STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING _____ B. WING _____	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(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 06/26/2022 through 06/30/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 64YG11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation survey was conducted on 06/26/2022 through 06/30/2022 at Event ID# 64YG11. 12 of 26 complaint allegations were substantiated resulting in deficiencies. The following intakes were investigated NC00184310, NC00186909, NC00187765, NC00188819, NC00189528, and NC00189640.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		8/5/22

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

Electronically Signed | 07/23/2022

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F 561	Continued From page 1 §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, resident and staff interviews, the facility failed to provide scheduled showers for 1 of 2 residents (Resident #46) reviewed for choices. Findings included: Resident #46 was admitted to the facility on 7/12/21. The quarterly Minimum Data Set dated 6/10/22 indicated that Resident #46 had moderately impaired cognition. She was coded for no behaviors or rejection of care. Resident #46 required extensive assistance or was totally dependent on staff for activities of daily living (ADL). She was totally dependent on staff for bathing with one-person physical assistance for bathing. An interview on 6/26/22 at 11:16 AM with Resident #46 revealed she has not been offered a shower. She stated she enjoys a hot shower and wants her hair washed. She stated she gets bed baths but didn't remember the last time she had or was offered a shower.	F 561	1. Resident #46 was offered a shower during the week of 6-27-22 during the recertification survey and resident refused - a bed bath was provided. 2. The shower schedules for the residents were reviewed and updated with a book being placed at each nurses station to ensure that the nursing staff has access to the shower schedules for the residents. The updated shower books will be placed at the nurses station by 8-3-2022. 3. The facility nursing staff were inserviced by the Director of Nursing on making sure that residents receive their showers on their designated days. The facility nursing staff were also inserviced on how to document if a resident refuses to take a shower. The MDS team was also inserviced to ensure that if a resident refuses showers on a regular basis then a care plan for refusal of care will be added to the residents care plan. The inservice will be completed by 8-3-2022.	

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F 561	Continued From page 2 An interview on 6/27/22 at 1:21 PM with Nursing Assistant (NA) #3 revealed she provided care for Resident #46 on a regular basis on the day shift. She stated she had never offered her a shower and did not know that the facility had a shower schedule for residents. She stated she provided a bed bath to the resident during her morning care. An interview on 6/29/22 at 9:45 AM with Nurse #1 revealed there used to be a shower book with specific days for residents to get showers, but it had not been updated in a while and as far as she knew there was no set schedule for residents to get showers. She stated she had never heard that Resident #46 refused a shower. An interview on 6/28/22 at 6:35 PM with the Director of Nursing revealed she was unaware of Resident #46's concerns related to showers, and she did not know why she had not been offered a shower. An interview on 6/29/22 at 3:30 PM with the Administrator revealed that he was unaware of Resident #46's concerns related to showers.	F 561	4. An audit will be performed to ensure that (1) residents are receiving their showers on their scheduled day(s) and (2) any refusals are properly documented. This audit will take place on a weekly basis x 4 weeks and then monthly x 3 months to ensure that residents are receiving their showers. This audit will be performed by the DON or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that residents are receiving their showers and that any refusals are properly documented. Compliance Date 8-5-22	
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be	F 582		8/5/22

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F 582	Continued From page 3	F 582		

charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the

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F 582	Continued From page 4 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to provide a completed Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) (Form CMS-10055) which included the estimated cost prior to discharge from Medicare Part A skilled services for 3 of 3 residents reviewed for beneficiary protection notification. (Resident #15, Resident #309, and Resident #17) Findings included: 1. Resident #15 was re-admitted to the facility on 03/21/2022. He was admitted to Medicare Part A on 03/21/2022. A review of his quarterly MDS assessment dated 03/28/2022 revealed he was moderately cognitively impaired. A record review revealed Resident #15's family member was his responsible party (RP) and primary financial contact. The SNFABN reviewed had Resident #15's name, the care listed as inpatient skilled nursing facility stay, that Medicare may not pay because he only needed assistive or supportive care and did not require a daily professional nurse or therapist, the date his services were to end (04/03/2022), and a check by option 3 (he didn't want the care listed and understood he was not responsible for paying for it). The form was signed by Resident #15's RP on	F 582	1. Since these notices were already given to the residents/responsible parties and the Medicare Part A stay was already exhausted the notices were not corrected. 2. Going forward all CMS SNFABN Forms CMS-10055 will be filled out completely, including ensuring that the estimated cost of services is filled out. 3. The facility's Business Office Manger was inserviced by the facility Administrator on ensuring that all portions of the CMS SNFABN Form CMS-10055 were filled out completely, including the estimated cost of services. This inservice will be completed by 8-3-2022. 4. An audit will be performed to ensure that the CMS SNFABN Form CMS-10055 is filled out completely, including the estimated cost of services. This audit will be performed weekly x 4 weeks and then monthly x 3 months. This audit will be completed by the Administrator or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that the CMS SNFABN Form CMS-10055 is filled out completely. Compliance date: 8-5-2022	

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F 582	Continued From page 5	F 582		

04/03/2022. The space for estimated cost of services was blank.

Resident #15 remained in the facility on private pay on 04/04/2022.

On 06/29/2022 at 11:50 AM an interview with the Business Office Manager (BOM) indicated she completed Resident #15's SNFABN. She stated she had not filled in the estimated cost on the form. The BOM went on to say residents might be going to a different payor source, they might be going to private pay and already have been on private pay so knew how much they would be paying or might be going on Medicaid. She stated residents going on Medicaid received an estimated cost in the mail directly from Medicaid. She further indicated she never filled the estimated cost in and did not provide this information to residents or their RPs.

On 06/29/2022 at 11:42 AM a telephone interview with Resident #15's RP indicated she did not recall anyone from the facility giving her an estimated cost when Resident #15 went to private pay on 04/04/2022. She stated he had been on private pay before and she had an idea what she had been paying per day. She stated she just paid the bills when they arrived.

On 06/30/2022 at 12:56 PM an interview with the Administrator indicated he was not aware the SNFABN forms were not being filled out to include the estimated cost. He stated he would expect the SNFABN forms to be filled out completely.

2. Resident #309 was admitted to the facility on 03/15/2022.

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F 582	Continued From page 6	F 582		

He was admitted to Medicare Part A on 03/15/2022.

A review of the admission MDS assessment for Resident #309 dated 03/22/2022 revealed he was cognitively intact.

A record review revealed Resident #309 was his own responsible party (RP) and primary financial contact. The SNFABN reviewed had Resident #309's name, the care listed as inpatient skilled nursing facility stay, that Medicare may not pay because he only needed assistive or supportive care and did not require a daily professional nurse or therapist, the date his services were to end (04/04/2022), and a check by option 3 (he didn't want the care listed and understood he was not responsible for paying for it). The form was signed by Resident #309 on 03/31/2022. The space for estimated cost of services was blank.

Resident #309 was discharged home on 04/04/2022.

On 06/29/2022 at 11:50 AM an interview with the Business Office Manager (BOM) indicated she completed Resident #17's SNFABN. She stated she had not filled in the estimated cost on the form. The BOM went on to say residents might be going to a different payor source, they might be going to private pay and already have been on private pay so knew how much they would be paying or might be going on Medicaid. She stated residents going on Medicaid received an estimated cost in the mail directly from Medicaid. She further indicated she never filled the estimated cost in and did not provide this information to residents or their RPs.

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F 582	Continued From page 7	F 582		

On 06/30/2022 at 12:56 PM an interview with the Administrator indicated he was not aware the SNFABN forms were not being filled out to include the estimated cost. He stated he would expect the SNFABN forms to be filled out completely.

3. Resident #17 was admitted to the facility on 02/15/2022.

She was admitted to Medicare Part A on 02/15/2022.

A review of the admission Minimum Data Set (MDS) assessment for Resident #17 dated 02/22/2022 revealed she was cognitively intact.

A record review revealed Resident #17's family member was her responsible party (RP) and primary financial contact. The SNFABN reviewed had Resident #17's name, the care listed as inpatient skilled nursing facility stay, that Medicare may not pay because she only needed assistive or supportive care and did not require a daily professional nurse or therapist, the date her services were to end (06/14/2022), and a check by option 3 (she didn't want the care listed and understood she was not responsible for paying for it). The form was signed by Resident #17's RP on 06/13/2022. The space for estimated cost of services was blank.

Resident #17 was discharged to the hospital on 06/14/2022.

On 06/29/2022 at 11:50 AM an interview with the Business Office Manager (BOM) indicated she completed Resident #17's SNFABN. She stated

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F 582	Continued From page 8 she had not filled in the estimated cost on the form. The BOM went on to say residents might be going to a different payor source, they might be going to private pay and already have been on private pay so knew how much they would be paying or might be going on Medicaid. She stated residents going on Medicaid received an estimated cost in the mail directly from Medicaid. She further indicated she never filled the estimated cost in and did not provide this information to residents or their RPs. On 06/30/2022 at 12:56 PM an interview with the Administrator indicated he was not aware the SNFABN forms were not being filled out to include the estimated cost. He stated he would expect the SNFABN forms to be filled out completely.	F 582		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 1 resident reviewed for quarterly MDS assessments timing. (Resident #4) Findings included: Resident #4 was admitted to the facility on 3/2/15.	F 638	1. A. quarterly MDS for Resident #4 was completed on 6-27-2022. 2. An initial audit was conducted to ensure that quarterly MDS assessments on the residents were completed. This audit was completed by the Administrator. The initial audit will be completed by 7-29-2022. The initial audit did not find any other quarter mds assessments that	8/5/22

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F 638	Continued From page 9 Record review revealed Resident #4's last comprehensive MDS was dated 11/28/21 and her last quarterly MDS was dated 2/26/22. During an interview on 6/27/22 at 10:35 AM the MDS Nurse stated she had been at the facility for 30 days and a corporate MDS Nurse was helping orient her as well as completing MDS assessments while they hired an MDS Coordinator. She concluded she did not know why Resident #4 had not had another quarterly MDS assessment. During an interview on 6/27/22 at 10:45 AM the MDS Consultant stated Resident #4 should have had a quarterly MDS prior to now and it was not done. She concluded she would complete a late quarterly MDS. During an interview on 6/27/22 at 11:34 AM the Administrator stated MDS assessments should be completed according to the regulations.	F 638	needed to be completed, all had been comdpleted. 3. The MDS nurse was inserviced by the Administrator on making sure that residents had a quarterly MDS completed during the appropriate time frame. This inservice will be completed by 8-3-2022. 4. An audit will be completed to ensure that quarterly assessments are being completed as required. This audit will be completed weekly x 4 weeks and then monthly x 4 months. This audit will be completed by the Director of Nursing, Administrator or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that quarterly MDS assessments are being completed as required. Compliance Date: 8-5-2022	
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 640		8/5/22

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F 640	Continued From page 10 (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to transmit a comprehensive	F 640	1. The discharge MDS dated for 3-2-22 for Resident #1 was transmitted by end of	

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F 640	Continued From page 11 Minimum Data Set (MDS) assessment for 1 of 1 resident (Resident #1) reviewed for resident assessment. Findings included: Resident #1 was admitted to the facility on 12-22-21 A nursing progress note dated 3-2-22 at 5:21pm revealed Resident #1 was sent to the hospital emergency room department. Review of the discharge MDS dated 3-2-22 revealed the MDS was completed but had not been transmitted. During a telephone interview with the facility's corporate MDS consultant on 6-29-22 at 2:28pm, the MDS consultant stated Resident #1's discharge MDS should have been transmitted within 14 days of its completion.	F 640	day on 6-30-2022. 2. An initial audit was performed to ensure that discharged MDS assessments were all transmitted as required. This inital audit will be performed by the Administrator will be completed by 7-29-2022. 3. The MDS nurse was inserviced by the Administrator on making sure that all completed discharge MDS assessments are transmitted as required. This inservice will be completed by 8-3-2022. 4. An audit will be completed to ensure that all completed discharge MDS assessments are being transmitted as required. This audit will be completed weekly x 4 weeks and then monthly x 3 months. This audit will be completed by the Administrator or their designee. This audit will be completed by the Administrator or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that all discharge MDS assessments are being transmitted as required Compliance Date: 8-5-2022	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		8/5/22

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F 641	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code Minimum Data Set (MDS) assessments for 6 of 24 MDS assessments reviewed. (Resident #42, Resident #60, Resident #12, Resident #6, Resident #49 and Resident #50) Findings included: 1. Resident #42 was admitted to the facility on 2/25/15. Resident #42's Facility Notification of Hospice Admission revealed Resident #42 was admitted to hospice services on 2/2/22. Resident #42's quarterly MDS assessment dated 5/9/22 revealed she was coded to not be receiving hospice care. During an interview on 6/27/22 at 10:35 AM the MDS Nurse stated she had been at the facility for 30 days and a corporate MDS Consultant was helping orient her as well as completing MDS assessments while they hired an MDS Coordinator. She stated the previous MDS Coordinator was the one who completed the 5/9/22 MDS assessment for Resident #42 and the coding for hospice was incorrect and she did not know why. During an interview on 6/27/22 at 10:40 AM the MDS Consultant stated Resident #42's 5/9/22 MDS was coded incorrectly for hospice, and they would correct it. During an interview on 6/27/22 at 11:34 AM the	F 641	1. A. Resident #42□s quarterly MDS assessment dated 5-9-22 was corrected to show that she was receiving hospice services. This correction took place by the end of day on 6-30-2022. B. Resident #60□s discharge MDS assessment dated 5-4-22 was corrected to show that she was discharged home. This correction took place by the end of day on 6-30-2022. C. Resident #12□s MDS assessment dated 3-25-22 could not be corrected to show the use of tobacco products. A quarterly assessment does not ask about the use of tobacco products. Section J1300 on the MDS is where you would code the use of tobacco for a resident. This question is only available on an Admission Assessment, a Significant Change Assessment or an Annual Assessment. Resident #12's annual assessment will take place in the month of December 2022 and the facility will ensure that the use of tobacco products is coded correctly. D. Resident #6□s MDS assessment dated 3-9-22 was corrected to show that the resident was incontinent of bowel and bladder. This correction took place by the end of day on 6-30-2022. E. Resident #49□s MDS assessment dated for 5-24-22 was corrected to show the use of oxygen therapy. This	

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Administrator stated resident status should be accurately reflected on the MDS.

2. Resident #60 was admitted to the facility on 3/3/22.

Resident #60's discharge summary dated 5/4/22 revealed Resident #60 was discharged home.

Resident #60's discharge MDS Assessment dated 5/4/22 revealed Resident #60's discharge status on 5/4/22 was to an acute hospital.

During an interview on 6/27/22 at 1:18 PM the Director of Nursing stated Resident #60 did not discharge to the hospital on 5/4/22 but instead went home.

During an interview on 6/27/22 at 1:37 PM the MDS Consultant stated Resident #60 was not hospitalized and the MDS dated 5/4/22 was incorrect and she would correct it. She concluded previous MDS Coordinator must have seen that a stretcher was used during transport and assumed it was a hospitalization.

During an interview on 6/27/22 at 11:34 AM the Administrator stated resident status should be accurately reflected on the MDS.

3. Resident #12 was admitted to the facility on 12/16/21. His diagnoses included diabetes and orthopedic aftercare following surgical amputation.

A smoking assessment dated 12/22/21 revealed resident was safe to smoke without supervision. The care plan for Resident #12 dated 3/17/22 stated he wished to smoke cigarettes and has been assessed as safe to smoke independently.

correction took place by the end of day on 6-30-2022.

F. Resident #50□s MDS assessment dated for 5-24-22 was corrected to show that the resident only had one fall with injury and no other falls during the look back period. This correction took place by the end of day on 6-30-2022.

2. An initial audit was completed to check: (1) residents who are receiving hospice services have this coded on their most recent MDS assessment, (2) that discharge MDS assessments are coded correctly to show their accurate place of discharge, (3) that residents who use tobacco have this coded accurately on their most recent MDS assessment, (4) that residents who are incontinent of bowl and bladder have this coded correctly on their most recent MDS assessment, (5) that residents who use oxygen have this coded correctly on their most recent MDS assessment, and (6) that residents with falls during their look back period have this coded correctly on their most recent MDS assessment. The initial audit will be completed by 8-1-2022.

3. The MDS nurse was inserviced by the Administrator on making sure that the coding on the MDS assessments are accurate for the residents. This inservice will be completed by 8-3-2022.

4. An audit will be conducted to check: (1) residents who are receiving hospice services have this coded on their most

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F 641	Continued From page 14 A smoking assessment dated 3/21/22 revealed Resident #12 was safe to smoke without supervision and was able to store items safely. The quarterly Minimum Data Set (MDS) Assessment dated 3/25/22 revealed Resident #12 was cognitively intact and was independent with activities of daily living. The MDS indicated he had no tobacco use. On 6/26/22 at 2:23 PM Resident #12 was observed in his room as he discarded an empty box of cigarettes into the trash can. Resident #12 stated he goes outside to smoke daily. On 6/29/22 at 10:56 AM Nurse #1 stated she completed the smoking assessment on 3/21/22 and she had to observe Resident #12 while he was smoking prior to completing the assessment. She confirmed she had observed Resident #12 smoke on the day of the assessment. On 6/29/22 at 11:25 AM the MDS Nurse stated the look back period for the quarterly MDS dated 3/25/22 was 7 days and included 3/21/22. She stated the smoking assessment indicated Resident #12 was a smoker and used tobacco. The MDS Nurse reported the MDS was incorrect. During an interview with the Administrator on 6/27/22 at 11:34 AM he stated the resident status should be accurately reflected on the MDS. 4. Resident #6 was admitted to the facility on 11/30/21 with diagnoses including chronic pain, hypertension, and urinary incontinence. The quarterly Minimum Data Set (MDS) dated	F 641	recent MDS assessment, (2) that discharge MDS assessments are coded correctly to show their accurate place of discharge, (3) that residents who use tobacco have this coded accurately on their most recent MDS assessment, (4) that residents who are incontinent of bowl and bladder have this coded correctly on their most recent MDS assessment, (5) that residents who use oxygen have this coded correctly on their most recent MDS assessment, and (6) that residents with falls during their look back period have this coded correctly on their most recent MDS assessment. This audit will be completed weekly x 4 weeks and then monthly x 3 months. The audit will include 5 random residents per week during the weekly audits and 10 random residents during the monthly audits. This audit will be completed by the Administrator or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that MDS assessments are being coded correctly. Compliance Date: 8-5-2022	

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3/9/22 indicated Resident #6 was cognitively intact. He required extensive assistance with his activities of daily living. He was coded as always continent of bowel and bladder.

A review of the plan of care documentation for Resident #6 from 3/3/22 through 3/9/22 was coded as incontinent of bowel except on 3/8/22 when he was coded as continent for 1 of 2 bowel movements that day. The documentation for urinary continence indicated he was incontinent of urine 2-3 times every day.

On 6/28/22 at 12:09 PM the MDS Consultant stated the 3/9/22 MDS where Resident #6 was coded as continent was incorrect.

During an interview with the Administrator on 6/27/22 at 11:34 AM he stated the resident status should be accurately reflected on the MDS.

5. Resident #49 was admitted to the facility on 3-25-19 with multiple diagnoses that included chronic obstructive pulmonary disease.

An active Physician order dated 2-19-20 revealed an order for Resident #49 to have oxygen by nasal canula at 2 liters per minute continuously.

Resident #49's care plan dated 2-28-22 revealed a goal that he would not have signs or symptoms of poor oxygen absorption. The interventions for the goal were in part to monitor for respiratory distress and oxygen by nasal canula continuously.

The quarterly Minimum Data Set (MDS) dated 5-24-22 revealed Resident #49 was moderately cognitively impaired and was not coded for oxygen therapy.

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During an interview with the facility's MDS consultant on 6-30-22 at 10:32am, the MDS consultant stated Resident #49 should have been coded for oxygen therapy and that it was a coding error. She explained the facility had hired a new MDS nurse and she was in training but planned on completing an audit to correct the MDS error.

The Administrator was interviewed on 6-30-22 at 12:57pm. The Administrator explained there had been much turnover in staffing but expected the residents to have the correct information on their MDS.

6. Resident #50 was admitted to the facility on 03/03/2015 with a diagnosis of dementia.

A review of Resident #50's medical record revealed he had one fall with injury on 03/22/2022. He was found with his head between his nightstand and mattress. He sustained an approximately 1 inch long cut to his head. This was treated at the facility. It did not require stiches. He did not require treatment at the hospital. No other falls were documented in Resident #50's medical record from 2/21/2022 through 5/24/2022.

A review of the quarterly Minimum Data Set (MDS) assessment for Resident #50 dated 05/24/2022 revealed he was severely cognitively impaired. Resident #50 had one fall with no injury, one fall with injury, and one fall with major injury since his prior MDS assessment dated 02/21/2022.

On 06/29/2022 at 9:25 AM an interview with the MDS Nurse indicated she completed the falls section of Resident #50's MDS assessment dated

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F 641	Continued From page 17 05/24/2022. She stated she was new to MDS and had been in training. She went on to say she must have misinterpreted the instruction manual for completing MDS assessments. The MDS Nurse further indicated Resident #50 only had one fall with injury since his prior MDS assessment. She stated he should not have been coded as having additional falls with no injury and major injury. She stated she would correct this. On 06/29/2022 at 11:11 AM an interview with the Director of Nursing (DON) indicated Resident #50 should have had one fall with injury coded on his MDS assessment dated 05/24/2022. She stated the other falls coded on this assessment were an error. She went on to say the MDS assessment should accurately reflect the status of Resident #50.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		8/5/22

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F 657	Continued From page 18 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to include the interdisciplinary team (IDT) and the resident's representative (RP) in the development of the comprehensive care plan after a significant change and quarterly assessment for 1 of 4 residents (Resident #41) reviewed for unnecessary medication, failed to develop a comprehensive care plan (Resident #259) and failed to include hospice in the current comprehensive care plan for 1 of 4 residents (Resident #42) reviewed for hospice. Findings included: 1. Resident #41 was readmitted to the facility after a hospitalization on 02/02/2022 with a diagnosis of congestive heart failure. A review of her significant change Minimum Data Set (MDS) assessment dated 02/09/2022 revealed she was severely cognitively impaired. Resident #41's quarterly MDS assessment dated 05/09/2022 revealed she was moderately cognitively impaired. A review of the current comprehensive care plan	F 657	1. A. Resident #41□s responsible party was contacted on 7-6-2022 and they were invited to a care plan review. The care plan review was set up with the responsible party for 7-7-2022. B. A comprehensive care plan for resident #259 was developed. C. A hospice care plan was added to resident #42 comprehensive care plan 2. A. All residents in the facility had their RP□s contacted to set up a care plan review to ensure that they had a chance to review the care plan with the facility IDT. All of the reviews were scheduled by 7-22-2022 and will be completed based on the date that the family chose. All meetings were scheduled by end of day on 7-22-22. B. An initial audit was performed to ensure that each resident had a comprehensive care plan developed for them. This audit will be completed by 8-5-2022. The audit will be completed by	

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for Resident #41 revealed multiple care plan focus areas first initiated on 02/10/2022 including: congestive heart failure, hypothyroidism, gastroesophageal reflux disease, antidepressant medication, right hemiparesis (paralysis), and oxygen therapy. A care plan focus area of unplanned weight loss was first initiated on 02/22/2022.

There was no documentation in Resident #41's medical record to indicate Resident 41's RP was invited to or that a care plan meeting which included her RP and the IDT team was held when Resident #41's comprehensive care plan was developed after her 02/09/2022 significant change MDS assessment or after her 05/09/2022 quarterly MDS assessment.

A care plan review note dated 04/20/2022 at 12:19 PM revealed the IDT met with Resident #41's RP to discuss each care plan focus area, goal and intervention. Resident #41's RP verbalized understanding and denied any questions or concerns.

On 06/29/2022 at 9:59 AM an interview with the Social Worker (SW) indicated she received the care plan meeting schedule from the MDS Nurse. She stated she used this schedule to coordinate with residents and their RPs and sent out a letter or contacted them by phone to arrange their participation in the meetings. She went on to say care plan meetings had gotten behind due to staffing changes.

On 06/29/2022 at 10:32 AM an interview with the MDS Nurse indicated she was new. She stated she had not provided the SW with any care plan meeting schedules in the 30 days she had been

the Administrator or their designee.

C. An initial audit was performed to ensure that each resident who is receiving hospice services to ensure that a hospice care plan is placed in the resident's comprehensive care plan. The audit will be completed by the Administrator or their designee. This audit will be completed by 8-5-2022.

3. The MDS team (MDS nurse, dietary manager, activities director, therapy director, social worker) were inserviced by the Administrator on ensuring that resident responsible parties were contacted and invited to a care plan review each time that care plan was being reviewed due to a significant change assessment or quarterly/annual assessment. The inservice will also include ensuring that each resident has a comprehensive care plan implemented and also that each resident who receives hospice services have a hospice care plan placed into their comprehensive care plan. This inservice will be completed by 8-5-2022.

4. An audit will be performed to ensure that (1) resident responsible party□s are being contacted and invited to attend a care plan review meeting with the facility IDT after that resident has had a significant change assessment or a quarterly/annual assessment, (2) that a comprehensive care plan is developed for each resident and (3) that each resident who is receiving hospice services has a

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F 657	Continued From page 20 in her position. She stated the MDS Consultant had been helping her work on schedules but they were not finished yet. On 06/29/2022 at 12:52 PM a telephone interview with Resident #41's RP indicated he recalled participating in a care plan meeting for Resident #41 in April 2022. He stated the only other care plan meeting he participated in was when Resident #41 was first admitted to the facility in 2019. He further indicated he did not recall being invited to attend any other care plan meetings. He stated he thought the facility had a couple of changes in management over the last couple of years and that could be the reason. He went on to say he would have participated in other care plan meetings if he had been invited. He further indicated he felt he understood the care his family member was receiving. In a follow up interview on 06/29/2022 at 1:07 PM the SW stated she had no record of any other care plan meetings for Resident #41 except on 04/20/2022. On 06/29/2022 at 1:23 PM a telephone interview with the MDS Consultant stated the facility had some staff turnover in the MDS role. She went on to say she was working with the MDS Nurse on care plan meeting schedules to get care plan meetings back on track. She further indicated care plan meetings should be held after each comprehensive MDS assessment including a significant change assessment, and at least every 92 days. She stated these meetings should include the participation of the IDT and the resident and RP. On 06/30/2022 at 11:42 AM an interview with the	F 657	hospice care plan placed in their comprehensive care plan. This audit will be completed by the Administrator or their designee. The audit will be completed weekly x 4 weeks and then monthly x 3 months. The weekly audit will look at 3 residents per week on the care plan schedule to ensure that their responsible parties were contacted about a care plan review with the care plan team. The monthly audit will look at 10 residents from the care plan scheduled to ensure that their responsible parties were contacted about a care plan review with the care plan team. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that residents responsible party□s are being contacted and invited to attend care plan review meetings with the facility IDT. Compliance Date: 8-5-2022	

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Director of Nursing (DON) indicated residents should be having their care plan meetings when they are due. She stated these meetings should include the participation of resident and resident's family and all other members of the IDT team.

On 06/30/2022 at 12:56 PM an interview with the Administrator indicated he was not aware care plan meetings were not being held. He stated care plan meetings were normally held as scheduled at least quarterly and should include the resident and their RP.

2. Resident #259 was admitted to the facility on 5/31/22 with diagnoses that included hypertension and Diabetes Mellitus.

The admission Minimum Data Set dated 6/07/22 indicated that Resident #259 was cognitively intact and was independent or required limited assistance for activities of daily living (ADL). He was coded for hospice.

Review of Resident #259's electronic medical health record revealed no care plan.

An interview on 6/28/22 at 11:20 AM with the MDS Consultant and MDS Nurse confirmed that Resident #259 did not have a comprehensive care plan. The MDS Consultant stated that a paper baseline care plan had been completed, but that a comprehensive care plan had not been initiated or completed.

An interview on 6/28/22 at 10:35 AM with the Director of Nursing revealed the facility had a new MDS nurse but that the comprehensive care plan should still have been completed.

An interview on 6/29/22 at 3:30 PM with the

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F 657	Continued From page 22 Administrator revealed that he was unaware of Resident #259's lack of care plan. 3. Resident #42 was admitted to the facility on 2/25/15. Her active diagnoses included duodenal ampullary adenocarcinoma. Resident #42's Facility Notification of Hospice Admission revealed Resident #42 was admitted to hospice services on 2/2/22. Resident #42's care plan dated 3/15/22 revealed she was not care planned for hospice care. During an interview on 6/29/22 at 2:44 PM the MDS Consultant stated Resident #42 should have had their care plan revised to reflect their hospice status prior to now. During an interview on 6/29/22 at 3:02PM the Director of Nursing stated hospice status should have been reflected on the care plan prior to now for Resident #42.	F 657		
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, staff interviews, and record review the facility failed to rinse soap from a resident's skin per manufacture's directions during a bath for 1 of 6 resident reviewed for activities of daily living care. (Resident #13) Findings included:	F 677	1. Resident #13 skin was washed again on 6-26-2022 to ensure that any residual soap was washed off. A skin check was also performed daily for 3 days to ensure no irritation or reactions were noted. 2. An initial audit was performed by the	8/5/22

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F 677	Continued From page 23 Resident #13 was admitted to the facility on 9/25/19. Her active diagnoses included coronary artery disease and hypertension. Resident #13's quarterly minimum data set assessment dated 3/28/22 revealed she was assessed as cognitively intact. She had no moods or behaviors and required extensive assistance with personal hygiene. She was also assessed to be totally dependent on staff for bathing. Resident #13's care plan dated 3/17/22 revealed she was care planned for activities of daily living self-care performance deficit related to osteoarthritis, osteoporosis and muscle weakness. The interventions included to provide sponge bath when a full bath or shower cannot be tolerated and provide extensive assist by 1 staff to turn and reposition in bed. Upon observation on 6/26/22 at 11:20 AM of the soap used for Resident #13's bath the directions on the back of the bottle indicated to apply soap to a wet washcloth, gently massage into skin, and then rinse with clean water. During observation on 6/26/22 at 11:15 AM Nurse Aide #1 was observed providing a bath to Resident #13. Nurse Aide #1 was observed to collect warm water in a basin. She then took a washcloth, dampened it with water, and put soap on the washcloth and then rung it out into the basin. There were soap suds visible in the basin. She then washed Resident #13 and soap suds were visible on Resident #13's skin. Nurse Aide #1 then dabbed Resident #13 dry with a dry towel and did not rinse the soap from Resident #13's	F 677	DON to ensure that the staff knew the difference between rinse and no rinse soap and how to perform a bed bath with both types of soap. The initial audit will be completed by 7-29-2022 and will be completed by the Director of Nursing (DON) or their designee. The initial audit will randomly pick 3 Certified Nursing Assistance on 1st and 2nd shift. 3. The Director of Nursing educated the nursing staff on all shifts, including part time and prn, on how to bathe a resident with both the non-rinse soap and also the regular soap. This inservice will be completed by 8-3-2022. 4. An audit will be performed to ensure that residents are receiving a proper bed bath based on the type of soap being used - the audit will be done by picking 5 residents and making sure that the bathing is being done properly based on the soap that is being used. The audit will take place weekly x 4 weeks and then monthly x 3 months. The audit will be performed by the DON or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that residents are receiving a proper bed bath based on the type of soap that is being used. Compliance Date: 8-5-2022	

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F 677	Continued From page 24 skin. Nurse Aide #1 washed Resident #13's body in this manner. Soap suds were visible on Resident #13's skin each time Nurse Aide #1 dabbed him dry with a dry towel. During an interview on 6/26/22 at 11:23 AM Nurse Aide #1 stated she thought the soap she was using was a non-rinse soap and did not realize it was not. The nurse aide concluded she should have rinsed the soap from the resident's skin before drying the resident to avoid skin irritation. During an interview on 6/26/22 at 2:57 PM the Director of Nursing stated the facility used non-rinse soap as well as soap that needed to be rinsed from the resident's skin. She concluded Nurse Aide #1 should have rinse the soap from the resident after applying the soap to prevent skin irritation.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Physician interviews the facility failed to obtain a Physician ordered lab (6-9-22) result for 1 of 1 resident (Resident #49) who had been coughing up green colored sputum, resulting in the	F 684	1. A new sputum specimen test was ordered by the physician on 6-29-2022 for another culture and sensitivity test. The order stated to obtain a sputum culture each shift x 7 days - d/c the order once	8/5/22

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F 684	Continued From page 25 Physician re-ordering the culture and sensitivity lab for Resident #49 on 6-29-22. Findings included: Resident #49 was admitted to the facility on 3-25-19 with multiple diagnoses that included chronic obstructive pulmonary disease. Resident #49's care plan dated 2-28-22 revealed a goal that he would not have any signs or symptoms of poor oxygen absorption. The interventions for the goal were monitor for respiratory distress, oxygen by nasal canula continuously. The quarterly Minimum Data Set (MDS) dated 5-24-22 revealed Resident #49 was moderately cognitively impaired. Nursing note dated 6-9-22 at 2:05pm revealed Resident #49 was "spitting out green thick sputum". The note documented the Physician was present and ordered a sputum culture and sensitivity test as well as a chest x-ray. Review of the preliminary sputum culture revealed it was returned to the facility on 6-9-22 with the Physicians signature on 6-15-22. The preliminary culture showed "many gram-positive cocci" (classification of bacteria). Resident #49's medical record did not have any documentation of the final sputum culture report or the sensitivity results. During an interview with Nurse #1 on 6-28-22 at 1:35pm, the nurse stated there was not one specific person assigned to monitor lab reports.	F 684	sputum culture was obtained. 2. An initial audit of ordered labs for all residents in the facility were reviewed to ensure that all necessary results were obtained. The initial audit was completed by the Director of Nursing and Administrator and the labs for the month of June 2022 were reviewed - this inital audit will be completed by 8-1-22. 3. The facility nurses were inserviced by the Director of Nursing to ensure that all ordered labs were followed up on timely to ensure that all results were properly obtained. This inservice will be completed by 8-3-2022. 4. An audit will be performed on all ordered labs to ensure that the lab results are followed up on properly and that all results for the labs have been obtained. This audit will take place weekly x 4 weeks then monthly x 3 months. The audit will be performed by the DON or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that all ordered labs were followed up on timely and that all results for those labs were obtained. Compliance Date: 8-5-2022	

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F 684	Continued From page 26	F 684		

She said she and another nurse (Nurse #2) were trying to keep track of the labs ordered and results but stated somedays she had to work the medication cart and did not have time to track labs. The nurse discussed the lab ordered on 6-9-22 for Resident #49's culture and sensitivity and stated the results had not been returned from the hospital lab and said the hospital should have been called to have the results faxed to the facility but it had been overlooked.

Nurse #2 was interviewed on 6-28-22 at 1:38pm. Nurse #2 discussed not having a point person to keep track of lab results. She explained she and another nurse (Nurse #1) had tried to keep track but sometimes she was asked to work the hall and could not always track the labs. Nurse #2 discussed the final culture and sensitivity results for Resident #49 from 6-9-22 were not faxed to the facility. The nurse stated the results should have been returned within 72 hours and when they were not. Someone should have followed up with the hospital lab to receive the test results.

An interview with Nurse #3 occurred on 6-28-22 at 2:08pm. Nurse #3 confirmed he was the nurse for Resident #49 and stated he did not know who was responsible for following up with lab results but said he thought it was Nurse #1 or Nurse #2. He explained he had never followed up on labs for his assigned residents.

The facility Physician was interviewed on 6-29-22 at 1:00pm. The Physician stated she had been informed today (6-29-22) that Resident #49's sputum culture and sensitivity results had not been completed and said she had ordered a new sputum specimen to be obtained today (6-29-22) for another culture and sensitivity test since

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F 684	Continued From page 27 Resident #49 continued to cough up green sputum. She stated she would have expected staff to follow up with the hospital lab for the final report and said she did not know why that did not occur. The Physician explained the turn around time for a culture and sensitivity test was a minimum of 72 hours and staff should have followed up within the time frame for the results. During an interview with the Administrator on 6-30-22 at 12:57pm, the Administrator explained the nurse who obtained the lab from Resident #49 should have followed through to ensure the results were received and the Physician was made aware of the results.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions. This was for 1 of 3 residents reviewed for supervision to prevent accidents. (Resident #50) Findings included: Resident #50 was admitted to the facility on	F 689	1. The mat for resident #50 was placed at his bedside on 6-30-2022. 2. An initial audit was performed to ensure that any resident who had a bedside mat for a fall intervention, that the mat was placed at bedside when the resident was in their bed. This audit was completed by the Administrator and Director of Nursing (DON). The audit was	8/5/22

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F 689	Continued From page 28 03/03/2015 with a diagnosis of dementia. A fall risk assessment for Resident #50 dated 02/17/2022 revealed he was at high risk for falls. A review of a nursing progress note for Resident #50 dated 03/22/2022 at 3:00 PM revealed Resident #50 was found with his head off his bed between his nightstand and mattress. His bed was in the low position, a fall mat was at his bedside and his call light was within his reach. He had an approximately 1 inch cut to his head. The area was treated in the facility. It did not require stitches or hospital evaluation. Resident #50's room was rearranged to prevent a recurrence. A review of the quarterly Minimum Data Set (MDS) assessment for Resident #50 dated 05/24/2022 revealed he was severely cognitively impaired. He required the extensive assistance of one person for bed mobility and transfers. Resident #50 had one fall with no injury, one fall with injury, and one fall with major injury since his prior MDS assessment on 02/21/2022. A review of the current comprehensive care plan for Resident #50 last reviewed on 06/14/2022 revealed a focus area of high risk for falls related to cognitive deficits and a history of falls. The goal was for Resident #50 to have no serious injury from fall through the next review. An intervention dated 05/04/2021 was fall mat to bedside. On 06/26/2022 at 2:49 PM Resident #50 was observed in bed. His bed was in the low position and his call light was in reach. No fall mat was observed at his bedside. On 06/27/2022 at 8:10 AM Resident #50 was	F 689	completed by 7-29-2022. The initial audit did not find any other bedside mats that were not in place for a fall intervention. 3. The facility nursing staff on all shifts, including part time and prn, were inserviced by the Director of Nursing on making sure that any resident who has an intervention of a bedside mat while in bed did in fact have bedside mats in their rooms and that they are placed at bedside when that resident is in their bed. The staff were informed that the mats that the facility uses did not have to be moved, even if the residents is out of bed. These mats are low profile and a wheelchair, bed side table can be rolled on top of the mats with ease and they were easy to stand on when providing care to a resident in their bed. The staff were informed that extra mats were available in the facility if they needed one. This inservice will be completed by 8-5-2022. 4. An audit will be performed on those residents with bedside mats as a fall intervention to ensure that those mats are placed at bedside when the resident is in their bed. This audit will be performed weekly x 4 weeks and then monthly x 3 months. This audit will be performed by the DON or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that those residents with a bedside mat as a fall intervention had those mats placed at bedside when they were in their bed.	

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F 689	Continued From page 29	F 689	Compliance date: 8-5-2022	

observed in bed. His bed was in the low position and his call light was in reach. No fall mat was observed at his bedside.

On 06/28/2022 at 8:23 AM Resident #50 was observed in bed. His bed was in the low position and his call light was in reach. No fall mat was observed at his bedside.

On 06/29/2022 at 9:55 AM Resident #50 was observed in bed. His bed was in the low position and his call light was in reach. No fall mat was observed at his bedside.

On 06/29/2022 at 10:37 AM an interview with Nurse Aide (NA) #2 indicated he was caring for Resident #50. He stated he also provided care to Resident #50 on 06/28/2022. He further indicated he was familiar with Resident #50. NA #2 stated Resident #50 was at risk for falls. He went on to say Resident #50 should have a fall mat at his bedside whenever he was in bed.

A follow-up interview with NA #2 on 06/29/2022 at 10:56 AM indicated he did not know if Resident #50 had his fall mat in place on 06/28/2022 or 06/29/2022. He further indicated he should have made sure Resident #50 had his fall mat in place when he cared for him. NA #2 stated if there was no fall mat in Resident #50's room, he could have gotten one from the storage room.

On 06/29/2022 at 10:50 AM an interview with Nurse #4 indicated she was caring for Resident #50 that day. She stated she was familiar with him. She further indicated Resident #50 should have a fall mat at his bedside whenever he was in bed. She went on to say she could not recall whether Resident #50 had this in place when she

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F 689	Continued From page 30 saw him that morning or not. On 06/29/2022 at 11:11 AM an interview with the Director of Nursing (DON) indicated Resident #50 was at high risk for falls. She stated a fall mat at bedside was an intervention initiated to prevent a serious injury if Resident #50 had a fall from his bed. She went on to say she would expect both the nurse and the NA caring for Resident #50 to be observing to make sure this mat was in place. She went on to say if Resident #50 did not have a fall mat in his room, either the nurse or the NA caring for him should have gotten one from the storage room. The DON stated the facility had plenty of fall mats available.	F 689		
F 812 SS=F	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 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	F 812		8/5/22

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F 812	Continued From page 31	F 812		

by:
Based on observations, record review and staff and Registered Dietitian interviews, the facility failed to maintain food items in the walk in freezer in a frozen state for 2 of 2 freezer observations, failed to maintain the correct concentration of sanitizer in the three compartment sink for 2 of 2 observations and failed to maintain the dish machine wash temperature at the minimum manufacture requirements for 2 of 2 wash cycles.

The findings included:

1. On 6/26/22 at 10:15 AM an observation of the walk in freezer with Cook #2 revealed foods in the freezer including hush puppies, three boxes of vegetables, and ice cream felt soft and not frozen. Cook #2 opened a sealed box of ice cream. One 3 ounce container of ice cream was removed. When the exterior of the ice cream cup was slightly compressed the lid popped off because the ice cream was soft and not frozen solid.

On 6/28/22 at 4:50 PM an observation of the walk in freezer with the Certified Dietary Manager (CDM) revealed food items including a box of vegetables and a box of ice cream were soft to the touch. The CDM stated he had contacted a repair service to determine why the freezer was not keeping the foods frozen.

2. On 6/28/22 at 4:40 PM Cook #1 was observed placing pots and pans into the sanitizer sink of the three compartment manual washing sink. She used a test strip for chlorine to test the strength of the sanitizer. The test strip read 0 ppm (parts per million). During the observation at 4:45 PM the CDM obtained a quaternary test strip

1. A. A repair call was placed to get the freezer looked at to ensure that foods in the walk in freezer could maintain a frozen state. The repair company came out to the facility on 6-28-2022 to look at the freezer - at this time parts for repair were ordered. The expected completed of the repair is scheduled for 8-3-2022

B. The 3 compartment sink was drained of sanitizer and refilled to ensure that the correct concentration of sanitizer was being read by the test strips.

C. A repair call was made to have the dishwasher adjusted to ensure that the wash temperature would reach 120 degree Fahrenheit. The repairman came to the facility on 7-21-22 to test the temperature of the dishwasher and it was reading above 120 degree Fahrenheit for 3 consecutive cycles. He did state that if the temperature starts to drop to drain the water and refill. He did order some parts just in case and will come back to the facility when the parts have been delivered. He expected the parts to be delivered the week of 8-1-2022.

2. An initial audit was completed by 7-29 -22 to ensure that foods in walk in freezer were maintaining a frozen state, that the sanitizing compartment in the 3 compartment sink was reading at least 200 ppm for proper sanitizing and that the dishwasher wash temp was reaching at least 120 degrees Fahrenheit. The initial audit showed that (1) the sanitizing

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F 812	Continued From page 32 to test the sanitizer strength. The test strip read 0 ppm. On 6/29/22 at 9:40 AM the CDM used a quaternary test strip and checked the sanitizer in the 3 compartment sink. The test strip registered 100 ppm. The CDM confirmed the 3 compartment sink used quaternary sanitizer and stated the sanitizer was not strong enough and needed to be 200 ppm. On 6/30/33 at 11:30 AM the corporate Registered Dietitian (RD) stated the 3 compartment sink sanitizer should be at 200 ppm for proper sanitizing. 3. A review of the manufacturer ' s guide for the dish machine used by the facility with an effective date June 2008 read on page 4 of 8, "If the water temperature does not reach 120 degrees F (Fahrenheit). ...drain water from machine and continue to fill until proper temperature is obtained." On 6/29/22 at 9:50 AM the temperature of the dish washer wash temperature registered 100 degrees F. On 6/29/22 at 9:55 AM the dish washer wash temperature registered 102 degrees F. On 6/29/22 at 10:02 AM the Certified Dietary Manager (CDM) obtained a handheld thermometer and checked the temperature of the wash water in the dish machine. The thermometer registered 108 degrees F. The Registered Dietitian was interviewed on 6/30/22 at 11:30 AM. She stated the dish	F 812	compartment in the 3 compartment sink was reading at least 200 ppm on the test that was performed, (2) the dishwasher temp was reaching at least 120 degrees Fahrenheit using a special thermometer that the facility purchased to place on the rack with the dishes that are being run through the dishwasher and (3) there were a couple of small containers of ice cream that did not feel in a frozen state, all other items checked were in a frozen state - the repairman for the freezer is expected to be at the facility on 8-3-22. 3. The dietary staff were inserviced on: (1) making sure that the food in the walk in freezer was maintaining a frozen state, (2) making sure that the sanitizing compartment in the 3 compartment sink was reading at least 200 ppm for proper sanitizing and (3) that the dishwasher wash temperature was reading at least 120 degrees Fahrenheit and what to do if it does not reach that temperature. This inservice was lead by the Certified Dietary Manager. The dietary staff inservice will be completed by 8-3-2022. 4. An audit will be performed to ensure the following: (1) that foods in the walk in freezer are maintaining a frozen state, (2) that the sanitizing compartment in the 3 compartment sink was reading at least 200 ppm for proper sanitizing and (3) that the dishwasher wash temperature was reading at least 120 degree Fahrenheit. This audit will be completed weekly x 4 weeks and then monthly x 3 months. This audit will be completed by the	

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F 812	Continued From page 33 machine wash temperature should be 120 degrees F. She added the dish machine was required to operate at the correct wash temperature so if it was not at the correct temperature the facility should call a repair person to have it worked on.	F 812	Administrator or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that foods in the walk in freezer are kept in a frozen state, that the sanitizing compartment in the 3 compartment since reads at least 200 ppm and that the dishwasher wash temperature was reading at least 120 degree Fahrenheit. Compliance date: 8-5-2022	
F 813 SS=B	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have a policy regarding outside food brought into residents by visitors that addressed the safe handling practices of foods for consumption. This had the potential to affect all residents. The findings included: A review of the facility policy titled Food Brought in From Outside (undated) revealed the policy would ensure proper handling, serving and storage of any food items brought into our community from outside sources. The Procedures included food items may be stored in facility refrigerators in the nourishment rooms or	F 813	1. The facility policy regarding food brought in from outside was updated to address safe reheating processes and other preparation activities for assisting residents or visitors with safe food handling practices. The policy was udpated on 7-29-2022. 2. The facility staff responsible for reheating residents food (the nursing staff normally reheats resident foods upon request) were informed about the new policy and the temperature that reheated food should be before taking it back to the resident. Going forward the updated policy on food brought in from the outside	8/5/22

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F 813	Continued From page 34 in personal refrigerators located in the resident ' s room. The policy addressed the foods would be dated when stored and discarded after 72 hours. The policy did not address safe reheating processes or other preparation activities for assisting residents or visitors with safe food handling practices. On 6/30/22 at 8:07 AM the Admission Director stated he told the resident or the responsible party that food items from outside of the facility needed to be in sealed containers or storage bags. He said he did not discuss how foods should be reheated or other safe food handling practices. He said he was not aware of the need to address the education or reheating procedures to ensure the food was safe. On 7/2/22 at 10:30 AM the Administrator reported the policy did not cover all the required elements and he was not aware the facility was responsible for providing education to ensure safe food reheating procedures were followed.	F 813	will be placed in the admission packet and made available for all current residents and their families. The new policy will be placed into the admissions packet. The new policy will be placed in the admission packet starting the week of 8-1-2022 and will be made available to any other family members in the facility. 3. All facility staff were inserviced by the Certified Dietary Manager (CDM) on the new policy regarding food brought in from the outside. All staff members, including part time and prn, were inserviced on the new policy. Food thermometers will be placed in each nourishment rooms (where the microwaves are located) so that any food that staff reheat for the residents can be checked to ensure that it reaches the proper temperature. The inservice will be completed by 8-5-2022. 4. An audit will be performed to ensure that foods brought in from the outside for residents followed the updated policy in regards to safe reheating processes and other preparation activities for assisting residents or visitors with safe food handling processes. This audit will be performed when a staff member reheats food brought in from the outside for a resident. The audit will take place weekly x 4 weeks and then monthly x 3 months. The audit will be performed by the Certified Dietary Manager (CDM) or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure the new policy	

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F 813	Continued From page 35	F 813	regarding food brought in from outside is being followed. Compliance Date: 8-5-2022	
F 849 SS=B	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified	F 849		8/5/22

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in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are

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necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives

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and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that

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F 849	Continued From page 39 each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews the facility failed to obtain a Physician's order for hospice services for 2 of 4 residents (Residents #58 and #259) reviewed for hospice. Findings included: 1. Resident #58 was admitted to the facility on 2/04/22 with diagnoses that included non-Alzheimer's dementia and cerebrovascular accident. The significant change Minimum Data Set dated 5/18/22 indicated that Resident #58 had severe cognitive impairment and was coded for hospice. Review of Resident #58's electronic medical health record and paper chart revealed no order for hospice. An interview on 6/28/22 at 10:35 AM with the Director of Nursing revealed that the resident should have an order for hospice, and she did not know why they did not. An interview on 6/29/22 at 3:30 PM with the Administrator revealed that he was aware of Resident #58's lack of hospice order and had already in-serviced the staff regarding this concern.	F 849	1. A.. The facility talked to the physician for Resident #58 and the facility received an order for hospice services on 6-27-2022 and this order was inputted into point click care on 6-27-2022. B. The facility talked to the physician for Resident #259 and the facility received an order for hospice services on 6-27-2022 and this order was inputted into point click care on 6-27-2022. 2. The electronic medical records for all other residents who are receiving hospice were checked to ensure that they had physician orders for hospice services. This initial audit was completed by the Administrator on 7-29-22. 3. The facility nurses, including part time and prn, were inserviced by the Director of Nursing regarding making sure that there is a physician order for any resident who is receiving hospice services. The administrator also called the directors of the hospice companies that the facility deals with to let them know that a physician□s order is needed at the facility before a resident begins to receive hospice services. The administrator called all the hospice directors that the	

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F 849	Continued From page 40 2. Resident #259 was admitted to the facility on 5/31/22 with diagnoses that included hypertension and Diabetes Mellitus. The admission Minimum Data Set dated 6/07/22 indicated that Resident #259 was cognitively intact and was coded for hospice. Review of Resident #259's electronic medical health record and paper chart revealed no order for hospice. An interview on 6/28/22 at 10:35 AM with the Director of Nursing revealed that the resident should have an order for hospice, and she did not know why they did not. An interview on 6/29/22 at 3:30 PM with the Administrator revealed that he was aware of Resident #259's lack of hospice order and had already in-serviced the staff regarding this concern.	F 849	facility deals with between 6-29-2022 and 6-30-2022. 4. An audit will be completed to ensure that all residents in the facility who are receiving hospice services have a physicians order to receiving hospice services. This audit will take place weekly x 4 weeks and then monthly x 3 months. This audit will look at all residents that are receiving hospice services to ensure that they have a doctor's order for hospice services. This audit will be completed by the Administrator or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that those residents who are receiving hospice services have a physician order to receiving hospice services Compliance Date: 8-5-2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and 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	F 880		8/5/22

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F 880	Continued From page 41 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the 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.	F 880		

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F 880	Continued From page 42 §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, staff and Physician interviews, the facility failed to wear Personal Protective Equipment (PPE) per the Centers of Disease Control and Prevention (CDC) guidelines for 1 of 6 residents (Resident #13) reviewed for Activities of Daily Living (ADL) care. This occurred when Nursing Assistant (NA) #1 did not don eye protection while providing ADL care and while performing COVID 19 testing for 2 of 2 residents (Resident #21 and Resident #23) when Nurse #7 did not don a gown. Findings Included: 1. The Centers for Disease Control and Prevention (CDC) guideline entitled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated 2/2/22 contained the following statements: If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom	F 880	1. A. The facility staff were provided with googles or faceshields to wear when having patient care encounters. The staff were provided with goggles or faceshields beginning on 6-28-2022 and informed that we will continue to wear these items when the county transmission levels are High. B. Nurse #7 was inserviced to ensure that they knew the correct PPE (googles/faceshield, face mask, gloves and gown) to wear when administering a covid test. The inservice was provided by the Director of Nursing to nurse #7 (who is now no longer with the company). The inservice took place on 6-30-22. 2. A. The provision of the googles/facemasks to the staff to wear when providing patient care resolved the issue for other residents being affected by this problem. The staff will continue to wear googles or a faceshield during patient encounters when the community	

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F 880	Continued From page 43 and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). Additionally, HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: · Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. Review of the COVID-19 Community Levels, calculated on 6/23/22, revealed the Pitt County community level was high. During observation on 6/26/22 at 11:15 AM Nurse Aide #1 was observed providing a bed bath and activities of daily living care to Resident #13. During the interaction with the resident, Nurse Aide #1 did not wear a face shield. During an interview on 6/26/22 at 11:23 AM Nurse Aide #1 stated to her knowledge staff were not required to wear a face shield during resident care by the facility. During an interview on 6/26/22 at 12:05 PM the Director of Nursing stated the Administrator looks at the county transmission rate weekly, usually on Mondays or Tuesdays. The Director of Nursing indicated she was the infection preventionist. The Director of Nursing stated she was not aware face shields or goggles needed to be worn by staff when the county transmission rate was high. She stated the health department had told her all they needed was face mask. During an interview on 6/28/22 at 9:31 AM the	F 880	transmission level is High. B. The facility nurses who are responsible for administering covid tests were inserviced by the Director of Nursing on the proper PPE to wear when covid tests are being performed. 3. A. The staff in the facility who would provide patient care encounters were inserviced by the Director or Nursing regarding the need to wear googles/faceshields when having a direct patient care encounter. This inservice included the video titled Keep COVID-19 Out! □ this inservice was presented by our DON/Infection Preventionist. The link to the video that was shown during the inservice is https://www.youtube.com/watch?v=7srwrF9MGdw. This inservice will be completed by 8-3-22. B. The facility nurses were inserviced on the proper PPE to wear when administering a covid test. This inservice included the video titled Keep COVID-19 Out! □ this inservice was presented by our DON/Infection Preventionist. The link to the video that was shown during the inservice is https://www.youtube.com/watch?v=7srwrF9MGdw. This inservice will be completed by 8-3-22. 4. A. An audit will be performed to ensure that the staff providing patient care are wearing goggles/facemasks during	

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F 880	Continued From page 44 Health Department Nurse stated he was the health department point person for the facility and stated he had never told the Director of Nursing that face shields or goggles were not needed when the transmission rate was high. He stated if any facility called and asked, he would inform them that face shields and goggles were needed during high transmission. During an interview on 6/28/22 at 11:03 AM the Health Department Supervisor from the health department stated she had told the facility that during high transmission rate and if the facility had a positive COVID19 resident then eye protection had to be worn. 2. Review of the Center for Disease Control (CDC) guidance "Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings" dated March 29, 2021, revealed the following items were required while performing COVID Testing; mask, gloves gown and eye protection. The facility's policy and procedure "Coronavirus Disease Testing Staff" dated September 2021 did not include procedures on what PPE was required while performing testing. Observation of COVID testing on Resident #21 and Resident #23 with Nurse #7 occurred on 6-28-22 at 4:35pm. The nurse was observed to be wearing goggles, mask and gloves but no gown while she performed the COVID test. Nurse #7 was interviewed on 6-28-22 at 4:40pm. Nurse #7 stated she was not aware she needed a gown while performing COVID testing. She explained she was trained by the Director of Nursing (DON) on performing COVID testing but did not remember being educated on the need for	F 880	the patient care encounter. This audit will be performed weekly x 4 weeks and then monthly x 3 months. This audit will be completed by the DON or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that the staff are wearing goggles/facemasks during patient care encounters. The audit will randomly pick 5 direct patient encounters to ensure that the staff are wearing proper goggles or faceshields. B. An audit will be performed to ensure that the proper PPE is being worn during the administration of a covid test. This audit will take place weekly x 4 weeks and then monthly x 3 months. The audit will be performed by the Administrator or their designee. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that the proper PPE is being worn during the administration of a covid test. This audit will pick 1-2 covid administration tests per week to ensure that proper PPE is being worn and then 2 covid administration tests per month to ensure that proper PPE is being worn. C. A root cause analysis will be performed on the wearing of goggles/faceshields during a patient care encounter and also on the wearing of proper PPE during the administration of a covid test. The root cause analysis will be discussed during the monthly facility Quality Assessment and Assurance	

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F 880	Continued From page 45 a gown. The DON was interviewed on 6-29-22 at 10:18am. The DON stated Nurse #7 was educated on the proper Personal Protective Equipment (PPE) needed while performing COVID testing. She stated the education included wearing a mask, gown, gloves and eye protection. The DON commented that Nurse #7 had told her she had forgotten to wear the gown. The facility physician was interviewed on 6-29-22 at 1:00pm. The Physician stated she did not know why staff did not wear the PPE that was available to them but expected staff to wear a mask, gown, gloves and eye protection when they were performing COVID testing.	F 880	committee meetings. Compliance date: 8-5-2022	
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms	F 886		8/5/22

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consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state

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F 886	Continued From page 47 and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review, review of the "COVID19 Staff Vaccination Status for Providers", staff and Physician interviews the facility failed to follow the Center for Disease Control (CDC) guidelines for testing not up to date staff per their county's transmission rate. This occurred for 3 of 3 staff members (Nursing Assistant (NA) #6, Dietary Aide (DA) #1, and NA #7) who were not up to date with their COVID19 vaccine. Findings included: Review of the CDC guidelines dated May 24th, 2022, revealed the term "up to date" as 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. The guideline further documented if you are not up to date you should be tested based on county transmission rates. Review of the facility's county transmission rate dated 6-18-22 through 6-24-22 showed the county transmission rate at a high level. Review of the "COVID19 Staff Vaccination Status for Providers" information provided on 6-28-22 revealed the facility had 111 employees with 10 employees exempt from the COVID 19 vaccine and a total of 62 employees who had received the COVID 19 vaccine but had not received their booster. Nurse #7 was interviewed on 6-28-22 at 4:35pm.	F 886	1. Going forward the facility will test all employees who are either unvaccinated or vaccinated without a booster shot based on the county transmissions rates, if county transmission rate is High 2 tests per week, if county transmission rate is Medium 1 test per week and if county transmission rate is Low 1 test per month. 2. By testing the unvaccinated and vaccinated without booster staff members based on the county transmission rates, this will take care of the issue. 3. All staff members, including part time and prn, will be inserviced by the Director of Nursing regarding the testing of unvaccinated staff and those vaccinated staff who have not had a booster shot based on the county transmission rate for our facility. The facility will inform the staff of the county transmission rates for our county on a weekly basis so that staff will know how often testing will be required. The facility will continue to schedule covid-19 vaccination clinic on a monthly basis to ensure that any staff that would like to receive a vaccine or booster shot is able to receive it. This inservice will be completed by 8-3-2022. 4. An audit will be performed to ensure that unvaccinated staff and staff who are vaccinated without a booster shot are	

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F 886	Continued From page 48 Nurse #7 stated she, Nurse #2 and the Director of Nursing (DON) were responsible for resident and staff testing. She stated she was testing non-vaccinated staff once weekly. She discussed not knowing about the county transmission rate and what that had to do with the number of times non-vaccinated staff had to test. The nurse also stated she did not know that staff who were eligible for boosters and did not get them were considered not up to date and needed to test per the county transmission rate level. During an interview with Nurse #2 on 6-28-22 at 4:54pm, Nurse #2 said she, Nurse #7 and the DON were responsible for the staff and resident testing. She discussed not being informed of the county transmission rate, so the unvaccinated staff were testing once weekly. The nurse stated she was not aware that staff who were eligible for their booster and did not receive a booster were considered not up to date and need to test per the county transmission rate. The DON was interviewed on 6-29-22 at 10:18am. The DON stated she understood the booster was a recommendation and not needed if the staff member did not want the booster. She also said she was not aware that if a staff member who was eligible for the booster and had not received the booster they were considered not up to date and had to test per the county transmission rate. She confirmed the "COVID19 Staff Vaccination Status for Providers" information was correct and there were 62 employees who were eligible for their booster but had not received them. The DON explained the non-vaccinated staff were testing per the county transmission rate.	F 886	tested based on the county transmission rates. This audit will be performed by the Administrator or their designee. The audit will be performed weekly x 4 weeks and then monthly x 3 months to ensure that unvaccinated staff and staff who are vaccinated without a booster shot are tested based on the county transmission rates. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meeting to ensure that unvaccinated staff and staff who are vaccinated without a booster shot are being tested based on the county transmission rates. Compliance Date: 8-5-2022	

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F 886	Continued From page 49	F 886		

The facility physician was interviewed on 6-29-22 at 1:00pm. The Physician stated she was not aware when staff needed to test in relation to their vaccination status but expected staff to test following the CDC guidelines.

An interview occurred with NA #6 on 6-29-22 at 3:15pm. NA #6 stated he had received his COVID19 vaccination series "sometime" in 2021. He said he had not received the booster because he thought it was for people over 55. The NA stated he had not tested and had not been asked to test since he received his COVID19 vaccine.

Dietary Aide (DA) #1 was interviewed on 6-29-22 at 3:31pm. The DA stated she had received her COVID vaccine in the spring of 2021. She explained the vaccine had made her sick, so she was not wanting to receive the booster. The DA stated no one had asked her to test since she received the vaccine last year but stated she would volunteer to test weekly or every other week. She also said she was unaware of the county transmission rate and the need to test according to the county transmission rate.

During an interview with NA #7 on 6-29-22 at 3:15pm, the NA stated he had received his COVID 19 vaccine in 2021. He said he had not received his booster vaccine because 'I just forgot about it." NA #7 discussed not being asked to test since he had received his vaccine and stated he had not tested. He stated he was not aware of the guidelines related to the booster and the need to test according to the county transmission rate.

The Administrator was interviewed on 6-30-22 at 12:57pm. The Administrator stated he was

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F 886	Continued From page 50 unaware that staff who were eligible for their booster and had not received the booster were required to test per the county transmission rate. He further said he believed the booster was optional.	F 886		