STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT CLAYTON	204 DAIRY ROAD CLAYTON, NC 27520

(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 7-18-22 through 7-21-22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FXIN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7-18-22 through 7-21-22. Event ID# FXIN11. The following intakes were investigated NC00190499 4 of the 4 complaint allegations were not substantiated.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		8/18/22

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

Electronically Signed | 08/11/2022

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to treat residents with dignity and respect by 1) not removing the resident from transmission-based precautions at the end of the required isolation period, and 2) not providing privacy while repositioning for 2 of 2 residents reviewed for dignity (Residents #38 and #12). The findings included: 1. Resident #38 was admitted to the facility on 6/9/22. A review of the physician's order dated 6/9/22 revealed that the resident was on enhanced isolation precautions.	F 550	F 550 1. No residents were harmed as a result of this deficient practice. Resident #38 discharged from the facility on 07/20/2022. Resident #12 was covered up after care was provided on 7/18/2022. 2. All residents have the potential to be affected by this deficient practice. Quarantine/ Isolation residents were audited to ensure they were not kept on quarantine/ isolation longer than was required by the Infection Preventionist/designee on 08/08/2022. Facility staff were inserviced by the Staff Development Coordinator/ designee on ensuring privacy is given to residents while providing care by 08/18/22. 3. Nursing staff, agency contract nursing	

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F 550	Continued From page 2 Review of the Admission Minimum Data Set (MDS) Assessment dated 6/15/22 revealed that Resident #38 had severe cognitive impairment. A review of Resident #38's vaccination record revealed she had received 3 doses of COVID-19 vaccine and completed the series on 1/8/22. An observation of Resident #38's room was conducted on 7/18/22 at 10:13 AM. Resident #38 had a sign which read enhanced droplet contact precautions on the door and staff were observed to dress in eyewear, gowns and gloves when entering her room. An observation of Resident #38's room was conducted on 7/19/22 at 1:18PM. Resident #38 had a sign which read enhanced droplet contact precautions on the door and staff were observed to dress in eyewear, gowns and gloves when entering her room. An interview was conducted with Nurse #1 on 7/19/22 at 1:00PM. Nurse #1 stated he was not sure why Resident #38 was still on isolation precautions. Nurse #1 stated that Resident #38 had been on quarantine since she arrived in June. An interview was conducted with the Infection Preventionist (IP) on 7/19/22 at 1:11 PM. The IP stated that Resident #38 was not moved due to her cognitive impairment. The IP stated Resident #38 did not have any symptoms that required her to remain on isolation and she was responsible for monitoring when residents came off isolation. The IP further stated that residents were placed on quarantine for 10 days when admitted from the hospital. The IP stated the decision to move the	F 550	staff and new hires were inserviced by the Staff Development Coordinator/ designee on ensuring privacy is given to residents while providing care by 08/18/22. Facility staff, agency contract nursing staff, and new hires were inserviced by the Staff Development Coordinator/designee on how long a resident should be kept on quarantine or isolation, when they should be placed on quarantine/ isolation, and when they should be discontinued from isolation/ quarantine as they have successfully fulfilled the guidelines by 08/18/2022. 4. 10 CNAs will be audited while giving care to ensure privacy is given during care by Unit Manager/ designee weekly times twelve weeks. Quarantine/ Isolation residents will be audited weekly times twelve weeks to ensure they are not kept on quarantine/ isolation longer than is required by the Infection Preventionist/ designee. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022	

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F 550	Continued From page 3	F 550		

resident from isolation to a room was discussed by the interdisciplinary team in the daily meeting.

An interview was conducted with the primary physician on 7/21/22 at 1:19 PM. The physician stated that he expected the facility would follow the recommendations set forth by their policy for length of time resident was on quarantine.

An interview was conducted with the Director of Nursing (DON) on 7/21/22 at 1:50 PM. The DON stated that residents were placed on quarantine upon admission from an acute care facility or when they had symptoms that required isolation.
2. Resident #12 was admitted to the facility on 9/20/21.

Resident #12's minimum data set assessment dated 4/29/22 revealed she was assessed as severely cognitively impaired. She required extensive assistance with bed mobility.

During observation on 7/18/22 at 11:55 AM Resident #12 was observed being positioned in bed by Nurse Aide #1 and Nurse Aide #2. Resident #12 was in the bed by the window of the room. The door to the room was open and the privacy curtain was not drawn closed. Nurse Aide #2 pulled the covers down on Resident #12 to take hold of the positioning sheet to move the resident up in bed. Resident #12's right buttock, hip, and thigh were exposed and observable from the hallway. The nurse aides moved Resident #12 up in the bed and then pulled the covers back up over the resident.

During an interview on 7/18/22 at 11:56 AM Nurse Aide #1 stated when providing care to residents, staff were to ensure privacy by closing the door

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F 550	Continued From page 4 and privacy curtain. She concluded she should have pulled the curtain closed for privacy but was hurrying and did not. During an interview on 7/18/22 at 11:59 PM Nurse Aide #2 stated when care was being given to residents, privacy was to be provided to the residents by closing the blinds, shutting the door, and pulling the privacy curtain closed. She concluded they should have pulled the curtain closed but were in a rush. During an interview on 7/18/22 at 2:09 PM Resident #12 indicated she would prefer staff close the door or pull the curtain before providing care for privacy reasons and when they did not, it bothered her a little. During an interview on 7/18/22 at 2:26 PM the Director of Nursing stated when staff were providing care which might expose the resident, staff were to close the blinds and draw the privacy curtain to provide privacy to the resident.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview the facility failed to place residents' call lights (Resident #39, Resident #14) within reach to allow to allow for the residents to request	F 558	F 558 1. No residents were harmed as a result of this deficient practice. Resident #39 had their callbell placed within reach on	8/18/22

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F 558	Continued From page 5 staff assistance if needed for 2 of 4 residents reviewed for accommodation of needs. The findings included: 1. Resident #39 was admitted to the facility on 3/10/21 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) Assessment dated 6/7/22 revealed Resident #39's cognition was severely impaired. He required supervision to limited assistance of 1 staff with bed mobility, dressing, toilet use and hygiene. He was independent with transfers and locomotion on/off unit. An observation was conducted of Resident #39 on 7/18/22 at 11:08 AM. He was lying on his back in bed and the cord to the call bell was wrapped around the wall port out of Resident #39's reach. An observation and interview were conducted with Resident #39 on 7/19/22 at 8:50 AM. Resident #39 was lying on his back in bed and the cord to the call bell was wrapped around the wall port out of Resident #39's reach. Resident #39 was not interviewable. An observation was conducted of Resident #39 on 7/19/22 at 1:20 PM. He was sitting up in bed with his head against the wall and eyes closed. The cord to the call bell was wrapped around the wall port and the call bell was out of Resident #39's reach. An interview was conducted with nursing assistant #10 on 7/19/22 at 1:30 PM. Nursing assistant #10 stated that Resident #39 was able to use the call bell and that she had placed the	F 558	07/19/2022. Resident #14 had their callbell placed within reach on 07/19/2022. 2. All residents have the potential to be affected by this deficient practice. Residents were checked on 08/09/22 to ensure that their callbells were within reach by the Unit Manager/ designee. 3. Facility staff, new hires, and agency contract staff were inserviced by the Staff Development Coordinator/ designee on ensuring callbells were placed within the residents' reach at all times by 08/18/2022. 4. Five residents will be audited 5 days a week to ensure their callbell is within reach times twelve weeks by the Unit Manager/ designee. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022	

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F 558	Continued From page 6	F 558		

call bell on the bed where Resident #39 could reach it. NA #10 stated that staff were responsible for making sure a resident's call bell was in reach. NA #10 further stated that she was not sure how the call bell got placed around the wall port out of Resident #39's reach.

An interview was conducted with the Director of Nursing (DON) on 7/19/22 at 2:12 PM. The DON stated that she expected that staff would check to make sure the resident's call bell was in reach after administering care.

2. Resident #14 was admitted to the facility on 10/29/20 with diagnoses that included Parkinson's disease and dementia.

The quarterly Minimum Data Set (MDS) Assessment dated 5/9/22 revealed Resident #14's cognition was moderately impaired. He required limited assistance of 1 staff with bed mobility, transfers, dressing, toilet use and personal hygiene.

An observation was conducted of Resident #14 on 7/18/22 at 11:10 AM. He was lying on his back in bed and the cord to the call bell was wrapped around the wall port and call bell was out of Resident #14's reach.

An observation and interview were conducted with Resident #14 on 7/19/22 at 8:52 AM. Resident #14 was lying on his back in bed and the cord to the call bell was wrapped around the wall port out of Resident #14's reach. Resident #14 was alert and interviewable. He stated that he wanted to get up to his wheelchair but was unable to reach his call light.

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F 558	Continued From page 7 An observation was conducted of Resident #14 on 7/19/22 at 1:20 PM. He was up in the wheelchair and the cord to the call bell was wrapped around the wall port on the opposite side of the bed with and the call bell was out of Resident #14's reach. An interview was conducted with nursing assistant #10 on 7/19/22 at 1:30 PM. NA #10 stated that Resident #14 was able to use the call bell and that she had placed the call bell on the bed where Resident #14 could reach it. NA #10 stated that staff were responsible for making sure a resident's call bell was within reach. NA #10 further stated that she was not sure how the call bell got placed around the wall port out of Resident #14's reach. An interview was conducted with the Director of Nursing (DON) on 7/19/22 at 2:12 PM. The DON stated that she expected that staff would check to make sure the resident's call bell was in reach after administering care.	F 558		
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	F 561		8/18/22

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F 561	Continued From page 8 applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to honor a resident's choice to get out of bed in the evenings for 1 of 1 resident (Resident #53) reviewed for choices. Findings included: Resident #53 was admitted to the facility on 8-7-21 with multiple diagnoses that included fusion of the lower spine and muscle weakness. The Quarterly Minimum Data Set (MDS) dated 6-26-22 revealed Resident #53 was cognitively intact, no refusal of care and required extensive assistance with 2 people for bed mobility and transfers, extensive assistance with one person for toileting, personal hygiene, total assistance with one person for bathing. Resident #53 was interviewed on 7-18-22 at	F 561	F 561 1. No residents were harmed as a result of this deficient practice. Resident #53's choice to get out of bed was honored on 07/20/2022. 2. All residents have the potential to be affected by this deficient practice. Residents were interviewed on 08/10/2022 by the Social Service Director/ designee to ensure their choices were honored for their care related to staying in bed or getting out of bed. If a resident was not interviewable, the resident's responsible party was contacted for their preference. 3. Facility staff, new hires, and agency contract staff were inserviced on honoring a residents' choices pertaining to care (staying in bed or getting up from bed) by the Staff Development Coordinator/ designee by 08/18/2022. This is also	

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F 561	Continued From page 9 11:55am. The resident was observed in the bed watching TV and discussed not being able chose when he gets out of bed and when he was able to go outside. Resident #53 explained this mostly happened on the 3:00pm to 11:00pm shift. He stated after lunch he liked to lay down and get back up around 4:00pm but he said when he asked to get back up, he was told he had to stay in the bed because there were not enough staff to get him up. On 7-19-22 at 5:00pm, Resident #53 was observed to be in the bed. Resident #53 stated he had requested to get up so he could smoke but was told the staff did not have time to get him up. Nursing Assistant (NA) #4 was interviewed on 7-20-22 at 4:15pm. The NA stated he was usually the NA assigned to Resident #53 on the 3:00pm to 11:00pm shift. He explained Resident #53 would request to get out of bed shortly after his shift started and there were times when he could honor the request but stated most of the time, he was not able to get Resident #53 out of the bed as requested because he was too busy and did not have time to get the resident out of the bed and put him back into the bed. Resident #53 was observed in the bed on 7-20-22 at 4:45pm. The resident stated he had requested to get up but NA #4 had told him he did not have time. The Administrator was interviewed on 7-21-22 at 10:29am. The Administrator stated she expected staff to honor the resident wishes to get out of bed.	F 561	reviewed during careplan meetings. 4. 5 residents per week will be interviewed by the Social Service Manager/ designee times twelve weeks to ensure a residents choices are honored (staying in bed or getting up from bed). The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022.	

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F 561	Continued From page 10 A telephone interview occurred on 7-21-22 at 12:01pm with NA #8. The NA stated she had been assigned to Resident #53 on the 3:00pm to 11:00pm shift on 7-1-22 and 7-5-22. NA #8 said Resident #53 had requested to get out of bed on both days but said she had not assisted the resident out of the bed. She stated she could not remember why she had not assisted him out of the bed as requested.	F 561		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		8/18/22

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F 623	Continued From page 11	F 623		

be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

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BRIAN CENTER HEALTH & RETIREMENT CLAYTON	204 DAIRY ROAD CLAYTON, NC 27520

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F 623	Continued From page 12 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a written notice of discharge to the responsible party (RP) or resident following a hospitalization for 2 of 2 residents reviewed for hospitalization (Resident #72 and Resident #61). Findings included: 1. Resident #72 was admitted to the facility on	F 623	F 623 1. No residents were harmed as a result of this deficient practice. Resident #72 and Resident #61 were provided a written notice of discharge to the responsible party or resident following a hospitalization by the Admission Coordinator/ designee on 08/08/2022. 2. Residents that are hospitalized have a potential to be affected by this deficient	

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F 623	Continued From page 13 6/9/22. Resident #72's progress note dated 6/23/22 revealed he had a change in condition and was sent to the hospital. The resident did not return to the facility. Review of Resident #72's records revealed there was no written notice of discharge provided to the resident or the family. During an interview on 7/20/22 at 12:52 PM the Admissions Director stated written notification of transfers to the hospital were not a part of the initial training when she came to this position in 7/2021, and she was unaware it was something she was responsible for, so it had not been done during that time. She concluded Resident #72 did not get a written notice of discharge following his hospitalization on 6/23/22. During an interview on 7/20/22 at 1:04 PM the Administrator stated a written notification of hospitalization should have been completed for Resident #72. She concluded education would be completed and the area would be corrected. 2. Resident #61 was admitted to the facility on 6/15/16. A review of the most recent Minimum Data Set (MDS) dated 6/27/22 revealed Resident #61 was cognitively impaired with short- and long-term memory issues. A review of a Situation Background Assessment Recommendations (SBAR) communication form dated 4/4/22 revealed Resident #61 was transferred to the hospital.	F 623	practice. Residents that discharged to the hospital during the month of July 2022 were audited by the Admission Coordinator/ Designee on 08/08/2022 to ensure the responsible party or resident received a written notice of discharge. If they did not receive a discharge notice, one was sent on 08/08/2022. 3. Department heads were inserviced on responsible parties or residents receiving a written discharge notice upon hospitalization by the Administrator/ designee by 08/18/2022. 4. Residents who discharge to the hospital will be audited weekly to ensure the responsible party or resident receive a written notice of discharge upon hospitalization by the Admission Coordinator/ designee times twelve weeks. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 14 A review of a nursing progress note dated 4/8/22 revealed Resident #61 was readmitted to the facility. An attempted interview was conducted with Resident 61's representative on 7/19/22 at 6:15 PM. They were unable to be reached. An interview was conducted with the Admission Coordinator on 7/20/22 at 2:23 PM. The Admission Coordinator stated that she had not been sending a written notification of transfer/discharge to the resident and/or resident representative. She indicated this was not her responsibility. An interview was conducted with the Administrator on 7/20/22 at 2:28 PM. The Administrator revealed that she expected the Admission Coordinator would call the resident representative within 24 hours and send out a written transfer/discharge notification that included the reason for the transfer/discharge.	F 623		
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 observation, record review, staff and resident interviews, the facility failed to provide a shower for 1 of 3 dependent resident (Resident #29) reviewed for Activities of Daily Living (ADL) care. Findings included:	F 677	F 677 1. No residents were harmed as a result of this deficient practice. Resident #29 had a shower on 07/21/2022. 2. All residents have the potential to be affected by this deficient practice. Residents' showers were audited for the	8/18/22

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	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 677	Continued From page 15 Resident #29 was admitted to the facility on 7-12-21 with multiple diagnoses that included hemiplegia and hemiparesis. The quarterly Minimum Data Set (MDS) dated 5-30-22 revealed Resident #29 was cognitively intact, had no refusal of care and required extensive assistance with 2 people for bed mobility, total assistance with 2 people for transfers, extensive assistance with one person for dressing and personal hygiene, total assistance with one person for toileting and bathing. Resident #29's care plan dated 6-8-22 revealed a goal that Resident #29 would maintain current level of functioning with Activities of Daily Living (ADL) care. The interventions for the goal were in part encourage active participation in tasks, resident is totally dependent on one person to provide a bath/shower. During an interview with Resident #29 on 7-18-22 at 10:55am, Resident #29 stated he felt the care he received was "terrible" and explained he was to receive a shower on Tuesdays and Fridays during the 3:00pm to 11:00pm shift. Resident #29 stated he had not been receiving a shower even when he had asked staff to provide him a shower. The resident's hair was observed to be greasy and unkempt. Review of the staff documentation for showers from 6-1-22 through 7-17-22 revealed no documentation of Resident #29 receiving a shower from 6-16-22 through 7-13-22. Nursing Assistant (NA) #3 was interviewed by	F 677	month of July 2022 to ensure residents received their showers by the Unit Manager/ designee. 3. Nursing staff, new hire licensed and unlicensed staff, and contract agency nursing staff were inserviced by the Staff Development Coordinator/ designee to ensure residents received showers, facility shower schedule, resident rights, and staff to honor timely any additional shower or schedule changes as requested as scheduled by 08/18/2022. 4. Five residents per week will be audited to ensure the residents received a shower as scheduled and to ensure resident requests were honored by the Unit Manager/ designee times twelve weeks. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022	

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	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 677	Continued From page 16	F 677		

telephone on 7-20-22 at 2:58pm. NA #3 stated she had been assigned to Resident #29 on 7-1-22 and 7-5-22. She said she could not remember if she had provided a shower to Resident #29 on 7-1-22 but stated if she had not documented a shower than she did not provide a shower to Resident #29. NA #3 stated on 7-5-22 she did not provide a shower to Resident #29 because he requested a shower at 9:00pm and she was informed by "somebody" 9:00pm was too late to be providing showers so she did not provide Resident #29 a shower.

An interview occurred with NA #4 on 7-20-22 at 4:15pm. NA #4 stated he had been assigned to Resident #29 on 7-8-22. He explained he was too busy to provide a shower to Resident #29 that day and stated the resident had requested a shower, but I was unable to provide the shower to Resident #29.

During a telephone interview with NA #5 on 7-20-22 at 6:32pm, The NA stated she had been assigned to Resident #29 on 6-28-22. She stated she could not remember providing a bath to the resident on that day and could not remember why she was not able to provide a shower to Resident #29.

A telephone interview occurred with NA #6 on 7-20-22 at 7:42pm. The NA stated she had been assigned to Resident #29 on 6-24-22. She stated she remembered she had not provided Resident #29 a shower on 6-24-22 but explained she could not remember why she was unable to provide him a shower.

An interview with NA #7 occurred by telephone on 7-21-22 at 9:34am. NA #7 stated she had been

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	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 17 assigned to Resident #29 on 6-21-22. The NA explained Resident #29 was not on her schedule for a shower and that she had not checked the schedule for what residents were scheduled for a shower. She stated she could not remember if Resident #29 had requested a shower and said she had not provided a shower to Resident #29. The Administrator was interviewed on 7-21-22 at 10:29am. The Administrator stated she expected staff to provide showers when requested by the resident and on the residents scheduled shower days.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff, physician, and resident interviews the facility failed to complete a wound dressing change per physician orders for 1 of 3 residents reviewed for wound care (Resident #71). Findings included: Resident #71 was admitted to the facility 5/25/22. Her active diagnoses included displaced spiral fracture of the shaft of the left tibia.	F 684	F 684 1. No residents were harmed as a result of this deficient practice. Resident #71 has their wound dressing changed on 07/18/2022. 2. Residents receiving wound care have the potential to be affected by this deficient practice. Residents that had orders for a wound dressing change were audited on August 08/10/2022 to ensure their wound dressing was changed as	8/18/22

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	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 684	Continued From page 18 Resident #71's minimum data set assessment dated 5/31/22 revealed she was assessed to have a surgical wound. Resident #71's care plan dated 6/7/22 revealed she was care planned for a potential and actual impairment to skin integrity of the left lower extremity. The interventions included provide treatment as ordered. Resident #71's order dated 7/15/22 revealed she was ordered clean surgical wound to left shin with wound cleanser and apply dry dressing daily every day shift. Resident #71's treatment administration record for 7/2022 revealed on 7/17/22 the treatment was documented with a number 9 by Nurse #3. During an interview on 7/18/22 at 10:29 AM Resident #71 stated she did not get her dressing change to the wound on her surgical site yesterday 7/17/22. During an interview on 7/19/22 at 1:41 PM Nurse #3 stated she was an agency nurse and on 7/17/22 she did not know there was a physical treatment administration record available and she did not have access to the electronic records until late in her shift. She stated due to this she was not aware Resident #71 had a dressing treatment until she had access to the electronic records. Once she got access, she saw the order and documented on the treatment record a 9 instead of a check mark. She stated the 9 meant "Other/See Progress Notes Effective." Nurse #3 stated she contacted the physician but did not document she contacted the physician because	F 684	ordered/ documented by the Unit Manager/ designee. 3. Licensed Nurses, new hire licensed nursing staff and agency contract licensed nursing staff were inserviced by the Staff Development Coordinator/ designee to ensure wound dressing changes are completed as ordered, and if wound care is not provided per physician order, the facility's expectation is to notify the physician immediately, and obtain new orders received, and document occurrence by 08/18/2022. 4. A weekly audit of wound dressing changes, treatment documentation in TAR, and verification if physician notification was necessary will be completed to ensure they are completed as ordered by the physician by the Unit Manager/ designee times twelve weeks. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022	

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F 684	Continued From page 19 she was tired, and it was late. She concluded the physician informed her that it was okay she had missed that dressing change and it would be okay for it to wait till the next dressing change was due. During an interview on 7/21/22 at 9:47 AM the Director of Nursing stated she had spoken with both the on-call physician as well as the nurse practitioner for 7/17/22 and both denied being notified of the missed wound treatment by Nurse #3 for Resident #71. The Director of Nursing stated the nurse should have completed the dressing change per physician orders and had access to the physical treatment record and could have called and spoken with the Director of Nursing as well and she did not. She concluded agency staff were trained to use the physical treatment and medication administration record including Nurse #3. During an interview on 7/21/22 at 1:01 PM Physician #1 stated he expected the nursing staff to complete dressing changes per his orders.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		8/18/22

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	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 686	Continued From page 20 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interview, the facility failed to provide treatment to a right heel pressure ulcer as ordered by the Physician. This occurred for 1 of 3 resident (Resident #40) reviewed for pressure ulcers. Findings included: Resident #40 was admitted to the facility on 8-15-19 with multiple diagnoses that included diabetes with diabetic neuropathy. Review of the Physician's order dated 4-12-22 Resident #40 had an order for betadine to be placed on his right heel daily for a pressure injury. The significant change Minimum Data Set (MDS) dated 6-15-22 revealed Resident #40 was severely cognitively impaired and was coded for 1 unstageable pressure ulcer. Resident #40's care plan dated 6-23-22 revealed a goal that his pressure ulcer would show signs of healing and remain free from infection. The interventions for the goal were in part administer treatments as ordered. Review of Resident #40's Treatment Administration Record (TAR) for the month of July 2022 revealed no documentation on 7-9-22, 7-10-22 and 7-16-22 that his treatment to his right heel was completed. Review of Resident #40's wound care	F 686	F 686 1. No residents were harmed by this deficient practice. Resident #40 physician was notified that pressure ulcer treatments were not completed on 7/9/2022, 7/10/2022, & 7/16/2022. No new orders resulted. 2. Residents with pressure ulcers have the potential to be affected by this deficient practice. Residents that have pressure ulcers were audited on August 10 2022 by the Unit Manager/designee to ensure pressure ulcer treatments were completed/documented as ordered by the physician. 3. Licensed nursing staff, new hire licensed nursing staff and agency contract licensed nursing staff were inserviced by the Staff Development Coordinator/ designee to ensure all licensed nursing staff, agency contract licensed nursing staff, and new hire licensed nursing staff are aware of facility expectation in treatment completion per their assignment while on duty, to document accurately on pressure ulcer treatments, and facility's expectation is to only initial the TAR if the licensed nurse physically completes the treatment as ordered by the physician by 08/18/2022. 4. A weekly audit of pressure ulcer treatments will be completed by the Unit Manager/designee to ensure they are completed/ documented on as ordered by	

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	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 686	Continued From page 21 documentation from 7-1-22 through 7-15-22 revealed no change in size to his right heel pressure ulcer. During a telephone interview with Nurse #5 on 7-20-22 at 11:07am, the nurse stated she was assigned to Resident #40 on 7-9-22. The nurse explained she was unaware that she needed to perform wound care on Resident #40 on 7-9-22 so she did not provide the care. She also stated even if she knew she had to perform wound care she did not know where the TAR was located or the wound care cart. The wound care (WC) nurse was interviewed on 7-20-22 at 11:20am. The WC nurse discussed when he was not present to complete wound care on Resident #40, the staff assigned to him were responsible for completing the treatments. An interview with Nurse #6 occurred on 7-20-22 at 2:30pm. The nurse stated she was assigned to Resident #40 on 7-10-22 and was aware he had wounds that needed treatment. She confirmed her initials were on the TAR as completing the wound care for Resident #40 on 7-10-22 but stated she did not complete the care. The nurse said she did not know why her initials were present on the TAR when she did not complete the treatment. Several attempts were made to contact the nurse scheduled on 7-16-22 with messages left for a return call. The Administrator was interviewed on 7-21-22 at 10:29am. The Administrator stated the staff assigned to the resident was responsible for completing all the treatments ordered if the WC	F 686	the physician weekly times twelve. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022	

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F 686	Continued From page 22 nurse was not present. She also stated she expected staff to complete all wound care treatments as ordered. The facility's Medical Director was interviewed by telephone on 7-21-22 at 1:02pm. The Medical Director stated he expected staff to follow all wound care orders and complete the treatments as ordered. He also stated if the treatment was not able to be completed or missed, he expected to be notified.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Medical Director interviews, the facility failed to provide necessary care and services to ensure a sterile technique was used to clean the inner cannula of a tracheostomy for 1 of 1 resident (Resident #17) tracheostomy care. Findings included: The facility's policy and procedure titled "Tracheostomy care" dated August 2013 was reviewed and revealed in part maintain a sterile field while cleaning the inner canula with a mixer	F 695	F 695 1. No residents were harmed as a result of this deficient practice. Resident # 17's inner cannula was changed with a new sterile inner cannula on 7/19/2022. Nurse #7 was not welcomed back into our facility. 2. Residents that have inner cannulas/ tracheostomies have the potential to be affected by this deficient practice. Licensed Nurses that care for a tracheostomy had a competency completed by the Staff Development	8/18/22

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	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 695	Continued From page 23 of hydrogen peroxide and normal saline. Sterile gloves are required. Resident #17 was admitted to the facility on 5-18-22 with multiple diagnoses that included tracheostomy. The Admission Minimum Data Set (MDS) dated 5-24-22 revealed Resident #17 was moderately cognitively impaired and was coded for a tracheostomy, oxygen and suctioning. Resident #17's active care plan dated 6-5-22 included goals and interventions for tracheostomy care. Resident #17 was observed on 7-19-22 at 9:05am squirming in his bed with his eyes wide open. The resident pointed to his tracheostomy and was observed that the inner canula had been dislodged. Nurse #7 came into Resident #17's room immediately and found the inner canula on his over the bed table. The nurse donned non-sterile gloves and rinsed the inner canula off with tap water then placed the inner canula back into the tracheostomy. Resident #17 was observed to stop squirming and his eyes relaxed. Nurse #7 was interviewed on 7-19-22 at 2:11pm. The nurse stated she was an agency nurse and she had not been trained on the proper procedure for cleaning inner cannulas but confirmed she did not have a sterile field, sterile gloves and did not wash the inner canula with hydrogen peroxide and normal saline solution. She further stated she thought it was "ok" to rinse the inner canula with tap water and did not think about introducing bacteria into the resident's air way. Nurse #7 discussed Resident #17 removing his inner	F 695	Coordinator/ designee to ensure a new sterile inner cannula is used or sterile technique is used for cleaning/ suctioning by 08/18/2022. 3. Licensed Nurses, new hire licensed nurses, and agency contract licensed nurses were inserviced by the Staff Development Coordinator/ Designee on sterile technique for cleaning/ suctioning a tracheostomy or replacing an inner cannula of a tracheostomy with a new sterile one by 08/18/2022. Nurse competencies were also completed to Licensed Nurses, new hire licensed nurses, and agency contract licensed nurses that care for a tracheostomy to ensure a sterile technique was used while cleaning/ suctioning or replacing an inner cannula with a new sterile one by 08/18/2022. Any licensed nurse scheduled to care for a tracheostomy resident will be verified by the DON/ designee prior to start of shift to ensure tracheostomy clinical competencies have been completed with return demonstration by 08/18/2022. 4. A weekly competency will be completed of a licensed nurse completing cleaning/ suctioning of the inner cannula of a tracheostomy resident or replace the inner cannula with a sterile one by the Staff Development Coordinator/designee times twelve weeks. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are	

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	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 695	Continued From page 24 canula himself at times and stated she thought that was what happened this morning. The Administrator was interviewed on 7-21-22 at 10:29am. The Administrator stated she expected all staff including agency staff to be educated on how to care for residents with a tracheostomy. The Medical Director was interviewed on 7-21-22 at 1:02pm by telephone. The Medical Director stated Nurse #7 should have cleaned the inner canula using a sterile technique and sterile solution to prevent any bacteria entering Resident #17's air way.	F 695	sustained and to address any concerns. 5. August 18 2022.	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and	F 726		8/18/22

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F 726	Continued From page 25 implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to train and orient agency staff and verify competency for 2 of 2 agency staff (Nurse #7 and Nurse #4) to deliver tracheostomy care to 1 of 1 resident (Resident #17) reviewed for tracheostomy care. Findings included: a. Resident #17 was observed on 7-19-22 at 9:05am squirming in his bed with his eyes wide open. The resident pointed to his tracheostomy and was observed that the inner canula had been dislodged. Nurse #7 came into Resident #17's room immediately and found the inner canula on his over the bed table. The nurse donned non-sterile gloves and rinsed the inner canula off with tap water then placed the inner canula back into the tracheostomy. Nurse #7 was interviewed on 7-19-22 at 2:11pm. The nurse stated she was an agency nurse and she had not been trained on the proper procedure for cleaning inner cannulas and thought it was "ok" to rinse the inner canula with tap water. b. Observation of tracheostomy suctioning for Resident #17 occurred on 7-20-22 at 8:54am.	F 726	F 726 1. No residents were harmed as a result of this deficient practice. Nurse # 7 was not welcomed back into our facility. Nurse # 4 had a competency completed on 08/08/2022 on sterile technique when cleaning/ suctioning/changing a resident's inner cannula while donning appropriate PPE by the Staff Development Coordinator on 08/08/2022. 2. Residents that have inner cannulas/ tracheostomies have the potential to be affected by this deficient practice. Licensed Nurses, new hire licensed nurses, and agency contract licensed nurses that care for a tracheostomy had a competency completed by the Staff Development Coordinator/ designee to ensure sterile technique was used to clean the inner cannula / suctioning or replacing the inner cannula while donning appropriate PPE by 08/18/2022. Agency staff will be oriented and trained with proof of return demonstration prior to working any shift at the facility by the Staff Development Coordinator/ designee using the "Agency Orientation Checklist" by 08/18/2022.	

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F 726	Continued From page 26 Nurse #4 was observed putting on sterile gloves but did not don eye protection. Nurse #4 was interviewed on 7-20-22 at 9:00am. The nurse discussed being an agency nurse and stated she had not had training on what PPE was required while suctioning a tracheostomy resident. The Assistant Director of Nursing (ADON) was interviewed on 7-20-22 at 9:30am. The ADON stated staff and agency nurses were trained in the care of tracheostomies to include PPE and how to clean an inner canula. She presented the education material she used to train agency staff which did not include tracheostomy care. The ADON concluded agency staff had not received training on tracheostomy care until today (7-20-22). The Administrator was interviewed on 7-21-22 at 10:29am. The Administrator stated she expected all staff including agency staff to be educated on how to care for residents with a tracheostomy.	F 726	3. Licensed Nurses, new hire licensed nurses, and contract agency licensed nurses were inserviced by the Staff Development Coordinator/ Designee on sterile technique for cleaning/ suctioning of an inner cannula of a tracheostomy or replacing the inner cannula with a new sterile cannula while donning appropriate PPE by 08/18/2022. Nurse competencies were also completed to include return demonstration that all Licensed Nurses that care for a tracheostomy to ensure a sterile technique was used while cleaning/ suctioning or replacing the inner cannula with a new sterile inner cannula while donning appropriate PPE by 08/18/2022. 4. . A weekly competency will be completed of a licensed nurse completing cleaning/ suctioning of the inner cannula of a tracheostomy or replacing the inner cannula with a new sterile inner cannula resident while donning appropriate PPE by the Staff Development Coordinator/designee times twelve weeks. Agency staff will be oriented and trained prior to working at the facility by the Staff Development Coordinator/ designee using the “Agency Orientation Checklist” by 08/18/2022. Any licensed nurse scheduled to care for a tracheostomy resident will be verified by the DON/ designee prior to start of shift to ensure tracheostomy clinical competencies have been completed with return demonstration by 08/18/2022. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the	

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F 726	Continued From page 27	F 726	Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		8/18/22

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F 756	Continued From page 28 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Medical Director and consulting Pharmacist interviews, the facility failed to act upon pharmacy recommendations for 1 of 5 resident (Resident #17) reviewed for unnecessary medications. Findings included: Resident #17 was admitted to the facility on 5-18-22 with multiple diagnoses that included Parkinson's disease and dementia. A Physician order dated 5-18-22 revealed Resident #17 was to receive Diclofenac (topical pain relief gel) 1%. Apply to affected area topically four times a day for pain related to primary osteoarthritis, right shoulder. The admission Minimum Data Set (MDS) dated 5-24-22 revealed Resident #17 was moderately cognitively impaired. Review of the pharmacy recommendations dated 6-2-22 revealed a clarification notification for the topical Diclofenac. The pharmacy clarification requested a dose for the Diclofenac and a site for administration. The review revealed there was no written response or physician signature indicating the physician had seen the pharmacy recommendation.	F 756	F 756 1. No residents were harmed as a result of this deficient practice. Resident #17's pharmacy recommendation was completed on 07/21/2022. Resident #17's physician was notified on 07/21/2022 by the DON. DON was inserviced on timely pharmacy recommendation completion on 07/21/2022 by the Administrator/designee. 2. Residents that receive pharmacy recommendations have the potential to be affected by this deficient practice. All pharmacy recommendations for the month of July 2022 were audited by the DON/ Designee to ensure proper follow up and physician notification by 08/18/2022. 3. Licensed Nurses, new hire licensed nurses, agency contract licensed nurses were inserviced on proper follow up on pharmacy recommendations and physician notification by Staff Development Coordinator/ designee by 08/18/2022. 4. A monthly audit of pharmacy recommendations will be completed by the DON/ designee times three months to ensure proper follow up and physician notification. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance	

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F 756	Continued From page 29 The Director of Nursing (DON) was interviewed on 7-21-22 at 9:49am. The DON explained when the consulting Pharmacist made a recommendation, the recommendation would be sent to her email, she would print the recommendation and place it in the Physicians folder for review. She said there was no follow up to the Pharmacist recommendation for Resident #17's Diclofenac because she had overlooked the email and never placed the recommendation in the Physicians folder to review. A telephone interview occurred with the previous consulting Pharmacist on 7-21-22 at 10:34am. The Pharmacist explained he was no longer consulting with the facility, but he confirmed he had made the recommendation for Resident #17's Diclofenac. The Pharmacist discussed Diclofenac typically having 2 doses, a 2 gram (gm) or a 4gm dose and the dose was dependent on the site of the pain. He stated he had to request the site of the pain so he could ensure the dose the Physician wrote would be accurate. During a telephone interview with the facility's Medical Director on 7-21-22 at 1:02pm, the Medical Director stated he was recently made aware of the missed pharmacy recommendation and said Diclofenac was ordered by application so Resident #17's Diclofenac order should have had a specific site and dose. The Administrator was interviewed on 7-21-22 at 10:29am. The Administrator discussed the process for pharmacy recommendations stating the recommendations were sent to the DON through email, the DON would print the recommendations and would be discussed with the Physician at his next visit. She stated she	F 756	Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022.	

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F 756	Continued From page 30 expected the DON to follow up with the Physician regarding any recommendations.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to secure medications in a medication cart when left unattended for 1 of 4 medication carts observed (200 hall medication cart).	F 761	F 761 1. No residents were harmed as a result of this deficient practice. 200 Wing medication cart was properly locked on 7/19/2022. 2. Residents receiving medication have	8/18/22

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F 761	Continued From page 31 Findings included: During observation on 7/19/22 at 8:28 AM the 200 hall medication cart was observed unlocked and unattended on the 200 hall as the locking mechanism was popped out to indicate the cart was unlocked. At 8:29 AM a therapy staff member was observed to walk by the unlocked medication cart. At 8:30 AM the therapy staff member again walked by the unlocked medication cart. At 8:31 AM Nurse #3 returned to the medication cart. During an interview on 7/19/22 at 8:30 AM Nurse #3 stated medication carts were to be locked when unattended. She concluded the 200 hall medication cart was hers and she should have locked the 200 hall medication cart before leaving it unattended and did not. During an interview on 7/19/22 at 1:18 PM the Director of Nursing stated medication carts were to be locked when unattended.	F 761	the potential to be affected by this deficient practice. All medication carts were audited on 7/19/2022 by the Unit Manager/ designee to ensure they were properly locked. Licensed nurses/ CMAs will be inserviced by the Staff Development Cooordinator/ designee to ensure they know when to properly lock and how to properly lock the medication cart by 8/18/2022. 3. Licensed nurses/ CMAs will be inserviced by the Staff Development Cooordinator/ designee to ensure they know when to properly lock and how to properly lock the medication cart by 08/18/2022. 4. Medication carts will be audited 5 days a week to ensure they are properly locked by the Unit Manager/ designee times twelve weeks. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		8/18/22

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F 842	Continued From page 32	F 842		

except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-

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F 842	Continued From page 33 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately document wound care treatments for 1 of 3 residents (Resident #40) reviewed for wound care. Findings included: Review of the Physician's order dated 4-12-22 Resident #40 had an order for betadine to be placed on his right heel daily for a pressure injury. Review of Resident #40's paper Treatment Administration Record (TAR) for 7-5-22 through 7-11-22 revealed on 7-9-22 there were no staff initials for Resident #40's wound care and on 7-10-22 nurse #6 had initialed that she had completed Resident #40's wound care. Review of Resident #40's electronic TAR for	F 842	F 842 1. No residents were harmed as a result of this deficient practice. Resident #40 had their treatment record accurately corrected by Nurse #6 and WC nurse. The physician was made aware on 07/20/2022. Immediate education and disciplinary actions were given to the assigned nurses involved as to the expectation for providing physician ordered wound care and not altering medical records. 2. Residents receiving wound care treatments have the potential to be affected by this deficient practice. Wound care treatment documentation/ proper physician notification and expectation of not altering medical records will be audited by the Unit Manager/ designee for	

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F 842	Continued From page 34 7-5-22 through 7-11-22 revealed the Wound Care (WC) nurse had placed his initials for completing Resident #40's wound care on 7-9-22 and 7-10-22. During an interview with the WC nurse on 7-20-22 at 11:20am, the WC nurse said he did not work on 7-9-22 and 7-10-22 and confirmed he was not in the building on 7-9-22 and 7-10-22 so he could not have completed wound care on Resident #40. He further confirmed his initials in Resident #40's electronic TAR as his initials and stated, "I just made a mistake." The WC nurse explained the electronic system had not been working from 7-5-22 through 7-11-22 and when the electronic system began working again, he signed into the electronic TAR and placed his initials as completing Resident #40's wound care from 7-5-22 through 7-11-22. The Director of Nursing (DON) was interviewed on 7-20-22 at 2:14pm. The DON explained the electronic medical record system was out of order from 7-5-22 through 7-11-22 and the staff were completing paper charting during that time. She stated the WC nurse should not have documented wound care treatments that he had not completed on Resident #40. An interview with the Administrator occurred on 7-21-22 at 10:29am. The Administrator stated she expected staff to document correctly in the electronic medical record.	F 842	the month of July 2022 by 08/18/2022. 3. Licensed Nurses, new hire licensed nurses, and agency contract licensed nurses will be inserviced by the Staff Development Coordinator/ designee on accurately documenting wound care treatments, proper physician notification, and facility expectation of not altering medical records by 08/18/2022. 4. A weekly audit will be completed on ensuring wound care treatments are accurately documented with proper physician notification, and no medical record altering is acceptable by the Unit Manager/ designee for twelve weeks. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		8/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	C 07/21/2022

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F 867	Continued From page 35 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility ' s Quality Assurance (QA) program failed to maintain implemented procedures and monitor interventions put into place following the recertification and complaint investigation survey of 5-9-19 to prevent the reoccurrence of deficient practice related to not securing medications in a medication cart which resulted in a repeat deficiency on the current recertification survey of 7-21-22 Label/Store Drugs and Biologicals. The continued failure of the facility during two federal surveys showed a pattern of the facility ' s inability to sustain an effective QA program. Findings included: This tag is cross referenced to: F761: Based on observation and staff interviews the facility failed to secure medications in a medication cart when left unattended for 1 of 4 medication carts observed (200 hall medication cart). Review of the facility's survey history revealed F761 was cited during the facility's annual recertification and complaint investigation survey on 5-9-19 for not securing medications in a medication cart on hall 200. The facility was re-cited during the current annual recertification and complaint investigation survey for the same issue of not securing medication in a medication cart on hall 200.	F 867	F 867 1. No residents were harmed as a result of this deficient practice. 200 Wing medication cart was properly locked on 7/19/2022. 2. Residents receiving medication have the potential to be affected by this deficient practice. All medication carts were audited on 07/19/2022 by the Unit Manager/ designee to ensure they were properly locked. Licensed nurses/ CMAs will be inserviced by the Staff Development Cooordinator/ designee to ensure they know when to properly lock and how to properly lock the medication cart by 08/18/2022. 3. Licensed nurses/ CMAs, agency licensed nursing staff and new hire licensed nursing staff will be inserviced by the Staff Development Cooordinator/ designee to ensure they know when to properly lock and how to properly lock the medication cart by 08/18/2022. 4. Medication carts will be audited 5 days a week to ensure they are properly locked by the Unit Manager/ designee times twelve weeks. The DON/ Designee will also audit medication carts to ensure they are properly locked 5 days a week times twelve weeks. Pharmacy consultant will audit medication carts on their monthly visit and as needed. The results of these audits/ concerns will be tracked and	

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F 867	Continued From page 36 The Administrator was interviewed on 7-21-22 at 10:29am. The Administrator stated she expected nursing staff to ensure their medication cart was locked and secure prior to leaving the cart unattended. She also explained she had been the Administrator at the facility since 7-1-22 and was unaware the facility had been previously cited for the same issue.	F 867	trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18 2022.	
F 880 SS=E	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 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	F 880		8/18/22

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F 880	Continued From page 37 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. §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 observation, record review, staff and	F 880	F 880 DPOC IC	

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F 880	Continued From page 38 Medical Director interviews the facility failed to (1) follow the facility's policy and procedure for tracheostomy care when Nurse #4 did not don eye protection while suctioning 1 of 1 resident (Resident #17) tracheostomy. The facility also failed to (2) develop and implement procedures for when hand hygiene was required, follow infection control practices when the Wound Care (WC) nurse did not perform hand hygiene or change gloves between removing a dirty dressing and applying a clean dressing to 1 of 1 resident (Resident #272) observed for wound care, and when Nursing Assistant (NA) #9 did not perform hand hygiene between resident contact while passing lunch trays for 1 of 5 NAs observed passing trays. Findings included: The facility's policy and procedure titled "Tracheostomy care" dated August 2013 was reviewed and revealed in part sterile gloves, mask and eye protection must be worn if splashes, spattering or spraying of bodily fluids is likely to occur. 1. Resident #17 was interviewed on 7-20-22 at 8:35am. Resident #17 was observed to have gurgling sounds and having difficulty breathing. The resident motioned that he needed to be suctioned. Resident #17's call light was observed to be next to him. Nurse #4 was made aware on 7-20-22 at 8:35am of Resident #17's condition and his request to be suctioned. Observation of tracheostomy suctioning for Resident #17 occurred on 7-20-22 at 8:54am.	F 880	1. No residents were harmed as a result of this deficient practice. Nurse #4 was educated on appropriate PPE to wear when performing tracheostomy care on 08/08/2022. The WC Nurse was educated on appropriate hand hygiene and changing gloves during a dressing change on 08/10/2022. Nursing assistant #9 was educated on washing her hands in between residents for tray pass on 08/10/2022. 2. Residents that have tracheostomies, dressing changes, and eat have the potential to be affected by this deficient practice. Licensed Nurses that care for a tracheostomy had a competency completed by the Staff Development Coordinator/ designee to ensure sterile technique was used to clean the inner cannula / suctioning or replacing the inner cannula while donning appropriate PPE by 08/18/2022. Residents that had orders for a wound dressing changes were audited on August 08/10/2022 to ensure their wound dressing was changed as ordered following proper hand hygiene and changing gloves during dressing change from dirty to clean by the Unit Manager/ designee. Residents that eat were audited to ensure handwashing occurred in between tray passes on 08/10/2022 by the Unit Manager/ designee 3.Licensed Nursing, new hire licensed nurses, agency contract licensed nurse staff were inserviced by the Staff Development Coordinator/ designee to ensure tracheostomy care is performed using sterile technique including suctioning and cleaning the cannula, or	

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F 880	Continued From page 39 Nurse #4 was observed to collect the needed supplies for the suctioning process while she explained to Resident #17 what she was doing. The nurse was observed putting on sterile gloves but did not don eye protection. Nurse #4 was interviewed on 7-20-22 at 9:00am. The nurse discussed being an agency nurse and stated she had not had training on what PPE was required while suctioning a tracheostomy resident but said she knew she should have worn eye protection from previous employment. She stated she was behind in her morning duties and was trying to hurry the process and just forgot to don eye protection. During an interview with Resident #17 on 7-20-22 at 9:15am, the resident stated he was feeling better. He said he was aware his call light was next to him, and he could have used it, but he was not thinking about using his call light. The Assistant Director of Nursing (ADON) was interviewed on 7-20-22 at 9:30am. The ADON stated staff and agency nurses were trained in the care of tracheostomies to include PPE and how to clean an inner canula. She presented the education material she used to train agency staff which did not include tracheostomy care. The ADON concluded agency staff had not received training on tracheostomy care until today (7-20-22). During an interview with the Administrator on 7-21-22 at 10:29am, the Administrator stated she expected staff to follow infection control guidelines and be trained on tracheostomy care prior to working with residents who have tracheostomies.	F 880	replacing the inner cannula with a new sterile inner cannula by 08/18/2022. Licensed nurses, new hire license nurses, and agency contract licensed nurses were also inserviced by the Staff Development Coordinator/ designee on proper hand hygiene during wound care and proper changing of gloves during wound care by 08/18/2022. All facility staff including contract agency staff were inserviced to complete hand hygiene in between resident tray pass and to utilize proper PPE source control to prevent the spread of infection by the Staff Development Coordinator/ designee by 08/18/2022. 4. An audit will be performed weekly times twelve on tracheostomy care to ensure proper PPE is utilized during care by the Unit Manager/ designee. An Audit will be performed weekly times twelve on wound care to ensure proper handwashing and proper changing of gloves occurring by the Staff Development Coordinator/ designee. An audit will be performed 5 days a week to ensure staff our properly washing their hands between resident tray pass and utilizing proper PPE source control by the Unit Manager/ designee. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 5. August 18th, 2022 See attached documents for DPOC	

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F 880	Continued From page 40	F 880		

The Medical Director was interviewed on 7-21-22 at 1:02pm by telephone. The Medical Director stated Nurse #4 should have been wearing eye protection while suctioning Resident #17 to help prevent the spread of any possibility of infection.

2. Review of the facility's "Infection Prevention Manual for Long Term Care, Standard Precautions" dated February 2018 revealed a statement for hand hygiene/hand washing refer to the policy on hand hygiene/hand washing.

During an interview with Assistant Director of Nursing (ADON) on 7-20-22 at 1:05pm, the ADON stated the facility did not have a policy on when to perform hand hygiene and provided the education tool she used when educating new hires on hand hygiene. Review of the tool covered how to perform hand washing and had a statement to wash or sanitize hands according to the standard of care. The ADON said she did not educate on when hand hygiene needed to be completed.

2a. Observation of lunch trays being passed occurred on 7-18-22 from 12:15pm to 12:20pm. Nursing Assistant (NA) #4 was observed to use hand sanitizer, obtain a tray from the meal cart and enter room 407. She delivered the meal tray to bed B touching the resident's tray table, opening the resident's drinks and handling the resident's silverware. NA #4 exited room 407 without performing hand hygiene, retrieved another tray from the meal cart and entered room 407. She approached bed A touching her tray table, removing the resident's drink lids and touching the resident's straw. NA #4 exited room 407 without performing hand hygiene, retrieved

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F 880	Continued From page 41	F 880		

another tray from the meal cart and entered room 405. She was observed touching the resident's tray table, removing the residents drink lids and handling the resident's silverware. She exited room 405 and performed hand hygiene using the hand sanitizer on the wall.

During an interview with NA #4 on 7-18-22 at 12:25pm, the NA stated she was trying to hurry and had forgotten to perform hand hygiene between contact with each resident. She stated she had education on infection control and knew she was supposed to perform hand hygiene but stated "I just forgot."

The Administrator was interviewed on 7-21-22 at 10:29am. The Administrator discussed the facility not having a staff development person which caused poor supervision and lack of education with staff. She further stated she expected staff to follow infection control practices and perform hand hygiene after each resident encounter.

The Medical Director was interviewed on 7-21-22 at 1:02pm by telephone. The Medical Director stated staff should be performing hand hygiene after resident contact to help prevent the spread of infections.

2b. A review of the Standard Precautions policy last updated 2/18/22 indicated that hand hygiene should be completed prior to donning gloves and gloves should be changed after having contact with infective material (wound drainage).

Resident #272 was admitted to the facility on 6/21/22 with a diagnosis of Stage 3 pressure ulcer to the sacrum.

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F 880	Continued From page 42	F 880		

On 7/20/21 at 1:20 PM, an observation was conducted of the Wound Nurse providing wound care for Resident #272. The nurse was observed to don gloves and remove the dressing from the sacral wound. The Wound Nurse removed his gloves and donned another pair of gloves without completing handwashing. The Wound Nurse cleaned the wound bed, discarded his gloves, and donned another pair of gloves without completing handwashing. The Wound Nurse then retrieved the Santyl medication tube that was laying on the barrier, placed the medication on a 4 X 4 gauze and placed the gauze into the wound.

An interview was conducted with the Wound Nurse on 7/20/22 at 1:40 PM. The Wound Nurse stated that he did not realize that he had failed to complete handwashing.

An interview was conducted with the Director of Nursing on 7/20/22 at 1:55 PM. The DON stated that the wound nurse should have performed hand hygiene after removing his gloves.

An interview was conducted with the Medical Director on 7/21/22 at 1:11 PM. The Medical Director stated staff should be performing hand hygiene after removing a dressing.