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	345522	A. BUILDING _____ B. WING _____	C 07/29/2022

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UNIVERSAL HEALTH CARE/FLETCHER	86 OLD AIRPORT ROAD FLETCHER, NC 28732

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E 000	Initial Comments An unannounced Recertification survey was conducted 07/25/22 through 07/29/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #OBL711.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted 07/25/22 through 07/29/22. A total of 51 allegations were investigated and 18 were substantiated. Intakes NC00187715, NC00186735, NC00187408, NC00187411, NC00189276, NC00190793, NC00188869, NC00186703, NC00186702, NC00184084, and NC00186002. Event ID #OBL711.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		8/31/22

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

Electronically Signed | 08/22/2022

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, Medical Doctor (MD), Nurse Practitioner (NP) and staff interviews, the facility failed to notify the MD or NP of laboratory results when received for 1 of 7 sampled residents reviewed for unnecessary medications (Resident #65). Findings included:	F 580	1. Resident #65 lab results were provided to the MD to review by the assigned charge nurse on 7/29/22. 2. Audit will be conducted by 8/31/22 by the Medical Records Coordinator and Administrative Nurses of all labs since 8/1/22. Any found to be out of compliance with notification will be brought to the MD	

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F 580	Continued From page 2 Resident #65 was admitted to the facility on 03/25/22. The quarterly Minimum Data Set (MDS) dated 06/29/22 assessed Resident #54 with intact cognition and was receiving dialysis. A physician's order for Resident #65 dated 06/06/22 read in part, liver function test (blood test to check the status of the liver) and thyroid-stimulating hormone (blood test to check if the thyroid hormone is functioning as it should) every six months, in June and December. Review of Resident #65's medical record revealed no lab results for liver function and thyroid-stimulating hormone tests obtained in June 2022. The laboratory results for Resident #65's liver function and thyroid-stimulating hormone tests were provided for review by the Medical Records staff member on 07/29/22 at 12:34 PM. The lab results showed they were reported to the facility on 06/07/22. The results of the liver function test revealed Resident #65 had a low albumin (a protein made by the liver that enters the bloodstream and helps keep fluid from leaking out of the blood vessels into other tissues) of 3.13 grams/deciliter (g/dl) with 3.50-5.70 g/dl being within normal limits. Further review revealed Resident #65 had a low total protein (amount of protein in the blood) of 5.9 g/dl with 6.0-8.3 g/dl being within normal limits. Review of the nurse progress notes for June 2022 revealed no documentation the MD or NP were notified of Resident #65's lab results dated	F 580	for review or order changes. 3. The Director or Nursing (DON), and Assistant Director of Nursing (ADON) will provide education to all licensed staff regarding the policy and procedures for lab results and reporting to the MD beginning by 8/31/22. New hires and agency staff will be in-serviced before starting their first shift. Nurses will be in-serviced to check the lab book daily to verify what labs were obtained. Nurses are to report abnormal lab results to the MD after receiving the results from the lab. Critical labs are to be called to the physician immediately upon receipt of results, even if received after hours. Notification to the physician regarding lab results will be documented on the lab log and/or in nurses notes. 4. The Clinical Nursing team will audit for lab results and notification of MD, beginning 8/17/22, utilizing the daily lab diagnostic log tool, five times per week for four weeks, then 3xper week for 4 weeks. The Director of Nursing or designee will continue these audits during morning clinical meetings on an ongoing basis. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assurance / Performance Improvement Committee (QAPI) by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to ensure ongoing	

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F 580	Continued From page 3 06/07/22. During interviews on 07/29/22 at 12:34 PM and 5:27 PM, the Medical Records staff member stated she was current with scanning all lab results reviewed by the MD or NP into Resident #65's electronic medical record and the only lab result not scanned was the one dated 06/07/22. The Medical Records staff member explained she printed of the lab results from the facility's lab system today and confirmed the results were not printed off from the lab system when received on 06/07/22 and had not been given to the MD or NP to review. During a telephone interview on 07/29/22 at 3:07 PM, the NP stated typically lab results were received from the lab the following day and nursing staff should have printed off the results for Resident #65 when received on 06/07/22 for her or the MD to review. During a telephone interview on 07/29/22 at 3:28 PM, the MD stated if lab results for Resident #65 were not printed off when received, it was unlikely he or the NP were notified of the results. The MD stated nursing staff knew they were responsible for printing off lab results the day they were received but must have forgot. During a joint interview on 07/29/22 at 4:25 PM, the Director of Nursing (DON) explained all orders for lab tests were placed in the lab communication book for them to be obtained when due. The DON stated nursing staff were responsible for checking the lab system daily to print off the results received for the MD or NP to review and she tried to follow-up weekly to double-check and make sure none were missed.	F 580	compliance with regulatory requirements. 5. 8/31/22	

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F 580	Continued From page 4 The DON confirmed the lab tests ordered for Resident #65 were documented in the lab communication book; however, they had not been marked off to indicate the results were received. The DON stated she was not sure where the breakdown occurred between receiving the results and getting them printed off for the MD or NP to review. During a joint interview on 07/29/22 at 4:25 PM, the Administrator stated he would have expected for lab results to have been provided to the MD or NP when received.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		8/31/22

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F 656	Continued From page 5 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff the facility failed to develop a comprehensive care plan to address diabetes care for 1 of 7 residents reviewed for unnecessary medications (Resident #42). The findings included: Resident #42 was admitted to the facility on 03/08/22 with multiple diagnoses that included diabetes mellitus (DM). Review of physician's order dated 03/23/22 revealed Resident #42 was ordered to receive sliding scale Novolog before meals and at bedtime. On 05/07/22, the physician added an order for Resident #42 to receive 15 units of Levemir subcutaneously once daily at bedtime.	F 656	1. Resident #42□s comprehensive care plan was updated with care plan for Diabetes Mellitus on 8/8/22 by the Minimum Data Set Coordinator. 2. Care plans for all residents with a diagnosis of Diabetes will be reviewed by the MDS Coordinator by 8/17/22. MDS Coordinator will include a care plan for Diabetes Mellitus with the comprehensive care plan for all Residents with diagnosis of Diabetes by 8/31/22. 3. Education on Care Plan completion and accuracy was provided by the Regional MDS Nurse for the facility□s MDS Coordinators by 8/16/22. New hires will be educated upon hire. MDS Coordinator will review each resident□s records with Diabetes Mellitus on admission, significant change, quarterly,	

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F 656	Continued From page 6 Review of medication administration records (MARs) from May through July 2022 indicated Resident #42 had received both insulins as ordered. The quarterly Minimum Data Set (MDS) assessment dated 06/10/22 coded Resident #42 with intact cognition and indicated she had received insulin daily in the 7-day assessment period. Review of Resident #1's comprehensive care plans on 07/26/22 revealed no care plan was developed for diabetes care. During an interview conducted on 07/26/22 at 4:01 PM the MDS Coordinator stated care plan was determined by the facility's interdisciplinary team (IDT) as a group decision. She acknowledged that there were no care plans in place to address Resident #42's diabetes care. She explained a care plan for diabetes care was not needed as physician's orders had included all the assessments, medications, and monitoring perimeters to address Resident #42's diabetic condition. Interview with the Director of Nursing (DON) on 07/26/22 at 4:11 PM revealed the MDS Coordinator was responsible to develop care plan as indicated for Resident #42. It was her expectation for the MDS Coordinator to develop a person-centered comprehensive care plan to address Resident #42's diabetes care. During an interview on 07/29/22 at 6:17 PM the Administrator stated it was his expectation for the facility to develop a comprehensive care plan to address Resident #42's diabetes needs.	F 656	and annually to ensure a care plan is active for Diabetes Mellitus, beginning 8/17/22. 4. MDS Coordinator will audit resident records with Diabetes Mellitus to ensure a care plan is active for Diabetes Mellitus weekly for four weeks, then monthly for two months, beginning 8/17/22. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assurance / Performance Improvement Committee (QAPI) by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to ensure ongoing compliance with regulatory requirements. 5. Completion date: 8/31/22	

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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 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident, staff and the Wound Doctor interviews, the facility failed to provide wound care to pressure ulcers per physician orders for 1 of 3 residents (Resident #33) reviewed for pressure ulcers. The findings included: Resident #33 was admitted to the facility on 5/24/22 with diagnoses that included pressure ulcer to the sacrum and pressure ulcer to the right heel. Resident #33's care plan initiated on 5/25/22 indicated Resident #33 had a pressure ulcer to her sacrum and right heel. Interventions included treatments as ordered, routine wound assessment, pressure reducing device to bed, observe for signs/symptoms of infection and notify physician as needed.	F 686	1. Resident #33 wound care was provided daily as ordered as of 7/26/22. 2. An audit will be conducted by the Director of Nursing and the Assistant Director of Nursing on all residents with pressure ulcers to verify that treatments are being provided and documented as ordered. Audit will be completed by 8/31/22. 3. By 8/31/22, all licensed nurses will be in-serviced by the Director of Nursing and/or the Assistant Director of Nursing on completion of treatments as ordered, and completion of documentation. New hires and agency staff will be in-serviced prior to starting their first shift. Residents with pressure areas will be reviewed weekly during standards of care meeting, and during morning clinical meetings starting on 8/17/22 to verify that treatments are being provided as ordered	8/31/22

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F 686	Continued From page 8 The admission Minimum Data Set (MDS) assessment dated 5/31/22 indicated Resident #33 was cognitively intact, had no rejection of care behaviors, required extensive physical assistance with all activities of daily living and was always incontinent of urine. The MDS further indicated Resident #33 was at risk of developing pressure ulcers/injuries and had two unstageable slough/eschar (necrotic tissue that adheres to the wound bed and has a spongy or leather-like appearance) present upon admission to the facility. A physician order dated 7/7/22 for Resident #33 indicated the following treatment to the stage 4 pressure ulcer to the left and right sacrum: cleanse with normal saline, apply zinc oxide to peri-wound, pack with ¼ (antiseptic) solution soaked gauze and cover with and abdominal pads once daily. A physician order dated 7/23/22 for Resident #33 indicated the following treatment to the stage 3 pressure ulcer to the right heel: cleanse with normal saline, apply a honey-based gel wound dressing and cover with a foam adhesive dressing once daily. A review of Resident #33's Treatment Administration Record (TAR) for July 2022 indicated the treatment orders for Resident #33's sacrum and right heel were marked as completed by Nurse #4 on 7/25/22. A follow-up interview with Nurse #4 on 7/28/22 at 4:04 PM revealed when she documented Resident #33's wound care after she had done it on 7/26/22 on her electronic medical record, she had noted that the slot for 7/25/22 was red which	F 686	and documented. 4. The Director of Nursing and Assistant Director of Nursing will conduct an audit of treatment records five times a week for four weeks, and then 3 times a week for four weeks to verify that treatments are being completed and documented as ordered. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI Committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to ensure ongoing compliance with regulatory requirements. 5. completion date: 8/31/2022	

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F 686	Continued From page 9	F 686		

meant it hadn't been done on that day, but she mistakenly clicked that it had been done. Nurse #4 stated she should have crossed it out and documented for the right day which was on 7/26/22.

An interview with Nurse #4 on 7/27/22 at 3:14 PM revealed she usually did all the treatments from Mondays to Fridays on the day shift, but she got pulled to work on a hall on 7/25/22 due to a nurse who had called in sick. Nurse #4 stated that whenever she got pulled to work on a hall, the nurse on the hall was supposed to be doing wound care to the residents assigned to them. Nurse #4 stated she did not have Resident #33 on her assignment on 7/25/22 and she did not have time to change her pressure ulcer dressings. Nurse #4 stated she found out on 7/26/22 from Resident #33 that her pressure ulcer dressings did not get changed on 7/25/22. Nurse #4 stated she was concerned because Resident #33's sacral pressure ulcer had bright green drainage when she changed her dressing on 7/27/22. She notified the Nurse Practitioner who ordered a wound culture.

An interview with Resident #33 on 7/27/22 at 3:51 PM revealed she didn't get the dressings to her pressure ulcers changed on 7/25/22 and the nurses were supposed to be changing them daily. Resident #33 stated it had happened before when her wound dressings didn't get changed daily whenever Nurse #4 was either not working or she was getting pulled to work on a medication cart. Resident #33 stated she had just completed a round of antibiotics for wound infection and was told by Nurse #4 that she observed bright green drainage which might mean her sacral wound could be infected again.

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F 686	Continued From page 10	F 686		

An interview with Nurse #5 on 7/27/22 at 3:38 PM revealed she knew Nurse #4 got pulled to work on a hall instead of doing treatments on 7/25/22 but she didn't get to change Resident #33's wound dressings because she was so busy and didn't have time to do it. Nurse #5 stated she got caught up with everything that it didn't even cross her mind that she needed to do wound care on Resident #33. She also forgot to tell the night shift nurse that she didn't get to do Resident #33's wound care on 7/25/22.

An observation of wound care on Resident #33 was made on 7/28/22 at 2:01 PM. Nurse #4 cleaned Resident #33's right heel pressure ulcer with normal saline, applied a honey-based gel to the wound bed and covered it with a foam dressing. The pressure ulcer to the right heel measured approximately 1 cm (centimeters) in length, 0.6 cm in width and 0.2 cm in depth. 80% of the wound bed was covered with slough (necrotic tissue that needs to be removed from the wound for healing to take place). The surrounding skin did not have any redness. Nurse #4 removed her gloves and washed her hands. She then proceeded to remove the dressing on Resident #33's sacral pressure ulcer which was dated 7/27/22. Resident #33's sacrum had two pressure ulcers, and both had a large amount of green drainage with a foul odor. The right sacral pressure ulcer measured approximately 2.5 cm in length, 1.6 cm in width and 0.5 cm in depth. The left sacral pressure ulcer measured approximately 1.5 cm in length, 1.8 cm in width and 2 cm in depth. Nurse #4 cleaned each ulcer separately and packed them with an antiseptic solution soaked gauze. She applied zinc oxide to the surrounding skin,

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F 686	Continued From page 11 covered both ulcers with an abdominal pad and secured it with tape. A phone interview with the Wound Doctor on 7/28/22 at 3:30 PM revealed Resident #33 had a previous infection with Pseudomonas (Pseudomonas is a common type of bacteria usually found in soil and water. It is a main cause of hospital-acquired infections.) and he believed that she might have been colonized and this was a reactivation of the infection based on the characteristics of the wound, drainage, and odor. The Wound Doctor stated that it was suboptimal that Resident #33 missed a dressing change on 7/25/22 but he didn't think this contributed to the current wound infection that she might be having. The Wound Doctor didn't think Resident #33 had a systemic infection and he thought the infection was localized to the wound bed, so he went ahead and changed the treatment order to include an antibiotic ointment to prevent worsening of the wound infection. The Wound Doctor further stated that it was unfortunate that Nurse #4 had to be pulled to work on a hall, but he still expected Resident #33's wound dressings to be done daily as ordered. An interview with the Director of Nursing (DON) 7/29/22 at 3:49 PM revealed the nurses on the hall were supposed to do the treatments whenever Nurse #4 was not working or whenever she got pulled to work on a hall. The DON stated she expected the nurses to do wound care on Resident #33 as ordered by the Wound Doctor.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		8/31/22

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F 689	Continued From page 12 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 provide nectar thickened liquids as ordered by the Physician for 1 of 6 residents reviewed for nutrition (Resident #59). Findings included: Resident #59 was admitted to the facility 06/23/22 with a diagnosis of dysphagia (difficulty swallowing) following a cerebral infarction (stroke). Review of Resident #59's Physician orders dated 06/23/22 revealed an order for nectar thickened liquids. The admission Minimum Data Set (MDS) dated 06/28/22 revealed Resident #59 was severely cognitively impaired and had a swallowing disorder which included loss of liquids or solids from mouth, holding food in mouth/cheeks, coughing/choking with meals/medications, and having pain or difficulty when swallowing. The MDS also indicated Resident #59 received a mechanically altered therapeutic diet. The nutrition care plan for Resident #59 initiated 06/30/22 revealed in part she was at risk for aspiration (the accidental breathing of food or	F 689	1. Resident #59 was provided with hydration utilizing thickened liquids as prescribed, on 7/25/22. 2. An audit by the Director of Nursing or designee will be conducted by 8/31/22 of all residents with orders for modified liquid consistency to ensure that all are captured in a written list. 3. A list of residents who have modified liquid consistency orders will be placed in the nurses report book by the Speech Therapist as changes occur, starting 8/17/22. All nursing staff will be in-serviced by the Director of Nursing and Assistant Director of Nursing on this procedure and adhering to resident orders for modified liquids by 8/31/22. New hires and agency staff will be in-serviced prior to starting their first shift. Residents on a modified liquid consistency diet will be identified on the Care Plan and Care Guide, as well as on the Medication Administration Record (MAR). The Speech Therapist will update the list of residents who have modified liquids and provide to Nursing staff as changes occur beginning 8/17/22. 4. The Director of Nursing or designee will audit the thicken liquid list five times a	

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F 689	Continued From page 13 fluids into the lung) related to her medical diagnosis and swallowing difficulty. Interventions included providing her diet as ordered and encouraging adequate hydration. An observation of Resident #59 on 07/25/22 at 03:57 PM revealed she reported she was thirsty to Nurse #8 and would like some water to drink. Nurse #8 poured Resident #59 a cup of water from the pitcher on the medication cart and handed the cup to Resident #59. Resident #59 began drinking water from the cup with no coughing or difficulty swallowing noted. During an interview with Nurse #8 on 07/25/22 at 04:02 PM she confirmed she gave Resident #59 regular water to drink. She stated Resident #59 should have received nectar thickened water instead of regular water. Nurse #8 stated giving Resident #59 regular water instead of nectar thickened water was an oversight because she usually worked as an MDS Coordinator and was not normally assigned to a medication cart. She stated a list of residents who received modified liquids was kept in the nourishment room and she had not had an opportunity to check the nourishment room before being assigned to a medication cart the afternoon of 07/25/22. An interview with the Speech Therapist (ST) on 07/27/22 at 11:56 AM revealed she had been working with Resident #59 and Resident #59 required nectar thickened liquids because she was at risk for silent aspiration (aspiration of food or liquids into the lungs without causing symptoms such as coughing or choking). She stated if a resident had an order for nectar thickened liquids, they should receive nectar thickened liquids.	F 689	week for four weeks and then three times a week for four weeks, beginning 8/17/22 to ensure correct consistency is provided as ordered. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI Committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to ensure ongoing compliance with regulatory requirements. 5. completion date: 8/31/2022	

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F 689	Continued From page 14 An interview with the Director of Nursing (DON) on 07/27/22 at 06:15 PM revealed she expected residents to receive liquids as ordered by the Physician. She explained if a resident had an order for modified liquids that information was on the resident's Medication Administration Record (MAR). The DON stated Nurse #8 did not usually work on the floor, had not started her evening medication pass, and it was an oversight that she provided Resident #59 with regular water instead of nectar thickened water. An interview with the Administrator on 07/29/22 at 04:33 PM revealed he expected residents to receive liquids according to the Physician's order.	F 689		
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 record review, observations, and interviews with resident, staff and the Medical Director, the facility failed to administer oxygen as prescribed by the physician for 1 of 2 residents reviewed for oxygen therapy (Resident #52). The findings included:	F 695	1. Resident #52 was provided with a full oxygen tank on 7/25/22 upon discovery of the empty tank. 2. An audit was conducted by department heads on 7/26/22 of all residents with orders for continuous oxygen to ensure that their oxygen delivery source was working properly.	9/11/22

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F 695	Continued From page 15 Resident #52 was admitted to the facility on 5/25/21 with diagnoses that included chronic obstructive pulmonary disease (COPD). A physician order dated 6/14/22 for Resident #52 indicated oxygen therapy at 2 liters per minute via nasal cannula continuous for COPD every shift. The significant change Minimum Data Set (MDS) assessment dated 6/20/22 indicated Resident #52 was cognitively intact, had no rejection of care behaviors, required extensive physical assistance with most activities of daily living and used oxygen therapy while a resident at the facility. Resident #52's Treatment Administration Record (TAR) for July 2022 included an order for oxygen therapy at 2 liters per minute via nasal cannula every shift. During an initial observation and interview with Resident #52 on 7/25/22 at 10:21 AM, Resident #52 was sitting in a wheelchair in her room with an oxygen tank behind her. Resident #52 did not have a nasal cannula on, and a coiled oxygen tubing was observed on top of the oxygen tank. The dial on the oxygen tank was pointed towards the red area at "0" level. Resident #52 stated she was supposed to be on oxygen continuously, but her oxygen tank was empty, and the staff needed to get her a new one. Resident #52 also had an oxygen concentrator in her room, but it wasn't on, and the nasal cannula connected to the oxygen concentrator was on top of her bed. Resident #52 did not show any signs of respiratory distress. A second observation of Resident #52 on 7/25/22	F 695	There were no further negative findings. 3. Nursing staff, Activities, and the rehab department were in-serviced on verifying that residents are receiving oxygen as ordered, check the 02 concentrators for proper settings and that the 02 tanks or not empty when in use. This education was provided by the Director of Nursing and/ or the Assistant Director of Nursing and completed by 8/31/22. New hires and agency staff will be in-serviced prior to starting their first shift. By 8/31/ 22 a list of residents receiving oxygen will be developed and maintained by Medical Records and placed the report book on each unit utilized by the direct care staff. Nurses will be inserviced to check oxygen delivery systems during med pass and to ensure residents are receiving oxygen as ordered, and documenting this on the MAR. 4. The Director of Nursing, the Assistant Director of Nursing and/or the charge nurse will randomly audit residents receiving oxygen 5x times per week for 4 weeks then 3xper for 4 weeks to verify that residents are receiving oxygen as ordered. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI Committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to ensure ongoing compliance with	

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F 695	Continued From page 16	F 695		

at 2:21 PM revealed her participating in an activity in the dayroom without using her oxygen. Resident #52 did not have a nasal cannula on, and her oxygen tank continued to have coiled tubing on top. Resident #52 continued to show no signs of respiratory distress.

A third observation with Resident #52 on 7/25/22 at 3:30 PM revealed her sitting in her wheelchair in her room with the same oxygen tank at the back of her wheelchair. Resident #52 did not have an oxygen nasal cannula on. Resident #52 stated staff had not been in her room to replace her oxygen tank.

An interview with Nurse #2 on 7/25/22 at 3:38 PM revealed when she went in to give Resident #52's morning medications at 8:30 AM, Resident #52 was still in bed, and she had a nasal cannula on which was connected to her oxygen concentrator. She went back into Resident #52's room around 12:00 PM to check her vital signs and observed Resident #52 sitting in her wheelchair but she was connected to her oxygen concentrator. Nurse #2 stated she did not know Resident #52 had an empty oxygen tank behind her wheelchair and that she needed a new oxygen tank. Nurse #2 stated whoever got Resident #52 up out of the bed should have notified her that Resident #52 needed a new oxygen tank. Nurse #2 stated Resident #52 would sometimes remove the nasal cannula off her nose, but she had never seen her turn off her oxygen concentrator. During the interview, Nurse #2 went into Resident #52's room and checked her oxygen saturation which was at 95% on room air.

A follow-up interview with Resident #52 on 7/25/22 at 4:26 PM revealed she didn't have her

regulatory requirements.
5. Completion date: 8/31/2022

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F 695	Continued From page 17	F 695		

oxygen on all shift, and she wasn't on her concentrator at 12:00 PM. Resident #52 stated she waited all day for staff to change her oxygen tank which was behind her wheelchair.

An interview with Nurse Aide (NA) #1 on 7/28/22 at 9:39 AM revealed she took care of Resident #52 on 7/25/22 on the day shift from 7:00 AM to 11:00 AM. NA #1 stated she got Resident #52 up out of her bed but as soon as she had gotten her up, a therapy staff member came to get her. NA #1 stated she could not remember if she had put Resident #52 on oxygen prior to therapy getting her. NA #1 stated she didn't see Resident #52 again before 11:00 AM and another nurse aide took over.

An interview with the Rehabilitation Director on 7/28/22 at 9:46 AM revealed he had worked with Resident #52 on 7/25/22 in the morning right after breakfast but he couldn't remember the exact time he got her out of her room. The Rehabilitation Director stated he had changed Resident #52's oxygen tank a few times before but he couldn't remember if he did on 7/25/22. He couldn't remember if Resident #52 had her oxygen on while he worked with her on 7/25/22.

An interview with the Medical Director on 7/28/22 at 11:41 AM revealed the nurses should administer Resident #52's oxygen according to the physician's order and that he expected Resident #52's oxygen orders to be followed.

An interview with the Director of Nursing on 7/29/22 at 3:49 PM revealed any staff member could have changed Resident #52's oxygen tank when it needed to be changed and the nurse should have made sure Resident #52's oxygen

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F 695	Continued From page 18 was delivered per physician's order.	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide sufficient nursing staff to provide wound care for 1 of 3 residents reviewed for pressure ulcers (Resident #33).	F 725	1. Resident #33 wound care was provided daily as ordered as of 7/26/22. 2. An audit will be conducted by the Director of Nursing and the Assistant Director of Nursing on all residents with	8/31/22

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F 725	Continued From page 19 The findings included: This tag was cross-referenced to F-686: F-686: Based on record review, observation and resident, staff and the Wound Doctor interviews, the facility failed to provide wound care to pressure ulcers per physician orders for 1 of 3 residents (Resident #33) reviewed for pressure ulcers. A review of the Resident Council Meeting minutes dated 2/24/22 indicated a concern brought up by the residents about staffing on second and third shift being too thin and on 6/23/22 about not having enough staff on the weekends. An interview with Nurse #6 on 7/27/22 at 10:18 AM revealed staffing on second shift and the weekends was still a problem but it was not as worse as when she first started working at the facility. Nurse #6 stated she still had to stay over and work second shift once or twice every 2 weeks to help out. An interview with Nurse #7 on 7/27/22 at 11:41 AM revealed there had been days when they were short-staffed especially on second shift and the nurses had been on their feet trying to help the nurse aides. Sometimes, they had staff members coming in at 7:00 PM to help on second shift. An interview with Nurse #8 on 7/27/22 at 5:31 PM revealed she was supposed to work as the second MDS (Minimum Data Set) nurse, but she had been pulled to work on the hall twice this week. Nurse #8 stated staffing was still an issue on second shift, and she had been asked to stay	F 725	pressure ulcers by 8/31/22 to ensure that treatments are being provided as ordered. 3. All licensed nurses will be in-serviced by Director of Nursing or designee on completion of treatments as ordered, and completion of documentation, by 8/31/22. New hires and agency staff will be in-serviced prior to start of first shift. The Staffing Committee consisting of the Administrator, Director of Nursing, HR Coordinator, and Scheduler will meet weekly on Wednesdays starting 8/17/22, and review schedules, assignment sheets, agency use, and procedures for addressing callouts. The Administrator will educate the Scheduler as to the required hours of labor per resident day to develop staffing schedules. This education was completed by 8/17/22. Staffing agencies will be utilized to supplement staffing as needed. Recruitment efforts will be ongoing utilizing new recruitment system called JazzHR that was put into place in May. 4. The Director of Nursing or designee will audit staffing schedules 5x per week for 4weeks, then 3 times a week for 4 weeks beginning 8/17/22, to ensure adequate staffing. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI Committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to ensure ongoing	

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F 725	Continued From page 20 over and work on the hall until she had administered the 4:00 PM medications. Nurse #8 stated she also used to be the treatment nurse, but she often got pulled to work on the hall. An interview with Nurse #9 on 7/29/22 at 2:35 PM revealed Nurse #4 always got pulled to work on a hall on Mondays because they didn't have enough nurses on first shift on Mondays and if they got an agency nurse to work, they often called in sick. Nurse #9 stated they used to have a supervisor who alternated with Nurse #4 about getting pulled to a hall, but the supervisor had been gone for about 2-3 weeks. A phone interview with Nurse #10 on 7/28/22 at 9:30 PM revealed she didn't have time to change a resident's wound dressing on 7/25/22 because she barely got done with her medication pass when it was time to leave at 3:00 PM. She reported to the second shift nurse that she didn't get the dressing changed. An interview with the Scheduler on 7/29/22 at 2:03 PM revealed he was supposed to staff the facility with 5 nurses and 9 nurse aides (NA) on first shift, 4 nurses and 5 NA on second shift and 2 nurses and 4 NA on third shift. The Scheduler stated he had staffing challenges on the weekends and on second shift because it was hard to get people to work this shift. He stated the facility currently had contracts with 4 staffing agencies and utilized them to obtain nurses and NA. The Scheduler also stated the facility had 10 open positions for NA and 5 open positions for nurses. They had been trying to recruit staff by posting employment advertisements on different websites and had talked about raising their wages to attract more employees. He stated that	F 725	compliance with regulatory requirements. 5. completion date: 8/31/2022	

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F 725	Continued From page 21 when there were scheduled staff members who couldn't make it in to work, he often tried to get a replacement by asking their staff first and then reaching out to a staffing agency if they had available staff members. The Scheduler stated on 7/25/22 when an agency nurse had called in, it was hard to get a nurse to come in because of the short notice so they ended up pulling Nurse #4 to work on the hall instead of doing treatments. An interview with the Director of Nursing (DON) and the Administrator on 7/29/22 at 4:39 PM revealed they tried to schedule enough staff to work but when things come up and they couldn't find anybody to replace them, then it was out of their control. The DON stated they used to have a supervisor who helped take over when a nurse called in, but she had been gone for about 2-3 weeks. The Administrator stated staffing hadn't been an issue until recently when the supervisor quit but they had just hired a nurse to replace her.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		8/31/22

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F 755	Continued From page 22 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff and Medical Director (MD) the facility failed to acquire and administer insulin per physician order. As a result, Resident #42 missed 3 doses of insulin within 8 days. This affected 1 of 7 residents reviewed for unnecessary medications (Resident #42). The findings included: Resident #42 was admitted to the facility on 03/08/22 with multiple diagnoses included diabetes mellitus (DM). Review of physician's order dated 03/23/22 stated Resident #42 was to receive sliding scale insulin (SSI) before meals and at bedtime. She would receive 2 units of Novolog, fast acting insulin, with capillary blood glucose (CBG) of 151 - 200	F 755	1. Insulin was made available and provided for Resident #42 as indicated by 7/10/22. 2. An audit will be conducted by the Director of Nursing and Assistant Director of Nursing by 8/31/22 on residents medical records with orders for insulin and verify that insulin is available. Any insulins not available a request will be sent to pharmacy. 3. All licensed nurses will be in-serviced by the Director of Nursing and/or the Assistant Director of Nursing by 8/31/22 on re-ordering insulin and administering insulin as ordered. Newly hired nurses and Licensed agency staff will be in-serviced prior to starting their first shift. Nurses on each hall and each shift will be inserviced to re-order medications as the	

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F 755	Continued From page 23 milligram per deciliter (mg/dl), and 4 units with CBG of 201- 250 mg/dl. The quarterly Minimum Data Set (MDS) assessment dated 06/10/22 coded Resident #42 with intact cognition and indicated she had received insulin daily in the 7-day assessment period. Review of the medication administration records (MAR) for July 2022 indicated Resident #42 did not get her 6:00 AM SSI when her CBG was 220 mg/dl and the 12:00 noon SSI when her CBG was 177 mg/dl on 07/02/22. On 07/09/22, Resident #42 did not get her 6:00 AM SSI when her CBG was 160 mg/dl. Review of medication administration histories revealed Nurse #1 was unable to locate Resident #42's Novolog on 07/02/22. On 07/09/22, Nurse #1 documented that the insulin was unavailable in the facility. An interview was conducted on 07/26/22 at 9:50 AM with Resident #42. She stated there were a few occasions that she did not get her SSI as indicated by the CBG. When she brought it up to the nurse, she was told that the facility had run out of her insulin. During a phone interview conducted with Nurse #11 on 07/26/22 at 6:47 PM. She confirmed she cared for Resident #42 on 07/01/22 from 3:00 PM through 11:00 PM. Resident #42 was not indicated to receive the 4:30 PM and 9:00 PM doses of SSI as her CBGs were low for both occasions. She could not recall the availability of Novolog in the medication cart in that evening.	F 755	quantity depletes to the specified reorder amount. If medications are not available in the 1st Dose machine, the nurse will be inserviced to notify the MD and to call the pharmacy immediately to have the medication delivered. 4. The Director of Nursing and/or the Assistant Director of Nursing will audit medication carts 5xper week x4 weeks then 3xper week for 4 weeks to verify insulin availability starting on 8/17/22.Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI Committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to ensure ongoing compliance with regulatory requirements. 5. Completion date: 8/31/2022	

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F 755	Continued From page 24 During a phone interview with Nurse #1 on 07/27/22 at 6:04 PM, she confirmed she was assigned to Resident #42 on 07/02/22 and 07/09/22. She stated the 6:00 AM doses of SSI on 07/02/22 and 07/09/22 were not administered as Novolog was unavailable for both occasions. She added once she realized that the facility had run out of Novolog, she reordered it through the pharmacy immediately. She did not know why the facility was out of Novolog and who was responsible to reorder the insulin before it ran out. An interview was conducted on 07/27/22 at 6:26 PM with the Director of Nursing (DON). She stated the nurses had the control of the medication carts and the medication records. They should check the availability of medication regularly to ensure reordering was in place before the last dose was to be given. It was her expectation for all the residents to receive insulin as ordered in timely manner. During a phone interview with the MD on 07/28/22 at 11:45 AM, he expected nursing staff to check the availability of insulin in medication cart regularly and communicate with each other to ensure reordering was in place in timely manner. An interview with the Administrator was conducted on 07/29/22 at 6:17 PM. He stated he expected the staff to follow the pharmacy protocol for reordering medications so that doses were not missed.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		8/31/22

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F 760	Continued From page 25 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interviews, the facility failed to prevent a significant medication error when they failed to acquire and administer insulin as ordered by the physician. As a result, Resident #42 missed 3 doses of insulin within 8 days. This affected 1 of 7 residents reviewed for unnecessary medications (Resident #42). The findings included: Resident #42 was admitted to the facility on 03/08/22 with multiple diagnoses included diabetes mellitus (DM). The physician's order dated 03/23/22 stated Resident #42 was to receive sliding scale insulin (SSI) before meals and at bedtime. She would receive 2 units of Novolog, rapid acting insulin, with capillary blood glucose (CBG) of 151 - 200 milligram per deciliter (mg/dl), and 4 units with CBG of 201- 250 mg/dl. The quarterly Minimum Data Set (MDS) assessment dated 06/10/22 coded Resident #42 with intact cognition and indicated she had received insulin daily in the 7-day assessment period. Review of the medication administration records (MAR) for July 2022 indicated the facility had failed to acquire and administer Novolog for Resident #42 per SSI when her 6:00 AM CBG was 220 mg/dl and the 12:00 noon CBG was 177 mg/dl on 07/02/22. On 07/09/22, the facility failed	F 760	1. Insulin was made available and provided for Resident #42 as indicated by 7/10/22. 2. An audit will be conducted by the Director of Nursing and/or the Assistant Director of Nursing on all orders for insulin to ensure the availability of the insulin by 8/31/22. 3. All licensed nurses will be in-serviced by the Director of Nursing and/or the Assistant Director of Nursing by 8/31/22 on obtaining insulin from the Emergency Drug supply, re-ordering insulin timely and administering insulin as ordered. Newly hired nurses will be provided access to the emergency drug supply during their orientation by the Director of Nursing. New hires and Licensed agency staff will be in-serviced prior to starting their first shift. Nurses assigned to each med cart each shift will be inserviced to reorder insulin as the quantity depletes to the specified reorder amount. If insulins are not available in the 1st Dose machine, the nurse will be inserviced to notify the MD if not administered as scheduled, and to call the pharmacy immediately to have the medication delivered. 4. The Director of Nursing, the Assistant Director of Nursing and/or charge nurse will audit medications carts 5xper week for 4 weeks then 3xper week for 4 weeks to verify insulin availability. Data obtained during the audit process will be analyzed	

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F 760	Continued From page 26 again to acquire and administer Novolog for Resident #42 when her CBG was 160 mg/dl. Further review of medication administration histories revealed Nurse #1 was unable to locate Resident #42's Novolog on 07/02/22. On 07/09/22, Nurse #1 stated the insulin was unavailable in the facility. An interview was conducted on 07/26/22 at 9:50 AM with Resident #42. She stated there were a few occasions that she did not get her SSI as indicated by the CBG. When she brought it up to the nurse, she was told that the facility had run out of her insulin. During a phone interview conducted on 07/26/22 at 6:47 PM. Nurse #11 confirmed she cared for Resident #42 on 07/01/22 from 3 PM through 11 PM. Resident #42 was not indicated to receive the 4:30 PM and 9:00 PM doses of SSI as her CBGs were low for both occasions. She could not recall the availability of Novolog in the medication cart in that evening. A phone interview conducted with Nurse #1 on 07/27/22 at 6:04 PM confirmed she was assigned to Resident #42 on 07/02/22 and 07/09/22. She stated the 6:00 AM doses of SSI on 07/02/22 and 07/09/22 were not administered as Novolog was unavailable for both occasions. She did not know why the facility was out of Novolog and who was responsible to reorder the insulin before it ran out. An interview was conducted on 07/27/22 at 6:26 PM with the Director of Nursing (DON). She stated the nurses had the control of the medication carts and the medication records. They should check the availability of medication regularly so that they could reorder before the last	F 760	for patterns and trends and reported to the QAPI Committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to ensure ongoing compliance with regulatory requirements. 5. Completion date: 8/31/2022	

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F 760	Continued From page 27 dose was to be given. It was her expectation for all the residents to receive insulin as ordered in timely manner. During a phone interview with the Medical Director (MD) on 07/28/22 at 11:45 AM, he stated missing 3 doses of insulin within 8 days was a significant medication error as it could trigger diabetic ketoacidosis (DKA), a life-threatening problem that affected people with diabetes. It occurred when the liver started to break down body fat too fast into a fuel consumed by body called ketones, in which it could cause the blood to become acidic. He expected nursing staff to check the availability of insulin in medication cart regularly and communicate with each other to ensure reordering was in place in timely manner. An interview with the Administrator was conducted on 07/29/22 at 6:17 PM. He expected the staff to follow the pharmacy protocol for reordering medications so that doses were not missed.	F 760		
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	F 761		8/31/22

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F 761	Continued From page 28 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 observations and staff interviews the facility failed to remove expired medications in accordance with the manufacturer's expiration date for 1 of 2 medication storage rooms (Main medication storage room), failed to lock the medication cart for 1 of 4 medication carts reviewed for medication storage, and failed to store eye drops prescribed for glaucoma in the medication cart for 1 of 1 resident observed with medications at bedside (Resident #68). The findings included: During an observation made on 07/27/22 at 10:28 AM, 7 unopened boxes of Flucelvax quadrivalent 2021-2022 formula influenza vaccines expired on 06/30/22 were found in the refrigerator in the main medication storage room. Each box contained 10 doses of 0.5 milliliter (ml) single-dose prefilled influenza vaccine, and they were available for use. An interview conducted with Nurse #2 on 07/27/22 at 10:32 AM revealed she did not know	F 761	1. Flu vaccine was removed from the med room and returned to pharmacy on 7/27/22. Med Cart was locked upon discovery on 7/25/22. Resident□s eye drops were returned to the secured med cart on 7/26/22. 2. By 8/31/22, an audit of all med carts, treatment carts, and med rooms will be conducted by the Director of Nursing, and/or the Assistant Director of Nursing to ensure meds are discarded according to manufacturer's expiration date. Any observed to be expired will be returned to the pharmacy. Rounds were conducted in resident□s rooms by Director of Nursing, and /or the Assistant Director of Nursing checking for meds at bedside starting 8/17/22. Any observed were returned to the med cart. The Director of Nursing also conducted rounds to ensure medication carts were locked when not attended. 3. In-service education will be provided by the Director of Nursing and/or the	

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F 761	Continued From page 29 who was responsible to check the medication storage room on regular basis. She stated when she pulled medication from the medication storage room, she would check the expiration date before putting it in her medication cart and check again each time before administration. During an interview conducted on 07/27/22 at 10:45 AM, the Assistant Director of Nursing (ADON) stated the Unit Manager (UM) was responsible to check the medication storage room at least once monthly to ensure all the medications were stored in proper temperature, condition, and free of expired medication. She explained the facility did not have an UM for about 3 weeks. She knew that those influenza vaccines were expired and planned to return them to the pharmacy but had forgotten to do it due to her oversight. An interview with the Director of Nursing (DON) on 07/27/22 at 11:02 AM revealed typically the night shift nurses who worked when the medication shipment arrived were responsible to put up the medications in the medication storage room. Other than the ADON or her designee checking the medication storage room at least once monthly or as needed, the consultant pharmacist had been checking the medication storage rooms during the monthly visit. In addition, she had checked the medication storage room randomly or as needed. She explained the facility had not been administering influenza vaccine for a while and it was an oversight. It was her expectation for the facility to be free of expired medication or vaccines. During an interview conducted on 07/29/22 at 6:17 PM, the Administrator stated it was his	F 761	Assistant Director of Nursing to all licensed nurses by 8/31/22 on discarding expired medications, keeping med carts locked, and keeping meds stored securely, including eye drops. Inservice will include that medications cannot be left at bedside without an order, being care planned or being properly secured. New licensed staff, and licensed agency staff will be in-serviced prior to starting their first shift. Nurses will be inserviced to check medications prior to administering during every med pass to ensure the medications have not surpassed their expiration date. The third shift nurse will check med storage room daily and remove any expired medications. 4. The Director of Nursing, Assistant Director of Nursing and/or charge nurse will audit, Medication storage areas to include medication carts, medications rooms and refrigerators for proper storage and expiration dates. Will also audit residents□ rooms to verify medications are not left at bedside. This auditing will be conducted five times per week for four weeks, then times per week for four weeks to ensure solutions are sustained. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI Committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to	

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F 761	Continued From page 30 expectation for the facility to remain free of expired medication. 2. During a continuous observation at the Main nurses' station on 7/25/22 from 2:24 PM to 2:47 PM, the 300 hall medication cart was observed with the lock mechanism in the unlocked position (the push-button to lock the medication cart was protruding about an inch from the medication cart). The medication cart was parked in front of the Main nurses' station. A housekeeper, a nurse aide and a nurse were all observed walking back and forth the hallway and passed the unlocked medication cart. Resident #3 parked his wheelchair beside the unlocked medication cart at 2:39 PM and was looking for the nurse to ask her a question about his medications. An interview with Nurse #10 on 7/25/22 at 2:57 PM revealed she knew she was supposed to lock the medication cart before leaving it unattended, but it probably didn't click all the way when she pushed the button to lock the medication cart. Nurse #10 stated she was in a hurry trying to get the new residents' medications in the cart which was probably how she missed locking the medication cart. An interview with the Director of Nursing on 7/29/22 at 3:49 PM revealed Nurse #10 should have made sure the medication cart was locked before leaving it unattended. 3. Resident #68 was admitted to the facility on 11/16/21 with multiple diagnoses including glaucoma. Review of a physician's order written on 05/31/22 was for Resident #68 to receive latanoprost 0.005% with directions to instill one drop into both	F 761	ensure ongoing compliance with regulatory requirements. 5. Completion date 8/31/22.	

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F 761	Continued From page 31	F 761		

eyes nightly for glaucoma. There was no order to self-administer medications.

Review of the quarterly Minimum Data Set (MDS) dated 06/28/22 assessed Resident #68's cognition as being intact.

Review of the July 2022 Medication Administration Record (MAR) revealed Nurse #3 initialed Resident #68's eye drops were administered at 9:00 PM on 07/25/22.

An observation on 07/26/22 at 8:33 AM revealed an opened bottle of latanoprost labeled with Resident #68's name was located on the bedside table available for use.

During an interview on 07/26/22 at 8:33 AM Resident #68 revealed she had received her eye drops from the nurse on the night shift on 07/25/22. Resident #68 stated her eye drops were administered at night and thought the night nurse on 07/25/22 forgot and accidentally left the drops on her bedside table. Resident #68 stated she didn't self-administer her eye drops the nurses did it for her.

An interview was conducted on 07/29/22 at 8:56 AM with Nurse #3. Nurse #3 confirmed his initials on the MAR meant that he administered eye drops for Resident #68 on 07/25/22 at 9:00 PM. Nurse #3 confirmed Resident #68 didn't have a physician order to self-administer, and the eye drops should be kept on the medication cart.

During an interview on 07/29/22 at 3:55 PM the Director of Nursing (DON) indicated finding latanoprost eye drops at the beside was mostly likely human error and thought it was possible

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F 761	Continued From page 32 Nurse #3 was distracted and left the drops in Resident #68's room. The DON revealed she knew Resident #68 didn't have a physician's order to self-administer and stated the eye drops should be kept on the medication cart.	F 761		
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 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;	F 842		8/31/22

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F 842	Continued From page 33 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff the facility failed to accurately document in the medical record an influenza vaccine was not administered for 1 of 6 residents reviewed for	F 842	1. Documentation related to the pressure ulcer treatment for Resident #33 was corrected upon discovery on 7/27/22 by the Director of Nursing.	

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F 842	Continued From page 34 immunizations (Resident #20); and failed to accurately document in the medical record a pressure ulcer treatment was not provided for 1 of 5 residents reviewed for pressure ulcers (Resident #33). The findings included: 1. Resident #20 was admitted to facility on 01/08/21 with diagnoses including dementia and history of stroke. Review of Resident #20's consent form for the influenza vaccine revealed it was declined on 01/07/21. Review of the significant change Minimum Data Set (MDS) dated 05/11/22 assessed Resident #20's cognition as being severely impaired. The MDS documentation indicated Resident #20 received the influenza vaccine in the facility on 10/19/2021. Review of the electronic medical record for immunizations revealed Resident #20 received an influenza vaccine on 10/19/21 in the facility and included the lot number and expiration date and location as given in the right deltoid. During an interview on 07/29/22 at 10:45 AM the Director of Nursing (DON) revealed the administration of the influenza vaccine on 10/19/21 in the electronic medical record for Resident #20 was inaccurate. The DON stated the information was entered by mistake and she expected the documentation in the residents electronic medical records to be accurate. 2. Resident #33 was admitted to the facility on	F 842	Documentation related to the flu vaccines has been identified as of 7/27/22. 2. An audit will be conducted by the Director of Nursing and Assistant Director of Nursing of resident vaccine records and pressure ulcer treatment records by 8/31/22. Any discrepancies found will be noted, and then brought to the attention of the person who completed the documentation for correction or clarification immediately. 3. The Director of Nursing and/or the Assistant Director of Nursing will provide education to all licensed nursing staff on the importance of documentation of administering medications and treatments as ordered by 8/31/22. New hires and agency staff will be in-serviced prior to the start of their first shift. The clinical team will review MAR and TAR documentation and progress notes daily during clinical meetings. 4. The Director of Nursing and /or the Assistant of Nursing will audit MARs, TARs and progress notes for accuracy 5xper for 4 weeks then 3xper for 4weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI Committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to ensure ongoing compliance with regulatory requirements. 5. Completion date is 8/31/2022.	

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5/24/22 with diagnoses that included pressure ulcer to the sacrum and pressure ulcer to the right heel.

A physician order dated 7/7/22 for Resident #33 indicated the following treatment to the stage 4 pressure ulcer to the left and right sacrum: cleanse with normal saline, apply zinc oxide to peri-wound, pack with ¼ (antiseptic) solution soaked gauze and cover with and abdominal pads once daily.

A physician order dated 7/23/22 for Resident #33 indicated the following treatment to the stage 3 pressure ulcer to the right heel: cleanse with normal saline, apply a honey-based gel wound dressing and cover with a foam adhesive dressing once daily.

A review of Resident #33's Treatment Administration Record (TAR) for July 2022 indicated the treatment orders for Resident #33's sacrum and right heel were marked as completed by Nurse #4 on 7/25/22.

An interview with Nurse #4 on 7/28/22 at 4:04 PM revealed she didn't have time to do Resident #33's treatments to her sacrum and right heel because she got pulled to work on a hall. When she documented Resident #33's wound care after she had done it on 7/26/22 on her electronic medical record, she had noted that the slot for 7/25/22 was red which meant it hadn't been done on that day, but she mistakenly clicked that it had been done. Nurse #4 stated she should have crossed it out and documented for the right day which was on 7/26/22.

An interview with the Director of Nursing (DON)

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F 842	Continued From page 36 on 7/29/22 at 3:49 PM revealed Nurse #4 should have paid attention to what she was documenting before clicking on the computer. The DON stated she should have crossed it out and not documented that the treatment was done when she didn't do it.	F 842		
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 possible communicable diseases or infections before they can spread to other	F 880		8/26/22

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F 880	Continued From page 37 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 observations, record review, and staff interviews, the facility: 1) failed to follow the "Special Droplet Contact Precautions" signage	F 880	F 880 Infection Prevention and Control 1. Nurse #12 was re-educated on 8/2/22 by the Director of Nursing regarding	

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F 880	Continued From page 38 posted by the door of a resident's room when 1 of 1 nursing staff (Nurse #12) did not sanitize hands and don gloves, gown and N95 mask prior to entering 1 of 4 resident rooms on droplet/contact precautions (Resident #180); 2) failed to follow their infection control policy and the Centers for Disease Control and Prevention (CDC) guidance by not placing newly admitted residents who were unvaccinated or not up-to-date with all recommended COVID-19 doses under quarantine for 4 of 4 sampled residents (Residents #127, #128, #229, and #230); and 3) failed to implement their infection control policies and procedures for hand hygiene when Nurse Aide #3, Nurse Aide #4, and Nurse Aide #5 did not remove their gloves and perform hand hygiene after providing incontinence care to soiled residents for 2 of 2 sampled residents (Resident #50 and #68). Findings included: 1. The Special Droplet Contact Precautions (SDCP) signage, with a revised date of 02/09/22, noted staff should follow the instructions listed on the signage before entering the resident's room which included: "all healthcare personnel must: 1) clean hands before entering and when leaving the room, 2) wear a gown when entering room and remove before leaving, 3) wear N95 or higher level respirator before entering the room and remove after exiting, 4) wear protective eyewear (face shield or goggles), and 5) wear gloves when entering room and remove before leaving." The facility's infection control policy, "COVID-10 Response Guidelines" with a revised date of 06/27/22 read in part, healthcare personnel should wear a N95 or higher-level respirator (or	F 880	Special Droplet Contact Precautions including sanitizing hands and donning gloves, gown, and N95 mask prior to entering a resident□s room who is on droplet/contact precautions, as with resident #180. The Director of Nursing and Assistant Director of Nursing were re-educated on 8/2/22 by the Regional Nurse Consultant regarding placement of newly admitted residents who are unvaccinated or not up to date with all recommended Covid-19 doses under quarantine. Nurse Aides #3, 4, and 5 were re-educated on 8/2/22 on hand hygiene during incontinence care as provided for resident #68 and #50. 2. Current facility residents were reviewed by the Director of Nursing on 7/25/22 for vaccine status. Determination was made as to whether isolation or quarantine protocols needed to be implemented and communicated to staff. No other residents were identified. Observations were made by the Director of Nursing on 7/27/22 for proper hand sanitizing including hand washing during incontinence care for the affected residents. 3. Re-education will be provided by 8/31/22 for all nursing staff by the Director of Nursing and Assistant Director of Nursing regarding Special Droplet Contact Precautions as related to vaccine status of newly admitted residents. Re-education will be provided by 8/31/22	

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F 880	Continued From page 39 facemask if a respirator is not available), eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown when caring for newly admitted residents who are not up-to-date with all recommended COVID-19 vaccine doses. Resident #180 was admitted to the facility on 07/26/22. A physician's order for Resident #180 dated 07/26/22 read in part, Resident #180 was unvaccinated for COVID-19. Quarantine for a minimum of 7 days, monitor for signs/symptoms of COVID, and perform a COVD test upon admission and every 3-5 days for 7 days. May discontinue quarantine on 08/02/22 if all COVID tests were negative and no signs or symptoms of COVID-19. During an observation on 07/26/22 at 1:30 PM, SDCP signage was posted on the wall beside Resident #180's room door and a 3-drawer plastic container containing extra Personal Protective Equipment (PPE) was located on the floor of the hallway beside Resident #180's room door. Nurse #12 was observed walking down the hall toward Resident #180's room wearing goggles and a pink KN95 facemask. Upon arriving at Resident #180's door, Nurse #12 opened the door and entered the room without sanitizing her hands and donning gloves, gown and N95 facemask. During an interview on 07/26/22 at 1:32 PM, Nurse #180 revealed she had received infection control education related to sanitizing hands and donning/doffing PPE when entering and exiting resident rooms on isolation precautions. Nurse	F 880	for all nursing staff by the Director of Nursing and Assistant Director of Nursing regarding donning and doffing Personal Protective Equipment. Re-education will be provided by 8/31/22 for all nursing staff by the Director of Nursing and the Assistant Director of Nursing regarding Hand Hygiene during incontinent care. New hires and agency staff will be in-serviced on these topics before starting their first shift. Incontinent Care observations will be conducted by the Director of Nursing and Assistant Director of Nursing to ensure proper infection control protocols are being adhered to consistently starting 8/17/22. These will be done five times a week for four weeks, then three times a week for four weeks to ensure solutions are sustained. Infection Control rounds will be made five times a week for four weeks, then three times a week for four weeks by the Director of Nursing or designee focusing on handwashing, special signage, and wearing of Personal Protective Equipment as indicated. All new admissions will be reviewed prior to admission for vaccine status by the administrative team during morning meeting to determine isolation status. New admission rooms will be pre-set with isolation signage on the door and Personal Protective Equipment will be placed outside the room for weekend admissions, if vaccine status has not been determined prior to admission to the facility.	

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F 880	Continued From page 40 #12 confirmed she did not perform hand hygiene or don the appropriate PPE as instructed on the SDCP signage prior to entering Resident #180's room. Nurse #12 explained she had been in and out of Resident #180's room all day and had doffed the PPE she exited the room to go and get something for Resident #180 but forgot to don any additional PPE when briefly reentering Resident #180's room just now. Nurse #12 confirmed she was instructed to don/doff PPE every single time when entering and exiting rooms on SDCP. During an interview on 07/26/22 at 2:17 PM, the Director of Nursing (DON) stated staff were trained to read precaution signage and follow the instructions for PPE to be worn. The DON stated she would have expected Nurse #12 to don/doff PPE as instructed on the SDCP signage when entering/exiting Resident #180's room. During an interview on 07/29/22 at 6:17 PM, the Administrator stated all staff were expected to follow the instructions for donning/doffing PPE as specified on the SDCP signage. 2. The Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," updated on 02/02/22 indicated the following information under "Manage Residents with Close Contact": *Manage Residents who had Close Contact with Someone with SARS-CoV-2 infection: *Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in	F 880	If facility is unable to obtain vaccine status of new admit prior to arrival, then the new resident will be placed under quarantine by floor nurse upon arrival to facility until vaccine status can be determined. Administrative Nurses and Admissions Director will communicate potential new admits to the floor nurses, so that necessary precautions can be put into place immediately upon the new resident□s arrival. The Admissions Director and Licensed Nurses will be inserviced regarding this new procedure by 8/31/22. 4. Date obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assurance/Performance Improvement Committee (QAPI) by the Director of Nursing monthly for three months. At that time, the QAPI Committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. The QAPI Committee will continue to review monthly during QAPI to ensure ongoing compliance with regulatory requirements. 5. Completion date is 8/26/22.	

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quarantine after their exposure, even if viral testing is negative. HCP (healthcare personnel) caring for them should use full personal protective equipment (PPE) (gowns, gloves, eye protection, and N95 or higher-level respirator).

The facility's infection control policy under "COVID-19 Response Guidelines" revised on 06/27/22 indicated HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for newly admitted residents who are not up to date with all recommended COVID-19 vaccine doses.

Resident #127 was admitted to the facility on 07/21/22.

Review of Resident #127's vaccination records revealed she had never been vaccinated with COVID-19 vaccine.

Resident #128 was admitted to the facility on 07/23/22.

Review of Resident #128's vaccination records revealed his COVID-19 vaccination was not up to date according to the facility's COVID-19 response guidelines.

An observation on the 400 hall on 07/25/22 at 10:02 AM revealed the rooms for Resident #127 (room 406 B) and Resident #128 (room 408 A) were not under quarantine. No signage or PPE were seen outside the rooms. Nurse #4 and Nurse Aide (NA) #2 were observed entering both rooms without gown, gloves, and N95 mask to provide care to both residents between 10:02 AM

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through 11:18 AM.

When this writer returned to the 400 hall on 07/25/22 at 12:15 PM, a special droplet/contact precaution signs were posted on Resident #127's and Resident #128's door. A plastic drawer cart which contained N95 masks, face shields, gowns and gloves was located beside Resident #127's and Resident 128's door respectively. The sign indicated the following instructions: clean hands before entering and when leaving room, wear a gown when entering and remove before leaving, wear N95 or higher-level respirator before entering the room and remove after exiting, wear protective eyewear and gloves when entering room and remove before leaving, place resident in private room and keep door close (if safe to do so).

An interview with NA #2 on 07/25/22 at 1:14 PM revealed neither the PPE nor the special droplet/contact precaution signs were in place for Resident #127's and Resident #128's room when she worked last Friday and this morning. The Assistant Director of Nursing (ADON) told her around noon that Resident #127 and Resident #128 were now under special droplet/contact precaution because of their COVID-19 vaccination status.

During an interview with Nurse #4 on 07/25/22 at 2:27 PM, she acknowledged that she had administered medications to both Resident #127 and Resident #128 this morning without wearing gown, gloves, and N95 mask. She did not know both residents were under special droplet/contact precaution as there were no signage's to identify that she needed to wear additional PPE's before entering. The ADON put both residents under

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special droplet/contact precaution just before lunch and told her that they had not been fully vaccinated. Typically, the Director or Nursing (DON) or the ADON reviewed all new admissions and would inform the floor nurse during admission to place the resident under special droplet/contact precaution as indicated.

An interview with the ADON on 07/25/22 at 2:56 PM revealed she and the DON were responsible to track COVID-19 vaccination status for new admission and place resident under special droplet/contact precaution as indicated. However, she was off last Friday through Sunday. She ordered to place Resident #127 under special droplet/contact precaution for 7 days on 07/21/22 and did not know why the order was not implemented. The ADON explained she was not working when Resident #128 was admitted. She added when she reviewed the admission list and vaccination status this morning, she noticed that both Resident #127 and Resident #128 were not up to date with all the recommended COVID-19 vaccine doses and required a 7-day quarantine.

During an interview conducted on 07/26/22 at 2:09 PM, the DON acknowledged that she had failed to communicate with the floor nurse last weekend causing residents who required quarantine were not properly quarantined. It was her expectation for the staff to follow CDC's recommendations and facility's infection control policy when admitting new resident.

An interview with the Administrator on 07/29/22 at 6:17 PM revealed he expected the facility to follow CDC's recommendations to quarantine newly admitted residents as indicated.

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3. The Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," updated on 02/02/22 indicated the following information under "Manage Residents with Close Contact":
*Manage Residents who had Close Contact with Someone with SARS-CoV-2 infection:
*Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. HCP (healthcare personnel) caring for them should use full personal protective equipment (PPE) (gowns, gloves, eye protection, and N95 or higher-level respirator).

The facility's infection control policy under "COVID-19 Response Guidelines" revised on 06/27/22 indicated HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for newly admitted residents who are not up to date with all recommended COVID-19 vaccine doses.
Resident #229 was admitted to the facility on 07/22/22.

Review of immunization records for Resident #229 revealed one dose of a multi-dose COVID-19 vaccine was received on 03/17/21.

Resident #230 was admitted to the facility on 07/20/22.

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Review of immunization records for Resident #230 revealed one dose of a single dose COVID-19 vaccine was received on 04/12/21.

An observation made on 07/25/22 at 10:58 AM revealed no sign on the entry doors to indicate special droplet/contact precautions were in place for Resident #229 and #230. There was signage beside the entry doors with instructions on how to properly don and doff personal protective equipment (PPE), but no visible storage bins of PPE located on hall 400.

During an interview on 07/25/22 at 11:05 AM Nurse Aide (NA) #2 revealed she was assigned to provide care for residents residing on the 400 hall, rooms 400 through 411. NA #2 revealed the 400 hall was designated for newly admitted residents and she was not aware of anyone placed on special droplet/contact precautions or being quarantined. NA #2 revealed the signs for PPE with instructions on how to don and doff were kept in place as a reminder and always posted.

An observation made on 07/25/22 at 1:12 PM revealed new signage posted on the entry doors to Resident #229 and #230's room along with a storage bin of PPE placed in the hall outside each door. The sign read in part; "special droplet contact precautions with directions to clean hands before entering and when leaving the room. Wear gloves and gown when entering and remove before leaving. Wear a N-95 or higher-level respirator before entering the room and remove after exiting and wear protective eyewear."

During an interview on 07/25/22 at 1:14 PM NA #2 revealed the storage bins of PPE and special

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droplet/contact signage were not in place when she last worked hall 400 on 07/22/22. NA #2 revealed the Assistant Director of Nursing (ADON) told her Residents #229 and #230 were not fully vaccinated and were being placed on special droplet/contact precautions. NA #4 revealed she hadn't donned PPE prior to entering either room until after the signage was placed to inform her.

During an interview on 07/25/22 at 2:27 PM Nurse #4 revealed she was not aware Residents #229 and #230 should've been placed on droplet/contact precautions or quarantine until just before lunch when the ADON placed the signage on the doors and storage bins of PPE in the hall. Nurse #4 revealed she didn't don or doff PPE prior to administering morning medications to Residents #229 and #230 when there was no signage posted to inform her. Nurse #4 explained typically the Director of Nursing (DON) or ADON reviewed newly admitted residents vaccination status and inform the admitting nurse to place the resident under droplet/contact precautions or quarantine.

An interview was conducted on 07/25/22 at 3:10 PM with the ADON. The ADON revealed either her or the DON inform the nurses when to quarantine a resident. The ADON explained her, and the DON were at a conference on 07/22/22 and she didn't work over the weekend and unsure who was responsible to check the vaccination status for newly admitted residents when they were not available. The ADON revealed when she reviewed the list of new admissions and their vaccination status on 07/25/22 Residents #229 and #230 were not up to date with their recommended COVID-19 vaccines therefore she

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placed the special droplet/contact precaution signage and storage bins of PPE. The ADON revealed Residents #229 and #230 should have been quarantined and placed under special droplet/contact precautions for 7 days upon their admission.

During an interview on 07/26/22 at 2:09 PM the DON stated they had dropped the ball to ensure Residents #229 and #230 were placed on quarantine with special droplet/contact precautions. The DON added the admitting nurses also didn't take the initiative to check Residents #229 and #230's vaccination status. The DON explained the hospital sent the resident's vaccination status prior to admission and either her or the ADON would communicate the information to the admitting nurse. The DON explained neither her or the ADON worked on 07/22/22 and there was a lack of communication between Department Heads and the admitting nurse. The DON revealed she expected newly admitted residents who were not up to date with their COVID-19 vaccines were placed under quarantine with special droplet/contact precautions upon admission.

An interview was conducted on 07/29/22 at 6:17 PM with the Administrator. The Administrator revealed he expected the facility to follow CDC's recommendations to quarantine newly admitted residents as indicated.

4. Review of the facility's policy titled "Hand Hygiene" revised July 2022 read in part as follows, "The purpose of the Hand Hygiene policy is to provide guidelines for staff in utilizing hand hygiene. Appropriate hand hygiene is essential in preventing transmission of infectious agents.

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This facility considers hand hygiene the primary means to prevent the spread of infections. Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and the environment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections."

A continuous observation of NA #3 and NA #4 provide care to Resident #68 for an episode of urinary incontinence was made on 07/27/22 from 5:40 PM to 5:50 PM. NA #3 entered the room and washed her hands using soap and water from the sink located in the resident's room. A dispenser of alcohol-based hand sanitizer was attached to the inside wall by the entry door of the room and Resident #68's bed was located by the window. NA #4 started incontinence care for Resident #68 by wiping the front perineal area clean. Without performing hand hygiene, NA #4 repositioned Resident #68 onto her side while NA #3 cleaned the buttocks area. Without performing hand hygiene both NA #3 and NA #4 repositioned Resident #68 to put on a clean brief then elevated the legs off the bed with a pillow then adjusted the bed linens to cover Resident #68. Without performing hand hygiene NA #4 also used the remote to adjust the head of the bed.

An interview was conducted on 07/27/22 at 5:50 PM with NA #3. NA #3 revealed she missed a step with infection control during incontinence

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care for Resident #68. NA #3 revealed she should have removed her gloves and washed her hands after Resident #68 was wiped clean for an episode of urine incontinence before she continued care.

An interview was conducted on 07/27/22 at 5:55 PM with NA #4. NA #4 confirmed she did not remove her gloves or perform hand hygiene during incontinence care for Resident #68. NA #4 revealed she was unsure when to perform hand hygiene during incontinence care and was uncomfortable leaving a resident to wash her hands in fear they might fall from the bed and get hurt.

An interview was conducted on 07/27/22 at 6:11 PM with the Director of Nursing (DON). The DON stated she would expect after a resident was wiped clean during incontinence care NA staff would remove their gloves and perform hand hygiene. The DON stated she did stress to nursing staff they should wash their hands before and after care.

5. Review of the facility's policy titled "Hand Hygiene" revised July 2022 read in part as follows, "The purpose of the Hand Hygiene policy is to provide guidelines for staff in utilizing hand hygiene. Appropriate hand hygiene is essential in preventing transmission of infectious agents. This facility considers hand hygiene the primary means to prevent the spread of infections. Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately after gloves are removed; and when otherwise indicated to avoid transfer of

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microorganisms to other residents, personnel, equipment and the environment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections."

A continuous observation of Nurse Aide (NA #5) on 07/27/22 from 09:20 AM to 09:28 AM revealed NA #5 provided urinary incontinence care for Resident #50 who was in the bed closest to the door of the room. With gloved hands, NA #5 cleaned urine with resident care wipes, removed the wet brief and placed it in a trash bag, placed a clean brief under Resident #50, secured the tabs of the brief, pulled down Resident #50's gown, pulled up Resident #50's bed cover, and removed her soiled gloves. NA #5 performed hand hygiene, tied up the trash bag containing the soiled brief, placed the trash bag in the soiled utility, and performed hand hygiene by using the dispenser of alcohol-based hand rub attached to the wall by the entry door of the room. NA #5 did not remove her gloves and perform hand hygiene after removing urine during incontinence care and touched Resident #50's gown and bed covers while wearing soiled gloves.

An interview with NA #5 on 07/27/22 at 09:35 AM revealed she had been trained to remove her gloves and perform hand hygiene after performing incontinence care. She stated it was an oversight that she did not remove her gloves and perform hand hygiene after performing incontinence care for Resident #50.

An interview with the Director of Nursing (DON) on 07/27/22 at 06:15 PM revealed she expected

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F 880	Continued From page 51 staff to remove soiled gloves and perform hand hygiene after cleaning urine. An interview with the Administrator on 07/29/22 at 04:33 PM revealed he expected staff to follow the hand hygiene policy.	F 880		