severe pain. (Narcotic analgesic that relieves pain for 4 to 6 hours)

Review of the Medication Administration Record (MAR) for May 2022 revealed Oxycontin Tablet ER 10MG every 12 hours (8AM, 8PM) was initialed as being administered to Resident #345 as scheduled on 05/05/22, 05/06/22, 05/07/22 and 05/09/22.

Review of the 200 Hall narcotics book sheet for Resident #345 revealed Oxycontin Tablet ER 10 MG every 12 hours for pain was not signed out in the narcotics book for the evening dose of 05/05/22, morning dose of 05/06/22, evening dose of 05/07/22 and morning dose of 05/09/22.

A comparison of the MAR and narcotics sheets revealed Resident #345 was administered Oxycodone instead of Oxycontin at 19:31 PM on 05/05/22, 9:00 AM on 05/06/22, 8:20 PM on 05/07/22 and 9:58 AM on 05/09/22.

Observation of Resident #345 on 05/09/22 at 11:05 AM revealed resident lying in bed resting

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and did not respond to knock on door.

Observation of Resident #345 on 05/09/22 at 12:56 PM revealed resident lying in bed resting with eyes closed and did not respond to name or knocking on door.

Record review revealed Resident #345 was sent out to the hospital on 5/10/22 at 3:27 AM due to a change of condition.

An interview was conducted with Med Aide #1 on 05/11/22 at 3:06 PM. She acknowledged that on the morning of 05/09/22, she gave Resident #345 her as needed Oxycodone instead of her ordered Oxycontin. She revealed she filled out the narcotic book sheet for the Oxycodone correctly and that is why the medication count was correct but filled out the MAR incorrectly. She acknowledged she made a mistake and should have double checked the medication with the orders and given Resident #345 the correct medication at the correct time.

A telephone interview was conducted with Med Aide #4 on 05/13/22 at 7:23 AM. She acknowledged she worked from 7 PM to 7 AM on 05/07/22 and remembers giving medication to Resident #345. She stated she does not recall an as needed order and gave Resident #345 the medication order for Oxycodone. She was not aware that she had given the wrong medication or of the Oxycontin order. She revealed the process when giving medications is to check the medications with the order and then once given sign off in the book and the computer.

A telephone interview was conducted with Nurse #9 on 05/13/22 at 10:57 AM. She acknowledged

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she worked on the evening of 05/05/22 and remembered giving medication to Resident #345. She stated she was aware Resident #345 had a standing order for pain medication and an as needed order for pain medication. She was not aware that she had given the wrong medication order of the Oxycontin order. She stated it was an error that does not typically happen, and she tries to double check order with the MAR and the narcotic notebook sheet.

Nurse #11 who was assigned to Resident #345 on 05/06/22 was not available for interview.

An interview with the Medical Director was conducted on 05/12/22 at 11:16 AM. He stated he was not made aware of the medication error regarding Resident #345 being administered Oxycodone instead of Oxycontin and requested to review the narcotic book sheet. He revealed not receiving pain medications as prescribed could affect pain level for a resident with her diagnoses. He stated medications should be given as ordered.

A telephone interview was conducted with the Director of Nursing (DON) on 05/13/22 at 6:19 PM due to the DON being out on medical leave that week. He stated it was not brought to his attention that Resident #345 was not administered her correct medication as ordered by the physician. His expectation would be that med aides and nursing staff would give the correct medication as ordered so resident would be free from pain, and he would consider Resident #345 not receiving the pain medication as ordered a significant medication error.

An interview with the Administrator was

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F 760	Continued From page 108 conducted on 05/13/22 at 7:20 PM. He stated he expected the staff to follow physician's orders.	F 760		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, and resident and staff interviews, the facility failed to provide snacks in 2 of 2 nourishment rooms for residents who required bedtime snacks and residents who wanted snacks during off hours. The findings included: A resident council meeting was held on 5/11/22 at 3:00 PM with 8 members who routinely attended the meetings on a monthly basis. Four of 8	F 809	1) Corrective action is not possible due to retroactive findings. 2) On 5/11/22, snacks were stocked in the nourishment rooms and made available for residents who require snacks at bedtime and for residents who want snacks after hours. On 6/9/22, the Director of Nursing (DON) reviewed diabetic residents and updated orders as appropriate for bedtime snacks. 3) Effective 6/22/22, the Staff	6/22/22

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F 809	Continued From page 109 residents at the resident council meeting complained about not receiving bedtime snacks like they should every night. An interview with Resident #2 on 5/13/22 at 9:20 AM revealed the staff did not offer her any snacks at bedtime. She stated they had not been offering snacks to the residents in a long time. An interview with Resident #17 on 5/13/22 at 9:30 AM revealed the staff did not offer snacks at bedtime and whenever she asked for some snacks, she was told by staff that they didn't have any. Resident #17 stated the dietary staff probably kept the snacks locked up in the kitchen. An interview with Resident #14 on 5/13/22 at 9:35 AM revealed he didn't get offered snacks at bedtime or even during the day. Resident #14 who was a diabetic resident, stated whenever he requested for some snacks, he was told by staff that it was hard for them to go and get some snacks from the kitchen because the kitchen was locked after hours. An interview with Resident #30 on 5/13/22 at 11:15 AM revealed she didn't get offered any snacks. Resident #30 who was a diabetic resident, stated whenever she asked for some snacks, the staff told her that they didn't have any in the nourishment rooms. An observation on 5/11/22 at 10:40 AM with Nurse #7 revealed the nourishment room on the 100 hall had 2 yogurts and 2 puddings in the refrigerator and 4 packets of cookies in the cabinet.	F 809	Development Coordinator (SDC) provided education to facility and agency Licensed Nurses and Medication Aides (MA) on ensuring snacks are available to residents who require snacks at bedtime and for residents who want snacks after hours. The WHO (dietary staff) will be responsible for stocking nourishment rooms daily and nursing will provide bedtime snacks for those with orders. Newly hired facility and agency Licensed Nurses and MAs will receive education upon hire and prior to first shift worked. 4) The DON and/or UM will observe nourishment rooms for ample snack supply and audit five (5) residents with orders for bedtime snacks to ensure snacks are being provided. The DON will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) Committee monthly and changes will be made to the plan as necessary to maintain compliance with providing and making snacks available. Completion Date: 6/22/22	

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F 809	Continued From page 110	F 809		

An observation on 5/11/22 at 10:45 AM with Nurse #7 revealed the nourishment room on the 200 hall had 3 cartons of milk, nectar-thickened apple juice, nectar-thickened milk, 1 can of regular cola and 1 can of diet cola in the refrigerator. There were 4 packets of cookies and 2 small bags of potato chips in the cabinet.

An interview with Nurse #7 on 5/11/22 at 10:45 AM revealed both nourishment rooms hardly had any snacks for the residents. Nurse #7 stated staff often had to go to the kitchen just to request some milk and cereal. She stated the dietary staff did not leave any sandwiches for the residents especially for the diabetic residents who needed snacks at bedtime. Some of the dietary aides would leave for the day without placing snacks in the nourishment rooms. They had to go to the kitchen before the dietary aides left or there wouldn't be any snacks to give out at bedtime.

A phone interview with Nurse Aide (NA) #18 on 5/12/22 at 5:26 PM revealed there were only a handful of nurse aides who would pass out snacks to the residents. NA #18 stated sometimes there were no snacks in the nourishment rooms, and they didn't have any snacks to give to the residents. NA #18 stated there were times that they didn't even have milk in the nourishment refrigerators.

An interview with NA #16 on 5/11/22 at 4:13 PM revealed they didn't always have snacks available in the nourishment rooms. NA #16 stated she often had to go to the kitchen and ask for snacks and sometimes she had to buy some for the residents.

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F 809	Continued From page 111 An interview with the Dietary Manager (DM) on 5/13/22 at 2:44 PM revealed the dietary aides usually put snacks in the nourishment rooms every night after the supper meal service and they went by how many residents were in the building at that time. They usually put puddings, chips, cookies, and crackers in the cabinet in the nourishment rooms. They only prepared sandwiches if the residents requested them, and they did not allocate any special snacks for diabetic residents. The DM stated she had told her staff to make sure they placed snacks in the nourishment rooms. She also stated she was not sure if the nurse aides were passing them out. An interview with the Administrator on 5/13/22 at 6:46 PM revealed he had seen that the nourishment rooms did not have enough snacks available. He said part of the problem was that some residents took multiple items out of the nourishment rooms. He stated he had not heard of any concerns from the residents about not being offered or given snacks.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		6/22/22

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F 812	Continued From page 112 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired food available for use in 2 of 2 reach-in coolers in the kitchen and failed to label and date leftover food and drink items in 2 of 2 nourishment room refrigerators. This practice had the potential to affect the food served to the residents. The findings included: 1. During the initial tour of the kitchen on 5/9/22 from 9:35 AM to 9:45 AM with the Dietary Manager (DM), an observation of the reach-in cooler next to the steam table revealed a small bowl of cut blueberries and strawberries with green and white fuzz on top. The date on the cover of the bowl was 4/29/22. The DM discarded the contents into the trash can. The DM stated it should have been discarded after 3 days of being placed in the cooler. An observation of the large reach-in cooler for leftover foods revealed an opened gallon container of cottage cheese marked with an expiration date of 5/7/22. The DM discarded it into the trash can. The DM stated the expired container of cottage cheese should have been discarded when it expired on 5/7/22. An interview with the DM on 5/9/22 at 9:45 AM	F 812	No residents were affected by this deficit practice. All undated and expired food has been removed from kitchen and nourishment rooms as of 6/10/2022. All residents are at risk for receiving outdated or expired food. 100% audit of kitchen and Nourishment rooms was completed by the administrator as of 6/10/2022. Staff Development Coordinator (SDC) in-serviced all staff on proper food storage as per facility policy for labeling and dating food as well as discarding expired foods as of 6/22/2022. SDC in-serviced all staff on storing their personal food in nourishment rooms as of 6/22/2022. Any new hires or new agency staff will be in-serviced on food storage prior to starting a shift. Dietary Managers in-serviced all dietary staff on labeling, dating and discarding all expired foods as of 6/22/2022. Administrator/ Dietary Manager will monitor Kitchen and nourishment rooms 5 times per week for 1 month then 3 times per week for 2 months for any unlabeled or expired foods as of 6/10/2022. Administrator will report and findings to Quality Assurance Performance	

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F 812	Continued From page 113 revealed they had not served cottage cheese within the last two weeks and the expired cottage cheese had gotten overlooked because they never used it. The DM stated she did not know how she missed the outdated fruit bowl and the expired cottage cheese because she inspected all the coolers and freezer in the kitchen every morning as soon as she came in to work. The DM further stated she worked Monday to Friday and sometimes helped on the weekends, but she didn't have to come in this past weekend. 2. An observation of the 200 hall nourishment room refrigerator with the Dietary Manager (DM) on 5/12/22 at 2:32 PM revealed: a. an iced coffee with 5/12/22 on the label and no name b. a take-out box dated 5/8/22 with no name contained leftover chicken and rice c. an unlabeled plastic container with cut watermelon d. 2 unopened 24 oz. (ounce) bottles of sweet tea dated 5/5/22 with no name An interview with the DM on 5/12/22 at 2:35 PM revealed all food and drink items in the nourishment room refrigerators should be dated and labeled with the resident's name. The DM stated all leftover items should be discarded after 3 days of being placed in the refrigerator. The DM discarded the unlabeled iced coffee and the take-out box marked 5/8/22. She also removed the unlabeled plastic container with watermelon from the refrigerator. The DM stated the 2 bottles of sweet tea belonged to Resident #22 and whoever placed it in the refrigerator should have put his name on the bottles. 3. An observation of the 100 hall nourishment	F 812	Improvement committee monthly for any needed changes in current plan. All concerns will be addressed immediately. Completion date: 6/22/2022	

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F 812	Continued From page 114	F 812		

room refrigerator with the DM on 5/12/22 at 2:41 PM revealed:

a. an unlabeled take-out box with re-fried beans, chicken, and macaroni

b. an unlabeled plastic container with rice and chicken

c. an unlabeled plastic bag with baby carrots

d. an unlabeled take-out container with leftover chicken

An interview with the DM on 5/12/22 at 2:47 PM revealed all food items in the nourishment room refrigerators should be labeled with the date they were placed in the refrigerator and the name of the resident to which the food belonged to. The DM discarded all the unlabeled leftover food items observed in the 100 hall nourishment refrigerator and stated that they probably belonged to staff members and not the residents. The DM stated staff had a refrigerator for their food in the breakroom and they should have placed their food there. The DM stated a dietary aide checked both nourishment rooms daily in addition to her checking them in the mornings. The DM stated she did not see any of the expired and unlabeled food items in the nourishment refrigerators when she inspected them in the morning.

An interview with the Administrator on 5/13/22 at 6:46 PM revealed expired foods in the kitchen should be discarded and all food items in the nourishment rooms should be labeled with date and name of the resident. He stated he heard that the DM had discarded a lot of food items that probably belonged to staff members but they should have placed their food in the breakroom refrigerator.

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F 867	Continued From page 115	F 867		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee put into place on 03/31/22. This were for two deficiencies in the area of notify of changes (injury/decline/room, Etc.) and residents are free of significant medication errors that were originally cited on the 03/03/22 complaint survey. These deficiencies were cited again on the current recertification survey with an exit date of 05/16/22. The continued failure of the facility during the two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The finding included: This citation is cross referenced to: F-580: Based on staff and Medical Director interviews and record review the agency failed to notify the physician of missed injections of Capoxone (for multiple sclerosis) for 1 of 1 resident reviewed for medications (Resident #17) and failed to notify the resident representative (RP) and the physician of transfer to the hospital	F 867	1)On 5/11/22, the Medical Director (MD) was notified of missed medications for Resident #17. On 5/11/22, the Medical Director was notified of Resident #84 hospital transfer on 5/7/22. Resident Representative (RR) was notified on 5/7/22. (F580) On 5/11/22, the Regional Director of Nursing notified the Medical Director and completed a medication error report for Resident #17. Medications will continue to be available and administered as ordered by the physician. Resident #345 discharged on 5/10/22. (F760) 2) On 6/9/22, the Interdisciplinary Team (IDT) conducted an Ah Hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss findings of repeat citations for F580 and F760 and necessary corrective action to ensure the facility has an effective QAPI program in place to prevent repeat citations. 3) On 6/9/22, the Regional Director of Nursing provided education to the IDT on maintaining an effective QAPI program to prevent repeat citations. Effective 6/16/22, the facility IDT will meet weekly for twelve (12) weeks to review results of ongoing	6/22/22

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F 867	Continued From page 116 for 1 of 1 resident reviewed for hospitalization (Resident #84). During the complaint investigation survey completed on 03/03/22 the facility failed to notify the physician/medical provider when residents on the 200-hall missed all of their scheduled medications for 8:00 AM, 12:00 PM, and 2:00 PM on 01/29/22 for 9 of 11 sampled residents. F-760: Based on record review, observations, staff and Physician interviews, the facility failed to prevent significant medication errors when pain medications were not administered as ordered by the physician for 2 of 8 sampled residents whose medications were reviewed (Resident #17 and Resident #345). Resident #345 was observed hollering out in pain on 5/9/22. During the complaint investigation survey completed on 03/03/22 the facility failed to prevent significant medication errors when medications were not administered as ordered for 9 of 11 sampled residents whose medications were reviewed. During a phone interview conducted on 05/16/22 at 4:09 PM, the Administrator explained the repeated citations were mainly due to the inability of facility staff to fully implement the corrective action plans that the QAA committee had put into place. It was his expectation for the staff to implement and monitor the corrective interventions as outlined and as thoroughly as it should be.	F 867	monitoring tools to ensure the current plan is effective. Changes will be made to the plan if compliance is not being maintained per corrective plan. 4) The Regional Director of Nursing and/or Nursing will attend QAPI meetings weekly for four (4) weeks then, monthly for two (2) months to validate the effectiveness of the facility QAPI program and its ongoing compliance with preventing repeat citations and make recommendations to the facility IDT as appropriate to maintain compliance with QAA improvement activities. Completion Date: 6/22/22	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		6/22/22

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F 880	Continued From page 117 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 118 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 when 1 of 3 staff members (Nurse Aide #3) failed to wear full PPE (personal protective equipment) while providing care to a resident on enhanced droplet precautions (Resident #75) and 1 of 1 staff member (Nurse #5) failed to perform hand hygiene during wound care for 1 of 2 residents (Resident #68) reviewed. These failures	F 880	Root Cause Analysis: On 6/9/22, the Interdisciplinary Team (IDT) including the Medical Director conducted and Ad Hoc quality Assurance Performance Improvement (QAPI) meeting to discuss survey findings for F880 and to determine root cause of deficient infection control practices utilizing the Five Whys Tool. The facility determined that the primary root cause of the deficient practice was due to facility failure to perform consistent environmental surveillance monitoring of	

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F 880	Continued From page 119 occurred during a COVID-19 pandemic. The findings included: 1. The Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," updated on 2/2/22 indicated the following information under "Manage Residents with Close Contact": Manage Residents who had Close Contact with Someone with SARS-CoV-2 infection: *Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. HCP (healthcare personnel) caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). *Cloth mask: Textile (cloth) covers that are intended primarily for source control. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel. The facility's infection control policy entitled, "Personal Protective Equipment," revised on 10/28/20 indicated PPE (personal protective equipment) will be utilized as part of standard precautions regardless of a resident's suspected or confirmed infection status. Wear goggles or face shield as added face/eye protection. Wear a NIOSH-approved N95 or higher-level respirator to prevent inhalation of pathogens transmitted by the airborne route.	F 880	staff complying with donning/doffing personal protective equipment (PPE) and facility failure to monitor staff performing proper hand hygiene during wound care. 1) On 5/12/22, the Infection Preventionist (IP) provided reeducation to Nurse Aide #3 on appropriate infection prevention practices including appropriate use of personal protective equipment (PPE) while providing care for a resident (#75) with enhanced droplet precautions. On 5/12/22, the IP provided reeducation to Nurse #68 on appropriate hand hygiene while providing wound care to a resident (#68). Education validated by competency completion. 2) On 6/7/22, the IP completed environmental surveillance rounds to observe for proper donning/doffing of PPE per transmission-based precautions and proper hand hygiene during wound care. No concerns observed. 3) On 6/9/22, the Regional Director of Nursing provided education to the Infection Preventionist on maintaining an effective infection prevention and control program. Education included task of performing routine environmental surveillance rounds to observe for proper use of PPE and hand hygiene and process of ensuring staff maintain knowledge and competency of infection prevention practices. Effective 6/22/22, the Staff Development Coordinator (SDC) provided education	

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F 880	Continued From page 120 An observation on the 200 hall on 5/12/22 at 12:10 PM revealed an enhanced droplet isolation sign posted on Resident #75's door. The sign indicated the following instructions before entering the room: wear N95 mask, private room and keep door closed, eye protection with patient encounters, gown and gloves when entering room and perform hand hygiene. A plastic drawer cart which contained N95 masks, face shields, gowns and gloves was located beside Resident #75's door. On 5/12/22 from 12:10 PM to 12:13 PM, Nurse Aide (NA) #3 was observed providing care to Resident #75 inside his room while wearing a leopard cloth mask and gloves. She was not wearing eye protection or a gown. She was observed lowering Resident #75's bed, elevating his head and straightening up his bed linens. After she was done, NA #3 removed her gloves and placed them on the soiled linen and trash cart that was placed across Resident #75's room door. NA #3 then applied hand sanitizer to both hands. An interview with NA #3 on 5/12/22 at 12:14 PM revealed Resident #75 was on enhanced droplet precautions because one of his family members who had visited him tested positive for COVID-19. NA #3 stated she had worn a gown when she provided incontinence care to Resident #75, but it had gotten soiled, so she removed it and placed it in the soiled linen cart. NA #3 stated she went back into the room to finish up with Resident #75 but didn't think she needed to put on another gown before entering the room. NA #3 stated she knew she was supposed to wear full PPE, but she had left her goggles in her backpack in her car, and she had not had a chance to get them.	F 880	with skills competency validation to current facility and agency staff on donning/doffing appropriate PPE and performing proper hand hygiene during wound care. Education and competency will be completed at least annually thereafter. Newly hired facility and agency staff will receive education and competency validation upon hire and prior to first shift worked. 4) The Infection Preventionist and/or DON will complete monitoring of infection control practices via observations of hand hygiene during wound care and proper PPE use during resident care. Audits will be completed for five (5) staff members five (5) times weekly for four (4) weeks then, weekly for eight (8) weeks. Results of monitoring will be reported by the IP during monthly QAPI meetings and changes will be made to the plan as necessary to maintain compliance with Infection Prevention practices and guidance. Completion Date: 6/22/22 Additional attachments: " Ad Hoc QA meeting with documentation of required attendees and Root Cause Analysis utilizing Five Whys Tool " Timeline for completion of infection control training " Attestation by Infection Preventionist of infection control training	

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NA #3 further stated she was wearing a cloth mask because she was allergic to surgical masks, and they broke her out. She had an N95 mask, but she left it at home. NA #3 stated she didn't realize the facility had extra N95 masks that were her size, and she should have gotten one to wear while working at the facility especially with Resident #75 who was on enhanced droplet precautions.

An interview with Nurse #6 on 5/12/22 at 1:44 PM revealed Resident #75 was visited by a family member who tested positive for COVID-19 so Resident #75 got tested for COVID-19 on 5/11/22 and it was negative. He was placed on enhanced droplet precautions in the afternoon of 5/11/22. All staff should wear full PPE including an N95 mask, gown, face shield and gloves prior to entering Resident #75's room and remove them prior to leaving the room and then wash their hands. Nurse #6 stated they were not supposed to enter Resident #75's room without full PPE on.

An interview with the Infection Preventionist (IP) on 5/12/22 at 3:37 PM revealed Resident #75 had a family member who visited him on 5/8/22 and another one who came on 5/9/22 who both tested positive for COVID-19. Resident #75's family called the Social Services Director on 5/11/22 to notify him of the positive COVID-19 tests. The IP completed a rapid test for COVID-19 on Resident #75 on 5/11/22 and it was negative. She also placed him on enhanced droplet precautions because he was not up to date with his COVID-19 vaccines. The IP stated she provided verbal instructions to staff who were working on the 200 hall about wearing full PPE prior to entering Resident #75's room but she failed to speak with NA #3. The IP stated NA #3 came in

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late on the morning of 5/12/22 so she didn't see her wearing a cloth mask, but she stated they were not supposed to use cloth masks because they were not appropriate PPE. The IP stated she needed to provide education to NA #3 about PPE use.

A phone interview with the Director of Nursing (DON) on 5/13/22 at 6:04 PM revealed staff members were not allowed to wear cloth masks and they were supposed to wear full PPE prior to entering a resident's room on enhanced droplet precautions.

2. Review of the facility's entitled "Hand Hygiene" policy revised on 10/29/20 revealed the following policy statement:
"All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Under the section "Policy Explanation and Compliance Guidelines," the policy read in part:
2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.
3. Alcohol-based hand rub is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.
Under the section "Additional considerations," the policy read:
a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.
"Hand Hygiene Table" read in part, use either

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soap and water or alcohol-based hand rub (ABHR is preferred) in the following conditions:
Before and after handling clean or soiled dressings, linens, etc.
Before performing resident care procedures
After handling items potentially contaminated with blood, body fluids, secretions, or excretions
When during resident care, moving from a contaminated body site to a clean body site

An observation of Nurse #5 performing wound care for Resident #68 was completed on 05/12/22 at 10:41 AM. Resident #68 had three wounds: left foot heel and lateral side of left foot, right foot between the 4th and 5th toes, and sacral wound. Nurse #5 washed her hands with soap and water and donned her gloves and removed the old dressing off the left heel and left lateral foot. She removed her gloves and without sanitizing her hands donned a clean pair of gloves. Nurse #5 proceeded to cleanse the lateral foot wound and placed the dressing over the foot wound. Nurse #5 removed her gloves and without sanitizing her hands donned a clean pair of gloves and applied skin prep to the peri area of the heel wound and applied Medi honey to the wound and covered with a clean dressing. Nurse #5 removed her gloves and without sanitizing her hands, donned a clean pair of gloves and proceeded to the wounds on the right 4th and 5th toes. She cleaned the 4th toe with normal saline and applied Medi honey and dry gauze to the toe. She applied skin prep to the 5th toe, and it was left open to air. Nurse #5 then took her gloves off and went into the resident's bathroom and washed her hands with soap and water. She donned a clean pair of gloves and removed the sacral dressing. Nurse #5 took her gloves off and without sanitizing her hands donned a clean pair

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of gloves and proceeded to clean the sacral wound. She applied medicated soaked gauze into the sacral wound and secured the gauze with a bordered foam dressing. Nurse #5 removed her gloves and washed her hands with soap and water and exited the room with left over supplies in her hands.

Interview on 05/12/22 at 4:16 PM with Nurse #5 revealed she was the treatment nurse for the facility and made rounds each week with the wound nurse practitioner (WNP). Nurse #5 stated she was nervous during the dressing change and stated she had not sanitized her hands between changing her gloves. She further stated there was not any alcohol-based hand rub (ABHR) in any of the resident rooms so she was not sure how she was supposed to sanitize her hands between gloves changes but would discuss with the Infection Preventionist for suggestions.

Telephone interview on 05/13/22 at 6:04 PM with the Director of Nursing (DON) revealed he expected staff to follow the policy and procedure for hand hygiene when providing care to the residents. The DON stated Nurse #5 should have sanitized her hands between changing her gloves.

Interview on 05/13/22 at 6:57 PM with the Administrator revealed he would have expected Nurse #5 to follow the policy and procedure for infection control and prevention when providing residents wound care.