STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING _____ B. WING _____	C 06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MONROE	204 OLD HIGHWAY 74 EAST MONROE, NC 28112

(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 investigation survey was conducted on 6/13/22 through 6/17/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Y6W911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/13/22 through 6/17/22. Event ID# Y6W911. The following intakes were investigated NC00188653 and NC00189521. Two of the 5 complaint allegations were substantiated resulting in deficiencies. The Statement of Deficiencies was amended on 7/6/22 at tags F550, F692, and F693.	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 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.	F 550		7/1/22

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

Electronically Signed | 07/04/2022

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record review the facility failed to 1) respond to the call bell when toileting assistance was required resulting in a resident who was occasionally incontinent becoming soiled causing the resident to feel "frustrated" and "upset"; 2) respond to a resident's need to go to bed and alleviate pain by not answering the call light for 40 minutes; and 3) stood up over a resident at the bedside while providing eating assistance for 3 of 3 residents (Residents #14, #6, & #16) reviewed for dignity.	F 550	F550 1. The facility failed to 1) respond to the call bell when toileting assistance was required resulting in a resident who was occasionally incontinent becoming soiled causing the resident to feel "frustrated" and "upset"; 2) respond to a resident's need to go to bed and alleviate pain by not answering the call light for 40 minutes; and 3) stood up over a resident at the bedside while providing eating assistance for 3 of 3 residents (Residents #14, #6, & #16) reviewed for dignity. Resident #14	

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F 550	Continued From page 2 The findings included: 1. Resident #14 was admitted to the facility on 12/30/21. Her diagnoses included Diabetes, muscle weakness and amyotrophic lateral sclerosis (ALS). The quarterly Minimum Data Set assessment dated 4/5/22 reported Resident #14 was cognitively intact. She required extensive assistance for toileting and transfers. Resident #14 required staff assistance for moving on and off the toilet. She was occasionally incontinent of bowel and bladder. The care plan revised on 1/3/22 indicated Resident #14 had an alteration in musculoskeletal status related to ALS. The interventions included "Anticipate and meet needs. Be sure call light is within reach and respond promptly to all request for assistance. The care plan also indicated Resident #14 had an ADL (Activities of Daily Living) self-care performance deficit related to her disease process of ALS. The intervention included "Toilet Use: The resident requires extensive assistance by staff for toileting." On 6/13/22 at 4:02 PM Resident #14 stated she had to wait over an hour to go to the bathroom. She said she used her call bell to ask for assistance, but no one came to provide her assistance to the bathroom. She said she did not remember the exact date but had it in a text message on her telephone. She explained the time of the text messages verified the length of time she had to wait before anyone came to assist her to the bathroom. On 6/14/22 at 5:26 PM a review of the text	F 550	was assessed on 6/14/22 and care plan was updated to ensure care rounds and toileting was offered at least every two hours. Facility staff assisted Resident #6 to bed, which alleviated her pain on 6/13/22. Resident□s care plan was updated to add her preference of being laid down in the afternoon to rest. Resident #6 was pleased with the resolution. A stool was placed in room with Resident #16 on 6/14/22 to use while assisting resident with their meals. NA#2 was immediately in serviced by Director of Nursing (DON) on providing dignity for the resident while feeding by sitting with them and not over them. 2. The DON or designee audited all residents to identify who required ADL assistance and updated their care plans as necessary for their preferences in respect to ADL care. 3. All facility and agency staff were educated on expectations of answering call lights timely. All facility and agency nursing staff were educated on care plan adherence with a focus on resident preferences and proper technique including positioning while assisting a resident with feeding. Education completed by DON by 7/1/22. Facility and agency staff as well as new hires not educated by 7/1/22 will be educated prior to working next shift. 4. The DON or designee will audit 5 resident care plans per week for 12 weeks	

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F 550	Continued From page 3 messages on Resident #14's telephone revealed on 4/3/22 no one responded to her call bell for over an hour and a half (messages at 8:59 am and 10:37 am), and she had a bowel movement on herself due to no one responding to her call bell. On 6/14/22 at 5:26 PM during an interview Resident #14 stated having a bowel movement on herself made her feel upset. She stated she was frustrated and more concerned about the damage it could cause to have stool in and around her peritoneal area which "could cause some infection or lead to an ulcer." A review of the Nursing Assignment for 4/3/22 revealed only Nursing Assistant (NA) #4 and NA #5 worked on the 7:00 AM -3:00 PM shift. Attempts to interview NA #4 and NA #5 were unsuccessful. On 6/17/22 at 10:10 AM Scheduler #1 stated she was a nursing assistant and on 4/3/22 worked the 3:00 PM - 11:00 PM shift. She stated she was not aware of Resident #14 having soiled herself that day. On 6/16/22 at 3:45 PM the Assistant Director of Nursing reported she was unaware Resident #14 had soiled herself due to her call bell not being answered. 2. Resident #6 was admitted to the facility on 3/11/22. The resident's active diagnoses included stroke, anemia, coronary artery disease, spinal stenosis of lumbar region with neurogenic claudication, and lower back pain. Resident #6's Minimum Data Set assessment	F 550	to ensure adherence to the resident□s individualized care plan; Call light audits on 5 random shifts 5 times weekly for 12 weeks; and 5 resident meals per week for 12 weeks to ensure staff adherence to providing dignity to residents□ requiring assistance with feeding. Data from audit will be brought by DON to monthly Quality Assurance Performance Improvement Committee for review and, if warranted, further action. 5. Completion Date: 7/1/22	

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F 550	Continued From page 4	F 550		

dated 3/18/22 revealed she was assessed as cognitively intact and had no behaviors. She required extensive assistance with bed mobility and transfers.

Resident #6's care plan dated 3/31/22 revealed she was care planned to have an activities of daily living self-care performance deficit related to activity intolerance, confusion, and impaired balance. The interventions included the resident required extensive assistance by staff for transfers.

During a continuous observation on 6/13/22 from 2:45 PM - 3:28 PM, Resident #6's call light was observed on. Resident #6 was observed up in her wheelchair in her room watching TV. The resident stated to the surveyor that her legs would get tired and start hurting around 3:00 PM when she was up in her wheelchair. She stated it was okay if the surveyor observed how long it would take for staff to answer her call bell. She stated it would probably be a while because she would request to go to bed and sometimes it took 'hours.' She stated she told the nurse about five minutes ago that she was in pain and needed to be put to bed which always alleviated the pain to her legs from being in the chair all day. Resident #6 stated the nurse gave her some pain medication and then informed her she would get the nurse aide. She stated she had considered going on the hall to find someone but she self-propelled with her feet and she believed it would cause her more pain to find someone than to wait for an hour. The resident stated her pain was at a 5 out of 10 which she considered bearable but being left in the chair made her feel uncomfortable. Resident #6 concluded she would let the surveyor know if the pain became

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F 550	Continued From page 5	F 550		

unbearable and needed the surveyor to find staff for her but would rather the surveyor see how long it took for the call light to be answered.

The continuous observation continued and on 6/13/22 at 3:24 PM Nurse Aide #2 entered the resident's room and asked what Resident #6 needed. Resident #6 informed the nurse aide she needed to go to bed. The nurse aide went to find another staff to assist, and Resident #6 was put in bed at 3:28 PM. Nurse Aide #2 stated she was not Resident #6's nurse aide but she had noted the call light was on, so she was helping. She did not know where the resident's nurse aide or nurse was.

During an interview on 6/13/22 at 4:07 PM Nurse Aide #1 stated she was Resident #6's nurse aide. She further stated she was unaware of Resident #6's call light being on because she had a split assignment and was on another hall, she then checked the halls before going to break at 3:00 PM. She stated she did not know how she missed her light was on at 2:45 PM as she had checked the hallways prior to break. She stated breaks lasted 30 minutes, so the issue was resolved before she returned to the hall. She concluded from 2:45 PM to 3:24 PM was too long for a call light to be on and it should have been answered immediately or within five minutes depending on if she was with another resident.

During an interview on 6/13/22 at 4:09 PM Nurse #1 stated she was Resident #6's nurse. She further stated call lights were to be answered as soon as they were noted to be on. She stated a call light being unanswered from 2:45 PM to 3:24 PM was too long for a call light to remain unanswered. She stated she went to break at

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F 550	Continued From page 6	F 550		

3:00 PM and it was a thirty-minute break which was why she had not identified Resident #6 had her light on.

During an interview 6/13/22 at 4:16 PM the Director of Nursing stated 40 minutes was not an acceptable amount of time for a resident to wait on a call light and that staff responsible for the same residents should coordinate their breaks to be staggered in order to have someone monitoring the hall during the other staff member's break.

3. Resident #16 was admitted to the facility on 9/27/19 with diagnoses which included non-Alzheimer's dementia and dysphagia (difficulty swallowing foods or liquids).

The quarterly Minimum Data Set indicated Resident #16 had severe cognitive impairment and was totally dependent on staff for eating.

On 6/13/22 at 12:45 PM an observation was made of Nurse Aide (NA) #2 standing at Resident #16's bedside while feeding the resident her lunch. The resident's head of bed was in an upright position and the NA stood above the resident's eye level during the dining experience. There was no chair in the room for the NA to use.

On 6/13/22 at 12:54 PM an interview was conducted with NA #2 who stated she had never been trained to sit while feeding a resident.

On 6/13/22 at 12:59 PM an interview was conducted with the Director of Nursing (DON) stated that staff should know to sit while feeding a resident and she did not know why the NA had not done so.

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F 550	Continued From page 7 On 6/15/22 at 3:31 PM an interview was conducted with the Administrator who stated that staff should not stand to feed a resident and he did not know why this had occurred.	F 550		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to update the care	F 657	1. The facility failed to update the care plan for over a year when a resident	7/1/22

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F 657	Continued From page 8 plan for over a year when a resident (Resident #20) no longer received palliative care. This was for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #20 was admitted to the facility on 2/28/20. Her diagnoses included emphysema, chronic obstructive pulmonary disease, and arthritis. The quarterly Minimum Data Set assessment dated 4/14/22 revealed Resident #20 was moderately cognitively impaired. The care plan revised on 1/10/21 indicated the advance directive was DNR (Do Not Resuscitate), Palliative services in place. The care plan indicated the name of the palliative care provider. On 6/14/22 at 4:42 PM Resident #20 stated she did not have any family left since her daughter got sick and could no longer care for her. She said she was going to continue to live at the facility until she died. A review of Resident #20's record revealed notes from the nurse practitioner and the facility physician. None of the notes indicated Resident #20 was on palliative care. On 6/16/22 at 9:39 AM the Social Worker stated Resident #20 was not on palliative care. He stated he called the palliative care provider and confirmed Resident #20's palliative care was discontinued on 11/10/2020. He said the care plan was not accurate and he was unsure why or	F 657	(Resident #20) no longer received palliative care. This was for 1 of 5 residents reviewed for unnecessary medications. Resident #20's care plan was updated on 6/14/22. 2. The Director of Nursing (DON) or designee reviewed all current facility residents care plans on 6/27/22 to ensure accuracy with respect to palliative and hospice services. No further issues were noted. 3. The Regional Nurse Consultant educated the Interdisciplinary Team including Minimum Data Set Director, Social Services Director, DON, Assistant DON, Activities Director, Rehab Director, and Dietary Director on accuracy, updating, and revision of care plans. Staff not receiving education by 7/1/22 or newly hired staff will be educated prior to working their next shift. 4. The DON or designee will review physician orders for needed care plan revisions 5 times a week for 12 weeks. Data from audit will be brought by DON to monthly Quality Assurance Performance Improvement Committee for review and, if warranted, further action. 5. Completion Date: 7/1/22	

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F 657	Continued From page 9 how it was not changed on the care plan when it was revised on 1/10/21, but he would fix it. On 6/17/22 at 8:45 AM the Administrator stated the care plan should have been updated when the resident palliative care was stopped.	F 657		
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, record review, and resident, staff, and Physician interviews, the facility failed to obtain orders and provide treatment of a right heel vascular ulcer (Resident #53) for 1 of 1 resident reviewed for wound care. Findings included: Resident #53 was admitted to the facility on 4/11/22. She had diagnoses which included congestive heart failure, Diabetes Mellitus and renal insufficiency. Review of Resident #53's hospital discharge instructions dated 4/11/22 read, in part, to apply Medihoney to right heel ulcer. Medihoney is a gel wound dressing.	F 684	1. The facility failed to obtain orders and provide treatment of a right heel vascular ulcer (Resident #53) for 1 of 1 resident reviewed for wound care. Resident #53 is no longer a resident at the facility. 2. All newly admitted residents are at risk of being affected by this deficient practice. The Director of Nursing (DON) or designee audited all new admissions for the past 30 days to ensure treatment orders are in place. Audit completed on 6/30/22. 3. The DON educated current facility and agency licensed nursing staff on treatment orders being put into place if	7/1/22

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F 684	Continued From page 10 The admission Minimum Data Set (MDS) dated 4/18/22 indicated Resident #53 was cognitively intact and required limited or extensive assistance for most activities of daily living. Her MDS was also coded to have no behaviors and to have 1 stage 3 pressure ulcer present on admission, 1 venous ulcer, and 1 surgical wound present on admission. Resident #53's admitting daily skin assessment dated 4/12/22 read, in part, that resident had a vascular right lateral leg wound. No wound measurements were included. Resident #53's wound care consultant note dated 4/12/22 read, in part, that the right foot was wrapped with kerlix (gauze bandage) with drainage on the bandage. Physician's orders revealed an order dated 4/18/22 for right heel vascular ulcer to be cleansed with wound cleanser, apply silver alginate (an absorbent antimicrobial dressing) and cover with gauze and kerlix wrap every day shift for wound care. Resident #53's Treatment Administration Record (TAR) for April 2022 revealed this order was signed as completed on 4/19, 4/20, 4/21, 4/22. There were no signatures on 4/18 or 4/23. An interview on 6/14/22 at 2:25 PM with the Wound Care Nurse revealed she first observed Resident #53's right heel wound on 4/18/22. She stated she initiated wound care orders and put a note in the Physician's communication book to notify him of the wound. She stated she completed the dressing change for the right heel wound on 4/18/22 and must have forgotten to	F 684	wound is noted and following physician's orders. Facility and agency licensed nursing staff as well as new hires not educated by 7/1/22 will be educated prior to working next shift. 4. The DON or designee will audit all new admissions to ensure treatments are in place as ordered weekly for 12 weeks. Data from audit will be brought by DON to monthly Quality Assurance Performance Improvement Committee for review and, if warranted, further action. 5. Completion Date: 7/1/22	

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F 684	Continued From page 11 sign the TAR. The Wound Care Nurse stated she only worked part-time so was unable to say when or if she had seen the wound before or when the dressing had been changed. An interview on 6/16/22 at 9:24 AM with Nurse #2 revealed she was responsible for wound care on 4/23/22 and did not remember if she had changed Resident #53's wound dressings or not. She stated if she had changed the dressing, she would have signed it. An interview on 6/15/22 at 4:29 PM with the Physician revealed he did not remember if he was notified of Resident #53's right heel vascular wound. He stated he expected the facility to follow hospital orders or notify him if they had questions. An interview on 6/15/22 at 3:01 PM with the Director of Nursing (DON) revealed that Resident #53 should have been assessed and wound care orders initiated on admission for her right heel wound. She stated she did not know why her right heel wound had no treatment orders until 4/18/22 or why her wound care treatment had been missed on 4/23/22. An interview on 6/15/22 at 3:33 PM with the Administrator revealed he was not at the facility in April and was unaware of Resident #53. He stated he expected the facility to follow established policies and procedures regarding wound care.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		7/1/22

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F 688	Continued From page 12 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, and Physician interviews, the facility failed to follow Physician orders to apply a right-hand splint daily (Resident #12) for 1 of 1 resident reviewed for range of motion. Findings included: Resident #12 was admitted to the facility on 2/27/17 with diagnoses which included traumatic brain injury and hemiplegia. The quarterly Minimum Data Set (MDS) dated 4/04/22 indicated Resident #12 had moderately impaired cognition and required limited or extensive assistance for most activities of daily living. Her MDS was also coded to have no behaviors or rejection of care. She was coded to have a right upper extremity impairment on one side.	F 688	F688 1. The facility failed to follow Physician orders to apply a right-hand splint daily (Resident #12) for 1 of 1 resident reviewed for range of motion. The resident refused application of splint on 6/14/22 when Director of Nursing (DON) attempted to place splint on resident after being notified of it not being in place. 2. The DON or designee reviewed current facility residents with orders for splints to ensure physicians orders were being followed. No further issues noted. 3. The DON or designee educated current facility and agency licensed nursing staff on accurate documentation of treatments in the electronic health	

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F 688	Continued From page 13 Resident #12's care plan last revised on 4/12/22 revealed a focus on limited physical mobility related to impaired balance and hemiparesis. This focus had an intervention which included for resident to have a light blue resting hand/wrist splint applied daily for 4 continuous hours as resident allows with a skin inspection before and after splint application. Resident #12's Treatment Administration Record (TAR) for May 2022 revealed an order to apply the right resting hand/wrist splint daily for 4 continuous hours and to inspect the skin before and after the splint application. Further review of the May TAR revealed Nurse #2 had signed this order as completed 8 times. Review of the May TAR also revealed the Wound Care Nurse had signed this order as completed 10 times. There were also 7 days that this splint order had no signature as being completed. Resident #12's TAR for Jun 2022 from June 1 through Jun 15, 2022, revealed that Nurse #2 had signed the right-hand splint order as completed 7 times, the Wound Care Nurse had signed as completed 4 times, and 1 day with no signature. Resident #12's nurses' progress notes revealed no documentation that the resident refused to wear the right-hand splint. An observation on 6/14/22 at 8:14 AM revealed the right-hand splint was laying on the bedside table. An observation and interview on 6/14/22 at 8:46 AM with Resident #12 revealed she was not wearing her splint. Further observation revealed	F 688	record. Education completed by 7/1/22. Facility and agency licensed nursing staff as well as new hires not educated by 7/1/22 will be educated prior to working next shift. 4. The DON will review residents with splint orders 5 times a week for 12 weeks to ensure compliance with following physician orders for splint applications. Data from audit will be brought by DON to monthly Quality Assurance Performance Improvement Committee for review and, if warranted, further action. 5. Completion Date: 7/1/22	

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F 688	Continued From page 14 the splint lying on top of the bedside table and not within the resident's reach. Resident #12 stated the staff did not put the splint on her right hand and she did not refuse to wear the splint. An interview on 6/15/22 at 11:43 AM with the Wound Care Nurse revealed she had never seen Resident #12's right-hand splint and had never applied it. She stated that she should have looked for the splint and applied it as ordered. An observation on 6/16/22 at 9:15 AM revealed the right-hand splint was laying on the bedside table. An observation and interview on 6/16/22 at 9:17 AM with Nurse #2 confirmed that Resident #12 was not wearing a right-hand splint. Nurse #2 stated the resident usually refused to wear the splint. Nurse #2 applied the splint to the resident's right hand and stated, "I don't know how to do this." She confirmed that the order was on the TAR and she had signed it off without putting it on. An interview on 6/15/22 at 10:06 AM with the Physician revealed he expected the facility to follow physician orders or notify him if they cannot be completed. An interview on 6/15/22 at 3:29 PM with the Director of Nursing revealed she expected the physician's orders to be followed or that the nurse notify him if it was unable to be completed.	F 688		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		7/1/22

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F 692	Continued From page 15 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and consultant Registered Dietitian and facility staff interviews the facility failed to provide the tube feeding as ordered and failed to put in interventions for significant weight loss for 1 of 1 resident (Resident #5). Resident #5 experienced a significant weight loss of 13.9 percent in 2 months. The findings included: Resident #5 was admitted to the facility on 1/11/17. His diagnoses included cerebral infarct, gastrostomy feeding tube, and aphasia. The current Care Plan revised on 12/22/21 indicated Resident #5 had potential for nutritional	F 692	F692 1. The facility failed to provide the tube feeding as ordered and failed to put in interventions for significant weight loss for 1 of 1 resident (Resident #5). Resident #5 experienced a significant weight loss of 13.9 percent in 2 months. The feeding pump was started immediately when Director of Nursing (DON) was notified of the pump not being on. Medical provider and registered dietician notified of issue. New orders were received. 2. The interdisciplinary team (IDT) reviewed all other residents with enteral feedings and all residents for possible weight loss/gain over the past 30 days	

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F 692	Continued From page 16 risk related to receiving 100% of nutrition via PEG (percutaneous endoscopic gastrostomy) tube. The interventions included observe/report to MD (physician) PRN (as needed) signs/symptoms of malnutrition ...significant weight loss. The current physician order dated 2/1/21 read, "(Commercial nutritional tube feeding formula) 1.5 calories liquid, Give 75 ml/hr. (milliliters per hour) via G-tube (gastrostomy tube) every day and night shift. Off from 10:00 AM to 12:00 PM. The quarterly Minimum Data Set Assessment dated 3/9/2022 revealed Resident #5 had no speech. He was assessed as severely cognitively impaired and totally dependent for all activities of daily living. He had range of motion impairment on both upper extremities. He had no significant weight loss. A progress note dated 5/26/22 written by Registered Dietitian (RD) #2 read in part, current body weight (CBW) 176.1 pounds. Despite current regiment exceeding his estimated nutritional needs he triggers for new onset of significant weight loss of 28.5#s (pounds) (13.9%) X (times) 2 months. No signs or symptoms of intolerance. The recommendations were to 1) stop the current commercial nutritional tube feeding formula and to 2) restart the same formula at a rate of 80 ml/hr for 22 hours. Off at 10:00 AM, on at 12:00 PM/noon plus to 3) re-weigh resident and 4) obtain weekly weights x 4 weeks. An observation of the feeding pump on 6/15/22 at 2:43 PM revealed the feeding pump was off. Observations on 6/16/22 revealed the feeding	F 692	and need for intervention. The audit was completed on 6/30/22. 3. The DON or designee will in-service all licensed staff on compliance with physician orders, and the facility□s weight loss protocol. Education completed by 7/1/22. Facility and agency licensed nursing staff as well as new hires not educated by 7/1/22 will be educated prior to working next shift. 4. The DON and IDT will review all residents with enteral feedings and all residents with unstable weights once per week at the weekly facility risk meeting. Individual care plan adjustments or interventions will also be reviewed during this meeting. The DON or designee will also ensure that all RD recommendations are acted upon timely. Data from audit will be brought by DON to monthly Quality Assurance Performance Improvement Committee for review and, if warranted, further action. 5. Completion Date: 7/1/22	

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F 692	Continued From page 17 pump was off from 1:00 PM until 3:30 PM when the Assistant Director of Nursing (ADON) entered the room to restart the tube feeding. A progress note from the ADON on 6/16/22 documented she restarted the tube feeding at 3:45 PM and notified the Nurse Practitioner (NP) of the tube feeding not being restarted at 12:00 PM as the current order specified. The ADON also documented she notified the NP that Resident #5 ' s had weight loss. RD #2 was interviewed via telephone on 6/16/22 at 4:30 PM. RD #2 stated she had made recommendations to increase the rate of the tube feeding formula due to weight loss identified on her visit on 5/26/22. She said the order to have the feedings held for 2 hours from 10:00AM until 12:00PM was in place prior to her contract as RD for this facility. She stated if the tube feeding was not infusing for 22 hours Resident #5 could experience weight loss. RD #2 added it was not good for Resident #5 not to receive the full amount of formula because it was his sole source of nutrition and could contribute to weight loss. On 6/17/22 at 10:50 AM the DON stated the tube feeding should have been restarted based on the orders. She added the Unit Manager was the person who turned off Resident #5 ' s tube feeding on 6/16/22 but she forgot to restart the tube feeding.	F 692		
F 693 SS=G	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 693		7/1/22

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F 693	Continued From page 18 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide the residents tube feeding according to the physician's orders for 1 of 1 resident (Resident #5) reviewed for tube feeding. Resident #5 expericenced significant weight loss of 13.9 percent. The findings included: Resident #5 was admitted to the facility on 1/11/17. His diagnoses included cerebral infarct, gastrostomy feeding tube, and aphasia. Resident #5's Care Plan last reviewed on 12/22/21 indicated he required tube feeding related to dysphagia. The interventions included, "See MAR (medication administration record) for	F 693	F693 1. The facility failed to provide the residents tube feeding according to the physician's orders for 1 of 1 resident (Resident #5) reviewed for tube feeding. Resident #5 experienced significant weight loss of 13.9. The feeding pump was started immediately per physician's order when Director of Nursing (DON) was notified of the pump not being on. Medical Provider and registered dietician notified of issue. New physicians ordered were received and acted upon 2. The interdisciplinary team (IDT) reviewed all other residents with enteral feedings and all residents for possible	

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F 693	Continued From page 19 current feeding orders. The Care Plan also indicated Resident #5 had the potential for nutritional risk related to receiving 100% of nutrition via PEG (percutaneous endoscopic gastrostomy) tube. The interventions included observe/report to MD (physician) PRN (as needed) signs/symptoms of malnutrition ...significant weight loss. A record review revealed a progress note dated 1/20/20 by Registered Dietitian (RD) #1 which read in part, resident may benefit from time off of tube feeding. The recommendation read to change the tube feeding to run for 22 hours and to be off from 10:00 AM until 12:00 PM. The current physician order dated 2/1/21 read, "(Commercial nutritional tube feeding formula) 1.5 calories liquid, Give 75 ml/hr. (milliliters per hour) via G-tube (gastrostomy tube) every day and night shift. Off from 10:00 AM to 12:00 PM. The quarterly Minimum Data Set Assessment dated 3/9/2022 revealed Resident #5 had no speech. He was assessed as severely cognitively impaired and totally dependent for all activities of daily living. He had range of motion impairment on both upper extremities. He had no significant weight loss. A progress note dated 5/26/22 written by RD #2 read in part, despite current regiment exceeding his estimated nutritional needs he triggers for new onset of significant weight loss of 28.5#s (pounds) (13.9%) X (times) 2 months. On 6/15/22 at 2:43 PM the feeding pump was observed to be off. There was no feeding infusing and the pump screen was no illuminated.	F 693	weight loss/gain over the past 30 days and need for intervention. The audit was completed on 6/30/22. 3. Systemic measures put in place to ensure the deficient practice dose not reoccur; the MAR for residents receiving enteral feeding will include a validation by the licensed nurse of the enteral feeding rate daily. The DON or designee will in-service all licensed staff on compliance with and following physicians' orders, and the facility's weight loss protocol. Education completed by 7/1/22. Facility and agency licensed nursing staff as well as new hires not educated by 7/1/22 will be educated prior to working next shift. 4. The DON and IDT will review all residents with enteral feeding and all residents with unstable weights once per week at the weekly facility risk meeting. Individual care pan adjustments or interventions will also be reviewed during this meeting. The DON or designee will also ensure that all RD recommendations are acted upon timely. The DON or designee will monitor residents with enteral feedings to ensure tube feeding orders are carried out as ordered by the physician five times a week for 12 weeks. Data from audit will be brought by DON to monthly Quality Assurance Performance Improvement Committee for review and, if warranted, further action. 5. Completion Date: 7/1/22	

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F 693	Continued From page 20	F 693		

On 6/16/22 at 1:00 PM the feeding pump was observed to be off.

On 6/16/22 at 1:43 PM the feeding pump was observed to be off.

On 6/16/22 at 2:22 PM the feeding pump was observed to be off.

On 6/16/22 at 2:23 PM the Medication Aide #1 assigned to the hall of Resident #5 stated she was not responsible for the tube feeding because she was Medication Aide. She stated she was not sure who turned the feeding pump off and she does not do anything with tube feedings.

On 6/16/22 at 2:54 PM the feeding pump was observed to be off.

On 6/16/22 at 2:57 PM the Nurse #2 who was the only nurse scheduled on 6/16/22 on the 7:00 - 3:00 PM shift was observed talking on the telephone at the nursing station.

On 6/16/22 at 3:22 PM the feeding pump was observed to be off. The Director of Nursing (DON) was present in the room for this observation. The DON stated the Medication Aide did not have any responsibility for the tube feeding and it would be the supervising nurse who would be taking care of the tube feeding for Resident #5. She stated today it was Nurse #2. When the DON was informed by Medicatin Aide #1 that Nurse #2 had gone on break, she said the Assistant DON would be next in command of responsibility for Resident #5.

On 6/16/22 at 3:28 PM the Assistant DON said it

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F 693	Continued From page 21	F 693		

was Nurse #2 who as responsible for Resident #5's tube feeding. The Assistant DON said she would turn his pump back on, but she needed to flush it first and check his orders. She stated she was not the nurse who turned the pump off and she did not know what time it was turned off.

On 6/16/22 at 4:51 PM Nurse #2 stated she was aware Resident #5's tube feeding was off for 2 hours each day, but she did not remember the exact time it was to be turned off or on. She stated she did not turn off his feeding today and was not aware of who was responsible for his care today. She stated she gave Resident #5 his scheduled morning medications, but she did not check his finger stick for blood sugar monitoring. She said there were usually 2 nurses and 1 medication aide scheduled during the week. One nurse worked the 100 hall and 1 nurse worked the 300 hall. She said today she was responsible for all of the 100 & 300 halls. She added she did not turn Resident #5's feeding pump off but she was blamed for not turning it back on. She said she did not remember it being on when she gave Resident #5 his morning medications.

The RD #2 was interviewed via telephone on 6/16/22 at 4:30 PM. RD #2 stated she had made recommendations to increase the rate of the tube feeding formula due to weight loss identified on her visit on 5/26/22. She said the order to have the feedings held for 2 hours from 10:00AM until 12:00PM was in place prior to her contract as RD for this facility. She stated if the tube feeding was not infusing for 22 hours Resident #5 could experience weight loss. RD #2 added it was not good for Resident #5 not to receive the full amount of formula because it was his sole source of nutrition and could contribute to weight loss.

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F 693	Continued From page 22 On 6/17/22 at 10:50 AM the DON stated the tube feeding should have been restarted based on the orders.	F 693		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to have 8 consecutive hours of Registered Nurse coverage for 2 of 30 days of staffing reviewed. (4/09/22 & 4/10/22) The findings included: A review of the Daily Staffing form for 4/9/22 revealed 1 Licensed Practical Nurse (LPN) and 2 Medication Aides (MA) were present on the 7:00 AM to 3:00 PM shift. There were 3 LPNs and 3 MAs on the 3:00 PM - 11:00 PM shift. There were 2 LPNs and 1 MA on the 11:00 PM - 7:00 AM shift. The Registered Nurse (RN) coverage was documented as 0 for the entire day.	F 727	F727 1. The facility failed to have 8 consecutive hours of Registered Nurse coverage for 2 of 30 days of staffing reviewed. (4/09/22 & 4/10/22) 2. On June 29, 2022, the Nursing Home Administrator (NHA), Director of Nursing (DON), and staffing coordinator reviewed RN coverage for all of July 2022 and August 2022. The facility will work to fill any vacancies. The DON has developed an on-call roster for administrative RNs to fill vacancies that cannot otherwise be	7/1/22

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F 727	Continued From page 23 A review of the Daily Staffing Form for 4/10/22 revealed 1 LPN and 1 MA were present on the 7:00 AM to 3:00 PM shift. There were 2 LPNs and 2 MAs on the 3:00 PM - 11:00 PM shift and 1 LPN and 1 MA on the 11:00 PM - 7:00 AM shift. The RN coverage for the entire day was documented as 0. On 6/17/22 at 11:00 AM the Director of Nursing confirmed there was no RN working on 4/9/22 or 4/10/22 so they did not have the required 8 consecutive hours of RN coverage.	F 727	filled. The NHA will assist as necessary to establish incentives for coverage as needed. 3. The DON or designee conducted in-service training for current facility and agency nursing staff concerning work schedule, RN coverage requirements, and attendance expectations. Education completed by 7/1/22. Facility and agency licensed nursing staff as well as new hires not educated by 7/1/22 will be educated prior to working next shift. 4. The DON will monitor RN Staffing daily for 12 weeks by reviewing the schedule. Data from audit will be brought by DON to monthly Quality Assurance Performance Improvement Committee for review and, if warranted, further action. 5. Completion Date: July 1, 2022	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		7/1/22

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F 761	Continued From page 24 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to secure medications in a treatment cart when left unattended for 1 of 2 treatment carts (Treatment Cart #2). Findings included: During observation on 6/13/22 at 12:56 PM Treatment Cart #2 was observed unlocked and unattended on the 300 hall. A resident was observed on the hall as well. At 1:02 PM the Wound Care Nurse Practitioner returned to the unlocked treatment cart. During an interview on 6/13/22 at 1:02 PM the Wound Care Nurse Practitioner stated the treatment cart should be locked when unattended, but she was unable to lock the treatment cart because she did not have a key to the cart. She concluded the cart contained medicated treatments. During an interview on 6/13/22 at 1:29 PM the Director of Nursing stated treatment carts should be locked when unattended. She concluded she	F 761	F761 1. The facility failed to secure medications in a treatment cart when left unattended for 1 of 2 treatment carts (Treatment Cart #2). The treatment cart was immediately locked, and the Nurse practitioner was educated on keeping medication/treatment carts locked. 2. The facility has 6 carts (3 pharmacy, 2 treatments, 1 crash) that can be affected. 3. The DON or her designee in-serviced current facility and agency licensed nursing staff on cart security and ensuring they remain locked. Education completed on 7/1/22. Facility and agency licensed nursing staff as well as new hires not educated by 7/1/22 will be educated prior to working next shift. 4. The Director of Nursing or designee will audit all 6 carts for cart security 5 times per week for 12 weeks. Data from	

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F 761	Continued From page 25 was not aware until now that the wound care nurse practitioner did not have a key to the cart and would get her one.	F 761	audit will be brought by DON to monthly Quality Assurance Performance Improvement Committee for review and, if warranted, further action. 5. Completion Date: July 1, 2022	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		7/1/22

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F 842	Continued From page 26 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to maintain accurate medical records	F 842	F842 1. The facility failed to maintain accurate	

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F 842	Continued From page 27 for (1) wound care (Resident #53) and (2) splint application (Resident #12) for 2 of 2 medical records review for accuracy. The findings included: 1. Resident #53 was admitted to the facility on 4/11/22 and died at the facility on 4/23/22. She had diagnoses which included congestive heart failure, Diabetes Mellitus and renal insufficiency. The admission Minimum Data Set (MDS) dated 4/18/22 indicated Resident #53 was cognitively intact and required limited or extensive assistance for most activities of daily living. Her MDS was also coded to have 1 stage 3 pressure ulcer present on admission, 1 venous ulcer, and 1 surgical wound present on admission. a. Review of Physician's orders revealed an order dated 4/13/22 for the left foot surgical wound to be cleansed with wound cleanser and apply a dry dressing every day shift for wound care. Review of Resident #53's Treatment Administration Record (TAR) for April 2022 revealed the left foot surgical wound was signed as completed 4/13, 4/14, 4/16, 4/19, 4/20, 4/21, and 4/22. There were no signatures on 4/15, 4/17, 4/18, or 4/23. b. Review of Physician's orders revealed an order dated 4/13/22 for the stage 3 pressure ulcer to the sacrum to be cleansed with wound cleanser and apply skin prep around the wound and silver alginate (an absorbent antimicrobial dressing) and cover with bordered foam dressing every day shift for wound care.	F 842	medical records for (1) wound care (Resident #53) and (2) splint application (Resident #12) for 2 of 2 medical records review for accuracy. 2. The Director of Nursing (DON) or designee will review treatment administration records (TAR) for the past 14 days for residents with splints and wounds. Medical provider will be notified of missed/not documented treatments. Audit completed on 7/1/22. 3. The DON or designee educated current facility and agency licensed nursing staff on accurate documentation of treatments in the electronic health record and following physician's orders. Education completed by 7/1/22. Facility and agency licensed nursing staff as well as new hires not educated by 7/1/22 will be educated prior to working next shift. 4. The DON will review 5 TAR's weekly for 12 weeks to ensure treatments are being documented per policy. Data from audit will be brought by DON to monthly Quality Assurance Performance Improvement Committee for review and, if warranted, further action. 5. Completion Date: 7/1/22	

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Review of Resident #53's TAR for April 2022 revealed the sacrum pressure ulcer wound was signed as completed 4/13, 4/14, 4/16, 4/19, 4/20, 4/21, and 4/22. There were no signatures on 4/15, 4/17, 4/18, or 4/23.

c. Review of Physician's orders revealed an order dated 4/18/22 for right heel vascular ulcer to be cleansed with wound cleanser, apply silver alginate and cover with gauze and kerlix wrap every day shift for wound care.

Review of Resident #53's TAR for April 2022 revealed the right heel vascular ulcer order was signed as completed on 4/19, 4/20, 4/21, 4/22. There were no signatures on 4/18 or 4/23.

An interview on 6/14/22 at 2:25 PM with the Wound Care Nurse revealed she first observed Resident #53's right heel wound on 4/18/22. She stated she completed the dressing change for the right heel wound on 4/18/22 and must have forgotten to sign the TAR. The Wound Care Nurse stated she only worked part-time so was unable to say when or if she had seen the sacrum pressure ulcer or left foot wounds before or when the dressings had last been changed. The Wound Care Nurse was unable to say whether or not she had completed the resident's wound care on the days the TAR had not been signed.

An interview on 6/16/22 at 9:24 AM with Nurse #2 revealed she was responsible for wound care on 4/17/22 and 4/23/22 and did not remember if she had changed Resident #53's wound dressings or not. She stated if she had changed the dressing, she would have signed it.

An interview on 6/16/22 at 1:43 PM with Nurse #1

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F 842	Continued From page 29	F 842		

revealed she was responsible for wound care on 4/15/22 and 4/18/22. She stated she completed wound care but forgot to sign it.

An interview on 6/15/22 at 3:01 PM with the Director of Nursing (DON) revealed that Resident #53 should have been assessed with documented wound measurements and wound care orders initiated on admission for her right heel wound. She stated she did not know why her right heel wound had no treatment orders until 4/18/22 or why her wound care treatment had been missed on 4/23/22. The DON revealed she expected staff to complete wound care prior to signing as completed. She stated that staff should not sign an order as completed if they had not done so.

An interview on 6/15/22 at 3:33 PM with the Administrator revealed he was not at the facility in April and was unaware of Resident #53. He stated he expected the facility to follow established policies and procedures regarding wound care.

2. Resident #12 was admitted to the facility on 2/27/17 with diagnoses which included Diabetes Mellitus.

The quarterly Minimum Data Set (MDS) dated 4/04/22 indicated Resident #12 had moderately impaired cognition and required limited or extensive assistance for most activities of daily living. Her MDS was also coded to have no behaviors or rejection of care. She was coded to have a right upper extremity impairment on one side.

Review of Resident #12's care plan last revised

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on 4/12/22 revealed a focus on limited physical mobility related to impaired balance and hemiparesis. This focus had an intervention which included for resident to have a light blue resting hand/wrist splint applied daily for 4 continuous hours as resident allows with a skin inspection before and after splint application.

Review of Resident #12's Treatment Administration Record (TAR) for May 2022 revealed an order to apply the right resting hand/wrist splint daily for 4 continuous hours and to inspect the skin before and after the splint application. Further review of the May TAR revealed Nurse #2 had signed this order as completed 8 times. Review of the May TAR also revealed the Wound Care Nurse had signed this order as completed 10 times. There were also 7 days that this splint order had no signature as being completed which were 5/09, 5/13, 5/16, 5/20, 5/23, 5/28, 5/29.

Review of Resident #12's TAR for Jun 2022 from June 1 through Jun 15, 2022, revealed that Nurse #2 had signed the right-hand splint order as completed 7 times, the Wound Care Nurse had signed as completed 4 times, and 1 day with no signature (6/13/22).

Review of Resident #12's nurses' progress notes revealed no documentation that the resident refused to wear the right-hand splint.

An observation on 6/14/22 at 8:14 AM revealed the right-hand splint was laying on the bedside table.

An observation and interview on 6/14/22 at 8:46 AM with Resident #12 revealed she was not

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F 842	Continued From page 31 wearing her splint. Further observation revealed the splint lying on top of the bedside table and not within the resident's reach. Resident #12 stated the staff did not put the splint on her right hand and she did not refuse to wear the splint. An interview on 6/15/22 at 11:43 AM with the Wound Care Nurse revealed she had never seen Resident #12's right-hand splint and had never applied it. She was unable to state why she had signed the order as completed on the TAR. She stated that she should have looked for the splint and applied it as ordered. An observation and interview on 6/16/22 at 9:17 AM with Nurse #2 confirmed that Resident #12 was not wearing a right-hand splint. Nurse #2 stated the resident usually refused to wear the splint. Nurse #2 applied the splint to the resident's right hand and stated, "I don't know how to do this." Nurse #2 also stated she did not know why she had signed the order as completed on May 1, 8, 14, 15, 21, 22, 27, 30 and June 8, 9, 11, 12. An interview on 6/15/22 at 3:29 PM with the Director of Nursing revealed she expected staff to complete treatments prior to signing as completed. She stated that staff should not sign an order as completed if they had not done so. An interview on 6/15/22 at 3:33 PM with the Administrator revealed he was not at the facility in April and was unaware of Resident #12. He stated he expected the facility to follow established policies and procedures regarding physician's orders.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/1/22

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F 880	Continued From page 32 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 33 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to remove their Personal Protective Equipment (PPE) prior to exiting an isolation room for 1 of 1 resident reviewed for COVID-19 isolation (Resident #155 and Nurse Aide #1). Findings included: The Centers for Disease Control and Prevention (CDC) guideline entitled "Interim Infection	F 880	F880 1. The facility failed to remove their Personal Protective Equipment (PPE) prior to exiting an isolation room for 1 of 1 resident reviewed for COVID-19 isolation (Resident #155 and Nurse Aide #1). Nurse Aide was immediately in-serviced on isolation precautions and the use of PPE by the Director of Nursing (DON) on 14 June 2022. 2. All other residents are at risk for this	

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F 880	Continued From page 34 Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" updated 2/2/22 contained the following statements: · In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission, and should be tested as described in the testing section above; COVID-19 vaccination should also be offered. The CDC guideline entitled "Stay Up to Date with Your COVID-19 Vaccines" Updated 5/24/22 contained the following statements: · You are up to date with your COVID-19 vaccines when you have received all doses in the primary series and all boosters recommended for you, when eligible. Resident #155's COVID-19 vaccination record revealed he received his first dose of the COVID19 vaccine on 3/26/21 and second dose on 4/16/22. He had not received any COVID19 booster doses. Resident #155 was admitted to the facility on 6/10/22. During observation on 6/14/22 at 8:29 AM Resident #155's room was observed to have PPE at the entrance to his room and signage which read that staff must wear a gown and gloves when entering the room and remove the gown and gloves prior to exiting the room. During observation on 6/14/22 at 8:30 AM Nurse	F 880	deficient practice. 3. A root cause analysis (RCA) was conducted June 28-30, June 2022 and presented during an ad hoc meeting with the Quality Assurance Performance Improvement Committee on July 1, 2022. The facility's DON, who is SPICE trained, and the Assistant DON, who is also SPICE trained and serves as the facility Infection control nurse, and serves as the facility infection control nurse, conducted in-services for all facility, contract, and agency staff which was completed on 7/1/22. Facility, agency, and contract staff as well as new hires not educated by 7/1/22 will be educated prior to working next shift. 4. The ADON or her designee will conduct 5 infection control audits per week for 12 weeks. DON and ADON attestations of education, root cause analysis and ad hoc QAPI committee review are attached as separate documents. Data from audit will be brought by DON to monthly Quality Assurance Performance Improvement Committee for review and, if warranted, further action. 5. Completion Date: July 1, 2022	

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	345345	A. BUILDING _____ B. WING _____	C 06/17/2022

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Aide #1 was observed to exit Resident #155's isolation room. The nurse aide had on a N95 mask, face shield, gown, and a glove on her left hand. The nurse aide was observed to walk across the hall to the clean linen cart, open the linen cart with her ungloved hand and reach inside and move some linen on the cart with her ungloved hand. She then returned to the resident ' s room and closed the door. At 8:43 AM the nurse aide exited the room as she removed her gown and glove and rolled it up and walked with the rolled-up PPE in her hands down the 300 hall to the 200 hall, entered the shower room, and discarded her PPE in the 200 hall shower room.

During an interview on 6/14/22 at 8:45 AM Nurse Aide #1 stated she was not supposed to exit isolation rooms with PPE on. She further stated the room did not have a trash bag or trash can available, so she first checked to see if the linen cart had any trash bags and when it did not, she then discarded her PPE in the shower room.

During an interview on 6/14/22 at 2:21 PM the Infection Control Nurse stated because the resident had both of his primary doses but had not received a booster and was eligible and recommended by the CDC to get the boosters, he was placed on isolation upon admission to the facility. She concluded staff were not to exit his isolation room with their gown and gloves still on due to risk of cross contamination of other items on the hall. The staff member placing the isolation equipment and signage should also place a biohazard waste container in the resident's room.

During an interview on 6/14/22 at 4:21 PM the Director of Nursing stated staff were to remove

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F 880	Continued From page 36 gown and gloves prior to exiting isolation rooms for infection prevention. She concluded there should be a biohazard waste container inside of isolation rooms for staff to discard their PPE prior to exiting the room.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents and facility staff and record review the facility failed to implement an effective pest control program to control the presence of live flies observed throughout 2 of 3 resident halls. The findings included: A review of the contracted pest control company logs from January 2022 through June 2022 revealed the facility was treated each month for cockroaches and mice. There were no treatments for flies. 1a. Resident #35 was admitted to the facility on 12/3/19. Her quarterly Minimum Data Set MDS) revealed she was cognitively intact. On 6/14/22 at 8:18 AM Resident #35 stated she was still trying to sleep but the flies were bothering her. She was observed to swat at a fly that landed on her face 3 times until it landed on the bed linens. b. Resident #47 was admitted to the facility on	F 925	F925 1. Pest control for rooms in which Residents #35, #47, #5, #28 and #154 were treated 0n June 15, 2022. 2. All residents are at risk for this deficient practice. 3. The Maintenance Director or designee inserviced all staff during the period June 30, 2022 to July 1, 2022 on how to immediately report pest control concerns for corrective action. These inservices included all contractors working in the facility routinely, such as therapists, housekeeping and dietary staff members. The Housekeeping Director, during the period June 16-July 1 2022, made a concerted effort to remove food sources from resident rooms, dining room, service hallway, front porch, resident courtyard and both smoking areas. Based on ongoing pest audits, these efforts have been effective. When audits identify an issue to be addressed, the maintenance director treats that area with a natural multi-pest elimination product. The	7/1/22

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F 925	Continued From page 37 2/28/22. His quarterly MDS dated 5/17/22 revealed he was cognitively intact. On 6/14/22 at 8:27 AM Resident # 47 stated the flies were bothering him all the time. He said there were none in his room right now because the nursing assistant killed 5 in his room yesterday. He said he could not remember the nursing assistant's name. c. Resident #5 was admitted to the facility on 1/11/17. His quarterly MDS dated 3/5/22 revealed he had no speech and was rarely/never understood and rarely/never understands. He had range of motion limitations on both upper extremities and was totally dependent on staff for all of his activities of daily living. On 6/15/22 at 8:36 AM a fly was observed in the room of Resident #5. The resident was observed to be unable to shoo the fly due to his physical limitations. He was also nonverbal. On 6/15/22 at 4:15 PM a fly was observed to land on the towel on Resident #5's chest. The fly was present on the towel approximately 30 seconds then if flew away as the nurse walked closer to the resident. d. Resident # 28 was admitted to the facility on 5/1/19. His annual MDS revealed he was cognitively intact. On 5/15/22 at 4:47 PM Resident #28 stated the facility had a very large fly problem. He said he purchased his own fly swatter because the flies were so bad in his room. He said the number of flies he saw today were much less than any other day this week. He said the flies have been bad in	F 925	maintenance director will monitor our 7 UV Flytrap lights, which are installed at exterior doorways and high-use areas, once each week and changes the integral insect glue board. The maintenance director or his designee will audit 6 resident rooms (two per hall), Lobby, dining room, kitchen, rehab gym activities room 5 days per week for 12 weeks. 4. The Maintenance Director will monitor and will report week meeting results and trends, for 12 weeks, on a monthly basis, to the facility Quality Assurance Committee for review and, if warranted, further action. 5. Completion Date: July 1, 2022	

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F 925	Continued From page 38	F 925		

the facility for the last year.

During an interview with the Maintenance Director on 6/15/22 at 3:08 PM he reported the contracted pest control company treated for cockroaches and put out traps for mice and cockroaches. He said the contracted pest control company did not complete any other service and they don't do anything to treat the facility for flies. He reported he had asked his corporate office for permission to add fly prevention services to the contract over a year ago due to the facility having livestock farms on both sides of the facility. He said the corporate office would not agree to add the fly service to the contract with the pest control company. He stated he was aware of the flies being in the building and most were on the 200 hall because more residents were present on that hall. He said fly lights were used to attract and kill the flies with the "sticky pad" located inside the lights. He reported he changed out the "sticky pads" monthly. The Maintenance Director added he had just changed the pads today hoping it would help reduce the number of flies. He reported he also had an insect spray he obtained from the contracted pest control company that he could use however it did not correct the fly problem. A review of the instructions on the bottle of insect spray revealed it was designed for immediate kill but had to be sprayed directly on the insect.

During an interview on 6/17/22 at 8:58 AM the Administrator stated he worked at the facility since last week on Wednesday and had some concerns with flies in the facility Monday and Tuesday. He stated on 6/15/22 the Maintenance Director spoke to him about his concerns with the flies and they called the pest control company on

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6/15/22 to ask them to treat for flies.
2. Resident #154 was admitted to the facility on 6/5/22.

Review of a brief interview for mental status assessment dated 6/5/22 revealed she was assessed as cognitively intact.

During an interview on 6/13/22 at 4:37 PM Resident #154 stated her only concern at the facility was the fly problem. She stated flies would get on food and in her drinks.

During observation on 6/13/22 at 4:39 PM a fly was observed to land on the mouth of the water pitcher's straw for Resident #154. The fly entered the straw briefly and then exited the straw and continued to circle the resident.

During an interview on 6/15/22 at 3:12 PM the Maintenance Director stated he was aware the facility had an ongoing fly problem. He requested the fly program from the pest control company but corporate had not approved it so the pest control company only treated for cockroaches and mice. He stated there were fly lights in the facility and he changed the sticky strips monthly. This intervention helped a little bit, but it was not enough as there were still flies in the facility. There were also fly fans at the back entrance and one at the back patio entrance. He stated he had asked a previous administrator to get the fly program added by cooperate, but he was told to do it himself, so he continued to request through his vender.

During an interview on 6/17/22 at 8:58 AM the Administrator stated he had been working at the facility since last week and had some concerns

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F 925	Continued From page 40 with flies in the facility. He stated on 6/15/22 the maintenance director spoke to him about his concerns with the flies and they called the pest control company on 6/15/22 to ask them to treat for flies. He concluded residents should be able to have their food and their drinks without worrying about flies landing on them.	F 925		