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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		11/16/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/04/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to establish and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to include/document facility based and community-based risk assessment, failed to address persons at risk, failed to establish policies and procedures, failed to develop a system to track residents' and staff, failed to maintain/ update current contacts, review and update the communication plan, update names and contact information, share information with residents or family members and failed to complete a tabletop or full-scale exercise and EP education. Findings included: A review of the facility's Emergency Preparedness plan 9-22-22 revealed: a. The EP plan did not contain a facility based and community-based risk assessment utilizing an all-hazards approach. b. The EP plan did not address persons at risk or the type of services the facility had the ability to provide. c. The EP plan did not have policies and procedures regarding the EP plan that would address at a minimum provision of subsistence, alternate source of energy, temperatures to	E 001	This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated. Corrective Action The facilities HVA was updated on 10-13-2022 The Executive Director attended an Emergency Preparedness education session on 10-31-2022. The facilities Emergency Preparedness Plan was updated on 11-16-2022 to include facility and community based risk assessment using an all hazards approach, identify persons at risk (all residents and staff have the potential to be affected) and a list of the facility’s service capabilities, policies and procedures for provision of subsistence, alternate energy sources, protection of residents health and safety, emergency lighting, fire detection, and handling of waste, a system for medical documentation to preserve resident	

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E 001	Continued From page 2 protect residents' health and safety, emergency lighting, fire detection and sewage and waste. d. The EP plan did not have a system for tracking residents or staff during an emergency e. The EP plan did not have a system documented for medical documentation that would preserve resident information. f. The EP plan did not have a communication plan in place to communicate with resident's family/representative nor did the plan include names and contact information for staff and resident's physician. The Plan also did not address an alternate means of communication, a method for sharing information and medical documentation with other health care providers. g. The EP plan did not include evidence of a training and testing program that would include a tabletop or community-based training and a yearly training program for staff. The Administrator was interviewed on 10-13-22 at 3:45pm. The Administrator stated the binder he had provided for the EP plan was the completed EP plan for the facility. He reviewed the Emergency Preparedness Worksheet (list of items required in an Emergency Preparedness plan) and said he had not ever had any of the information on the worksheet as part of his EP plan and was unaware the information on the worksheet needed to be part of the facility's EP plan.	E 001	information, a system to track residents and staff if they must evacuate the facility, a list of current contacts including staff and resident physician, information will be shared with families and staff through our VoiceFriend App and through Epic with local healthcare providers, and documentation of a table top/ full-scale exercise and EP education. Systemic Changes The facility safety committee, consisting of the Administrator, DON, ADON, Staff Development, Maintenance Director, Housekeeping Manager, Medical Records, and Central Supply Clerk met on 11-3-2022 to review the HVA and discuss corrections/updates to the EP Plan. The changes/updates were completed and reviewed by the safety committee(Administrator, DON, ADON, Staff Development, Maintenance Director, Housekeeping Manager, Medical Records, and Central Supply Clerk) on 11-16-2022. Quality Assurance The changes/updates to the HVA and Emergency Preparedness plans will be reviewed by the QAPI committee at their next scheduled meeting. The HVA and Emergency Preparedness Plan will be reviewed annually by the facility safety committee.	
F 000	INITIAL COMMENTS A recertification and complaint investigation were	F 000		

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F 000	Continued From page 3 conducted from 10/10/22 through 10/13/22. Event ID# G01E11. The following intakes were investigated NC00184734, NC00185472, NC00185957, NC00187421, NC00191357, NC00193640. One of the 12 complaint allegations was substantiated but did not result in a deficiency. Eight of the 12 complaint allegations were substantiated resulting in deficiencies. Past-noncompliance was identified at CFR 483.25 at tag F689 at a scope and severity (G).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		11/16/22

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F 550	Continued From page 4 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to keep 2 of 2 residents (Resident #78 and Resident #77) covered while providing care and the facility failed to provide incontinent care for 1 of 7 residents (Resident #16) who stated he felt "mad" and "ignored". Findings included: 1.Resident #78 was admitted to the facility on 9-2-22 with multiple diagnoses that included nontraumatic subarachnoid hemorrhage and hydrocephalus. The 5-day Minimum Data Set (MDS) revealed Resident #78 was severely cognitively impaired. An observation of Activities of Daily Living (ADL)	F 550	Corrective Action for the Resident Affected On 10/10/22 (8) and 10/13/2022 (13), the Director of Nursing (DON) provided 1:1 re-education to NA #8 and NA #13 on incontinent care and keeping the residents covered while providing incontinent care. On 10/12/22, the DON provided 1:1 re-education to Nurse Practitioner (NP) #1 and the treatment nurse on closing the window blind when assisting in performing treatments. On 11/1/22, the DON spoke to resident #16 about how he felt mad and ignored, the DON apologized for how the resident felt and reassured him it would be addressed with staff.	

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care occurred on 10-13-22 at 10:48am with Nursing Assistant (NA) #13. The NA was observed providing Resident #78 a full bed bath. He was observed removing the resident's gown, not covering Resident #78's lower half, leaving the resident laying in the bed with a brief. NA #13 washed the upper half of the resident's body then removed the resident's brief without covering the upper half of the resident's body. The NA was observed to continue completing Resident #78's bath leaving the resident fully exposed with no cover or brief. Once the bath was completed, the NA left Resident #78 on his back fully exposed as the NA cleaned up the dirty linen. NA #13 was then observed to place a brief and gown on the resident.

NA #13 was interviewed on 10-13-22 at 11:10am. The NA discussed his usual practice was to keep the resident covered during a bath but stated he did not think about covering Resident #78 because he was hurrying, and he was nervous. NA #13 said since the resident did not have a privacy curtain it would have been better to cover the resident in case someone walked into the room.

The DON was interviewed on 10-13-22 at 1:00pm. The DON discussed being pleased NA #13 provided good care, but she expected staff to maintain resident dignity and privacy during care.

2. Resident #77 was admitted to the facility on 5-25-21 with multiple diagnoses that included pressure ulcer stage 4 of sacral region.

The quarterly Minimum Data Set (MDS) dated 8-31-22 revealed Resident #77 was cognitively intact.

F 550

Corrective Action for the Residents Potentially Affected
On 11/2/2022, the DON and or Administrative Nurses reviewed all other residents requiring incontinent care. Of 93 residents, 81 require bladder incontinent care.
On 11/2/2022, the DON and or Administrative Nurses reviewed all other residents requiring incontinent care, 81 require bladder incontinent care 35 residents require increase monitoring for their incontinence care and made corrections in the electronic health record.
On 11/2/2022, the DON and or Administrative Nurses reviewed all other residents requiring treatments. Of 93 residents, 23 receive treatments.
On 11/8/2022, the DON and or Administrative Nurses reviewed all other residents that had a diagnosis of speech deficits. Of the 92 residents, 18 have unclear speech-slurred or mumbled words, 5 with no speech and out of both categories 2 use an alternative way of communication.

Systemic Changes
On 11/2/2022-11/9/2022, the Staff Development Coordinator in-serviced Licensed Nursing staff and Certified Nursing Assistants on incontinent care, monitoring more frequently and keeping residents covered while providing incontinent care to maintain dignity. Agency staffing was included on this in-service. Any staff including agency staff not available for the in-service, will be educated prior to their next scheduled

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An observation of wound care occurred on 10-12-22 at 10:21am with the Treatment Nurse and Nurse Practitioner (NP) #1. Resident #77's window blind was open, and the window was observed to be facing the driveway and walkway. The Treatment Nurse was observed to turn the resident on her side and remove Resident #77's brief allowing the resident's buttocks to be exposed to the open window blind.

The Treatment Nurse was interviewed on 10-12-22 at 10:33am. The Treatment Nurse stated she should have closed the blind because anyone walking by could have seen Resident #77's buttocks. She commented she did not think about closing the blind or the window being a breech of dignity and privacy.

During an interview with the Director of Nursing (DON) on 10-12-22 at 3:08pm, the DON stated the Treatment Nurse should have closed the blind in Resident #77's room so the resident would not have been exposed to anyone walking by. She also said she expected staff to provide respect and dignity to all residents when providing care.

The Administrator was interviewed on 10-13-22 at 3:58pm. The Administrator stated all staff needed to provide privacy and dignity to all residents when receiving care.
3) Resident #16 was admitted to the facility on 4/2/22. His diagnoses included hemiplegia of the right dominant side, speech deficit, diabetes, and chronic obstructive pulmonary disease.

The quarterly Minimum Data Set (MDS) assessment dated 7/8/22 indicated he was moderately cognitively impaired. He required

F 550

shift.
On 11/7/2022, the Staff Development Coordinator added incontinent care, monitoring more frequently per electronic health record and keeping residents covered to maintain dignity while providing care added to the orientation packet for new hires.
The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with a diagnosis of bladder incontinence are being covered while receiving incontinent care and are being monitored more frequently for incontinence per electronic health record, utilizing the QA monitoring tool for Privacy during incontinence care and changing the residents more frequently.
On 11/2/2022- 11/9/2022, The Staff Development Coordinator in-serviced the Licensed Nursing staff on ensuring that the window treatments are closed to maintain dignity while performing treatments. Agency staffing was included on this in-service. Any staff including agency staff not available for the in-service, will be educated prior to their next scheduled shift.
On 11/7/2022 Ensuring that the window treatments are closed while performing treatments was added to the orientation packet for new hires.
The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with an order for treatments are receiving

F 550

Continued From page 7

extensive assistance with all activities of daily living including toileting, bathing, and personal hygiene. He was always incontinent of bowel and bladder.

The care plan for Resident #16 indicated he had impaired mobility related to right sided hemiplegia. The approaches included assist with ADLs to completion and assist resident with toileting needs PRN (as needed).

On 10/10/22 at 2:22 PM Resident #16 reported the last time he had received incontinent care was on the 11:00 PM to 7:00 AM shift. He acknowledged he was soiled and had been wet for a long time.

On 10/10/22 at 2:55 PM an observation of incontinent care was completed with Nurse Aide (NA) #8 and revealed Resident #16's adult brief was saturated with a dark dry ring on the inside. The Resident's under pad was noted to be wet with a dark dry ring around the edges. The Resident's gown was noted to be wet.

On 10/10/22 at 3:18 PM NA #8 said she and NA #9 worked together to meet the residents' needs but she was assigned to Resident #16. She said she provided incontinent care to Resident #16 between 8:00 and 9:00 AM that morning. She said the resident's pad was dirty when she provided care, but there were no clean pads available, so she used a folded sheet instead of a pad. When asked about the resident having a soiled pad, she stated there were no pads in the clean utility room. She said she was told by the 11:00 PM - 7:00 AM shift that Resident #16 received a partial bath that morning so she did not provide a bath for Resident #16.

F 550

their treatments with the window treatment closed utilizing the QA monitoring tool for keeping the window treatment closed while performing treatments.
On 11/9/2022, The Staff Development Coordinator in-serviced the Licensed Nursing staff and Certified Nursing Assistants on how to communicate with residents with speech deficits, including those that require using a communication board. The in-service also included to use respect and dignity, slowing down and understanding the proper communication needs. Agency staffing was included on this in-service. Any staff including agency staff not available for the in-service, will be educated prior to their next scheduled shift. All new hires will receive this in-service during the orientation process.
The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with speech deficits and utilizing communication boards are communicated with respect and dignity utilizing the QA monitoring tool for resident with speech deficits.

Quality Assurance
The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review by the Interdisciplinary Team members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to

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F 550	Continued From page 8 On 10/11/22 at 3:00 PM NA #10 reported she worked on the 11:00 PM to 7:00 AM shift on 10/10/22 and was assigned to Resident #16. She reported she provided incontinent care to him between 12:30 AM and 1:00 AM then again at 4:00 AM and around 6:00 AM. She said she did not provide a full bath. On 10/13/22 at 3:30 PM the Director of Nursing (DON) stated the NA should be checking the residents more frequently as least every 2-3 hours and a resident should not remain in wet briefs for an entire shift. On 10/13/22 at 4:00 PM Resident #16 stated being left wet during the 7:00 AM - 3:00 PM shift on 10/10/22 made him feel mad and ignored because he did not have a voice. He felt the staff did not provide care to him because he could only communicate with his communication board.	F 550	evaluate and modify monitoring as needed.	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		11/16/22

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§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident and staff interviews, the facility failed to (1) honor resident choice to receive a shower for 2 of 2 residents (Resident #82 and Resident #77), (2) honor resident choice when to receive tracheostomy care and enteral feedings for 1 of 1 resident (Resident #16) and the facility failed to (3) honor resident choice to receive double portions as ordered by the Physician for 1 of 1 resident (Resident #25) reviewed for choices.

Findings included:

1 Resident #82 was admitted to the facility on 8-18-19 with multiple diagnoses that included hemiplegia affecting nondominant side.

The quarterly Minimum Data Set (MDS) dated 9-2-22 revealed Resident #82 was mildly cognitively impaired with no documentation of refusal of care. The MDS documented Resident #82 required extensive assistance with one person for bed mobility, dressing, personal

F 561

Corrective Action for the Resident Affected
On 11/1/2022, the Director of Nursing (DON) met with resident's #82 and #77 to discuss their showers and what days they would like the showers on. Both Residents was offered showers 2x's /week. Resident #82 stated they would like their showers on Thursdays during 2nd shift and only one shower per week. Resident #77 stated they would like their showers on
Tuesdays during 2nd shift, and once a week for now. The resident's care plans were updated to reflect their choices.
On 11/1/2022, the DON met with resident #16 to discuss when they would like to receive their tracheostomy care and enteral bolus feedings. Resident #16 stated they would like their tracheostomy care for 11-7 shift to be on or around 6 am and their enteral bolus feedings during the hours of 7am-11pm. The residents care

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hygiene, total assistance with 2 people for transfers and total assistance with one person for toileting and bathing. The MDS also documented Resident #28 choosing a tub or bed bath or shower was very important to him.

Resident #82's care plan dated 9-2-22 revealed a goal of Activities of Daily Living (ADL) constant. The interventions for the goal were provide a shower on scheduled shower days.

An attempt was made to locate the facility's shower schedule for Resident #82 however there was not a shower schedule available.

Review of Resident #28's bathing documentation from August 2022 through October 2022 revealed the resident had not received a shower but had consistently received a bed bath.

Resident #82 was interviewed on 10-10-22 at 11:20am. The resident discussed receiving a bed bath daily but stated he would like to have a shower "at least once a week." Resident #82 commented he had not received a shower "in a very long time."

Nursing Assistant (NA) #13 was interviewed on 10-12-22 at 7:13am. The NA stated he had been working at the facility for a month and had never seen a shower schedule. He discussed never providing a shower to a resident nor being informed that he needed to be providing showers to residents. NA #13 stated he had been assigned to Resident #82 and that the resident had requested a shower, but he did not provide a shower to him because he was not aware he needed to provide showers.

F 561

plan was updated to reflect their choices.
On 11/2/2022, the Dietary Manager met with resident #25 and discussed their double portions as ordered.

Corrective Action for the Residents Potentially Affected
On 11/2/2022, the DON and or Administrative Nurses met with all other residents with a BIMS score of 9 and above and discussed their shower schedules. 5 out of 34 requested their showers to be changed. Changes were made and their care plans updated to reflect their choices.
On 11/2/2022, the DON and or Administrative Nurses met with all other residents with a BIMS score of 9 and above and discussed their tracheotomy care. 1 of 2 requested their tracheostomy care to be performed on 11-7 shift @ 6am as mentioned in the corrective action above. Changes were made and their care plan updated to reflect their choices.
On 11/2/2022, the DON and or Administrative Nurses reviewed all other residents receiving enteral feedings. The DON and or Administrative Nurses reviewed their BIMS score and those with a 9 and above were asked when they preferred their Bolus feedings. One of One requested their bolus feedings to be changed. Changes were made and their care plans updated to reflect their choices.
On 11/2/2022, the Dietary Manager reviewed the last 30 days of dietary orders to ensure that any residents with a diet order of double portions was reflected on

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An interview with NA #14 occurred on 10-12-22 at 7:20am. NA #14 stated the facility did not have care guides for the residents, but the NAs could look in the computer for the residents required care. She stated she was familiar with Resident #82 and said she was not aware of the resident's shower days because they no longer had a shower schedule. NA #14 stated she could not remember if the resident ever requested a shower and she had never provided a shower to Resident #82.

During an interview with NA #11 on 10-12-22 at 7:24am, the NA stated she had not seen a shower schedule but would provide a shower if the resident requested. NA #11 stated she was familiar with Resident #82 and said he had requested a shower in the past, but she did not give him one because she did not feel comfortable showering the resident.

Nurse #7 was interviewed on 10-12-22 at 7:28am. The nurse discussed the facility stopping all showers when COVID19 started 2 years ago. She stated since then she had not been provided a shower schedule for the residents and had not seen any of the residents including Resident #82 receive a shower.

The Assistant Director of Nursing (ADON) was interviewed on 10-12-22 at 7:55am. The ADON stated showers had stopped when COVID19 started but said she did not know why. She explained the staff were educated 2 months ago on resident showers restarting. The ADON explained the showers were supposed to start back on hall 200 west first and then the facility would gradually start showers back on the other halls. She explained since Resident #82 resided

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their tray ticket.

Systemic Changes
On 11/2/2022, the Staff Development Coordinator in-serviced the Licensed Nursing staff and Certified Nursing Assistants on residents’ self-determination and or choices. Specifically, the resident’s shower. Agency staffing was included on this in-service. Any staff including agency staff not available for the in-service, will be educated prior to their next scheduled shift.
On 11/7/2022, the Staff Development Coordinator added the education on residents’ self-determination and or choices to the Orientation packet for choices and preferences of showers for Licensed Nursing staff and Certified Nursing Assistants.
The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents are receiving their showers per their choice, utilizing QA monitoring tool for self-determination - Showers.
On 11/2/2022, the Staff Development Coordinator in-serviced the Licensed Nursing staff on self-determination and or choices with tracheostomy care. Agency staffing was included on this in-service. Any staff including agency staff not available for the in-service, will be educated prior to their next scheduled shift.
On 11/7/2022, the Staff Development Coordinator added to the Orientation process to include Self-determination and

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on hall 200 east there would not be a shower schedule for him yet since the new schedule started on hall 200 west.

The Director of Nursing (DON) was interviewed on 10-12-22 at 8:05am. The DON stated the facility had not been providing showers to the residents since the start of COVID. She explained the facility had to work on preparing the shower rooms by disinfecting before showers could resume. The DON discussed hall 200 west was supposed to start back showering the residents on their assigned days but said the facility had struggled in reimplementing showers into the NAs schedule.

2. Resident #77 was admitted to the facility on 5-25-21 with multiple diagnoses that included paraplegia.

The quarterly Minimum Data Set (MDS) dated 8-31-22 revealed Resident #77 was cognitively intact with no documentation of refusing care. The MDS documented the resident required extensive assistance with one person for bed mobility, dressing, personal hygiene, extensive assistance with 2 people for transfers and total assistance with one person for toileting and bathing.

Resident #77's care plan dated 8-31-22 revealed a goal of Activities of Daily Living (ADL) constant. The interventions for the goal were record personal hygiene and record bathing.

An attempt was made to locate the facility's shower schedule for Resident #77 however there was not a shower schedule available.

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or choices with tracheostomy care and choice of time of care and preferences.
The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with tracheostomies receive their care per their choice, utilizing the QA monitoring tool for tracheostomy care.
On 11/2/2022, the Staff Development Coordinator in-serviced the Licensed Nursing staff on self-determination and or choices with enteral bolus feedings. Agency staffing was included on this in-service. Any staff including agency staff not available for the in-service, will be educated prior to their next scheduled shift.
On 11/7/2022, the Staff Development Coordinator added to the Orientation process to include self-determination and or choices with enteral bolus feedings such as times to meet resident's schedule and preferences.
The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with G-tubes receive their enteral feeding per their choice, utilizing the QA monitoring tool for enteral feedings.
On 11/2/2022, the District Dietary Supervisor in-serviced the Dietary Manager and dietary staff on residents with diet orders to receive double portions. Any staff not available the in-service, will be educated prior to their next scheduled shift.
The Dietary Manager will monitor meal

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Review of Resident #77's bathing documentation from August 2022 through October 2022 revealed the resident had not received a shower but had consistently received a bed bath.

Resident #77 was interviewed on 10-10-22 at 11:28am. The resident discussed receiving a bed bath but stated she had never received a shower. Resident #77 stated she would like to have a shower 1-2 times a week. She stated she had asked several times for a shower but was told the NAs were not able to provide a shower.

Nursing Assistant (NA) #13 was interviewed on 10-12-22 at 7:13am. The NA stated he had been working at the facility for a month and had never seen a shower schedule. He discussed never providing a shower to a resident nor being informed that he needed to be providing showers to residents. NA #13 stated he had been assigned to Resident #77 and that the resident had requested a shower, but he did not provide a shower to him because he was not aware he needed to provide showers.

An interview with NA #14 occurred on 10-12-22 at 7:20am. NA #14 stated the facility did not have care guides for the residents, but the NAs could look in the computer for the residents required care. She stated she was familiar with Resident #77 and said she was not aware of the resident's shower days because they no longer had a shower schedule. NA #14 stated she could not remember if the resident ever requested a shower and she had never provided a shower to Resident #77.

During an interview with NA #11 on 10-12-22 at 7:24am, the NA stated she had not seen a

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trays 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with diet orders for double portions are receiving their meals as ordered utilizing the QA monitoring tool for double portions.

Quality Assurance
The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review by the Interdisciplinary Team members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed.

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shower schedule but would provide a shower if the resident requested. NA #11 stated she was familiar with Resident #77 and said she can not remember if the resident ever requested a shower but stated she had not ever provided a shower to Resident #77.
Nurse #7 was interviewed on 10-12-22 at 7:28am. The nurse discussed the facility stopping all showers when COVID19 started 2 years ago. She stated since then she had not been provided a shower schedule for the residents and had not seen any of the residents including Resident #77 receive a shower.

The Assistant Director of Nursing (ADON) was interviewed on 10-12-22 at 7:55am. The ADON stated showers had stopped when COVID19 started but said she did not know why. She explained the staff were educated 2 months ago on resident showers restarting. The ADON explained the showers were supposed to start back on hall 200 west first and then the facility would gradually start showers back on the other halls. She explained since Resident #77 resided on hall 200 east there would not be a shower schedule for her yet since the new schedule started on hall 200 west.

The Director of Nursing (DON) was interviewed on 10-12-22 at 8:05am. The DON stated the facility had not been providing showers to the residents since the start of COVID. She explained the facility had to work on preparing the shower rooms by disinfecting before showers could resume. The DON discussed hall 200 west was supposed to start back showering the residents on their assigned days but said the facility had struggled in reimplementing showers into the NAs schedule.

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The Administrator was interviewed on 10-13-22 at 3:58pm. The Administrator stated he expected staff to be providing showers to residents when the resident had asked.
3. Resident #16 was admitted to the facility on 4/2/22.

The quarterly Minimum Data Set (MDS) assessment dated 7/8/22 indicated he was moderately cognitively impaired. He received tube feedings and tracheostomy care.

A review of the physician's orders for October 2022 revealed his tube feeding order was for 250 ml (milliliters) the name brand tube feeding formula 5 times per day. The scheduled times were 10:00 AM, 2:00 PM, 6:00 PM and 10:00 PM and 7:00 AM. The orders also included a water flush of 100 ml before and after each bolus which was scheduled for 10:00 AM, 2:00 PM, 6:00 PM 10:00 PM and 02:00 AM. The order for the tracheostomy care was scheduled as every shift without a specific designated time. The change of the inner cannula was ordered daily on the 7:00 AM to 3:00 PM shift and as needed.

A review of the Medication Administration Record for October 2022 revealed the 7:00 AM tube feeding was marked through and changed to 02:00 AM. It was signed as being given at 02:00 AM from 10/05/22 through 10/12/22. The Medication Administration Record documented the tracheostomy care was provided during the 11:00 PM to 7:00 AM shift but no specific time was documented.

On 10/10/22 at 10:09 AM during an interview with Resident #16 he communicated he did not like

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that he received tracheostomy care and tube feedings between 1:00 AM and 2:00 AM. He did not like to be awakened at that time to receive this care and felt it could be scheduled at a different time, so he was not awakened in the middle of the night.

On 10/13/22 at 3:21 PM during a follow-up interview Resident #16 communicated he was frustrated by being awakened during the night for changing out his tracheostomy tube and getting tube feedings.

On 10/12/22 at 3:55 PM Nurse #8 who worked on the 3:00 PM to 11:00 PM shift stated Resident #16 received tube feedings 2 times on her shift and also received tracheostomy care once on her shift. Nurse #8 said Resident #16 also received a feeding on the 11:00 PM to 7:00 AM shift.

A telephone interview was attempted with the 3rd shift nurse, Nurse #8. She was unable to be reached.

On 10/13/22 at 3:30 PM the Director of Nursing stated she was not aware Resident #16 had expressed concerns for being awakened during the night to have his tracheostomy changed and to receive a bolus tube feeding. She said he should not have to be awakened during regular sleeping hours to have this type of care provided and it should be scheduled differently to provide the resident quality sleep.
4. Resident #25 was re-admitted to the facility on 7/9/2022.

A review of his quarterly Minimum Data Set (MDS) assessment dated 7/19/2022 revealed he was cognitively intact. Weight loss of 5 percent

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(%) or more in the last month or 10% or more in the last 6 months was no.

A review of Resident #25's October 2022 active physician's orders revealed a diet order of mechanical soft large (double) portions.

On 10/13/2022 at 1:36 PM a telephone interview with the facility Registered Dietician (RD) indicated she was familiar with Resident #25. She stated when Resident #25 was first admitted to the facility, he shared with staff that he was not getting enough food on his meal trays. She went on to say this was addressed with a physician's order for large portions. The RD stated the portion size was increased because of Resident #25's choice and preference and not based on nutritional needs or because he was losing weight. She went on to say Resident #25's weight was currently stable.

On 10/10/2022 at 12:36 PM an interview with Resident #25 indicated he was not getting enough food on his meal trays. He stated he spoke with someone from dietary about this and was told he would be getting large portions but he had not been. He went on to say he wasn't still hungry because his family brought him snacks. Resident #25 stated did not think he had lost weight but he felt he should be getting more food during his meals.

On 10/13/2022 at 12:37 PM an observation of Resident #25's lunch meal tray ticket present on his lunch meal tray with the District Dietary Manager (DDM) revealed his serving sizes for the meal were listed as a #8 scoop (4 ounces) of ground baked chicken breast, 2/3 cup of buttered macaroni noodles, 2/3 cup of roasted green

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F 561	Continued From page 18 beans, a roll and a #16 scoop (2 ounces) of pureed sugar cookie. The lunch meal ticket indicated Resident #25 was to receive large portions. An interview with the DDM at that time indicated Resident #25 did not have large or double portions of food on this lunch meal tray. She stated the portion sizes of food present on Resident #25's lunch meal tray were standard size portions. On 10/13/2022 at 1:10 PM an interview with Cook #1 indicated he plated the food present on Resident #25's lunch meal tray that day. He stated a dietary aide read each meal ticket out loud in the kitchen to him and would have read out the large portion instruction which was present at the bottom of Resident #25's lunch meal ticket. He stated when this was read, he should have added additional portions of food to Resident #25's meal. Cook #1 stated he must have either misheard or not heard the dietary aide that day because he had not added additional portions of food for Resident #25. On 10/13/2022 at 4:15 PM an interview with the Director of Nursing (DON) indicated Resident #25 should be receiving what was listed on his meal ticket and what he requested	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		11/16/22

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F 580	Continued From page 19 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or 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	F 580		

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room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff and family interviews the facility failed to notify the resident's representative (RP) of a new diagnosis and medication order and an outside physician consult appointment. This was for one of one resident (Resident #89) reviewed for notification of change.

Findings included:

Resident #89 was admitted to the facility on 3/31/2020 with a diagnosis of dementia.

A review of her quarterly Minimum Data Set (MDS) assessment dated 8/24/2022 revealed she was severely cognitively impaired.

A review of Resident #89's medical record revealed a new physician's order dated 9/27/21 for Tobrex (an antibiotic eye drop) 0.3 percent (%) 2 drops each eye every 4 hours for 3 days. The diagnosis was conjunctivitis (an eye infection). The order was signed as being reviewed by Nurse #1. A further review of Resident #89's medical record revealed no documentation that her RP was notified of this new diagnosis of conjunctivitis or the new antibiotic eye drop medication order.

On 10/11/22 at 2:08 PM a telephone interview with Resident #89's RP indicated she was not notified of the new diagnosis of conjunctivitis or the new order for an antibiotic eye drop for her family member. She stated she found out at a visit after the medication was already started. She

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Corrective Action for the Resident Affected
On 11/2/2022, the Director of Nursing (DON) called resident #89's responsible party to discuss their new diagnosis and medication order as well as the outside physician consult appointment.

Corrective Action for the Residents Potentially Affected
On 11/2/2022, the DON and or Administrative Nurses reviewed orders for the past 30 days to ensure that residents and their representatives were notified of new diagnosis, medication orders and outside physician consult appointments, injury, decline and or room change, etc.

Systemic Changes
On 11/2/2022, the Staff Development Coordinator began in-servicing the Licensed Nursing staff on Notifying of changes of new diagnosis, medication orders, outside physician consult appointments, injury, decline and or room change, etc to the resident and the resident's representative. Agency staffing was included on this in-servicing. Any staff including agency staff not available for the in-service, will be educated prior to their next scheduled shift.
On 11/7/2022, the Staff Development Coordinator added the education of Notification of change of the resident to the resident and the resident's

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went on to say she expected the facility to notify her of any change in her family members condition or new medication order. She further indicated the facility was aware of her desire to be notified.

On 10/13/22 at 8:21 AM an interview with Nurse #1 indicated she was the nurse who reviewed and signed off the new physician's order with the diagnosis of conjunctivitis and an antibiotic eye drop for Resident #89 on 9/27/2021. She stated which ever nurse reviewed and signed off a new order for a resident would be responsible for notifying the RP. She went on to say if there was no documentation in the progress notes she could not recall if she notified Resident #89's RP of this new order or not. She further indicated if she had notified Resident #89's RP, she would have documented this notification in Resident #89's progress notes.

A further review of Resident #89's medical record revealed a physician's order dated 12/22/21 for an orthopedic (a branch of medicine concerned with disorders of the musculoskeletal system) consult due to left knee swelling.

A facility physician's progress note dated 1/25/22 revealed Resident #89's RP was not present when Resident #89 saw the orthopedist.

On 10/11/22 at 2:08 PM a telephone interview with Resident #89's RP indicated she was not made aware that Resident #89 had an orthopedic consult appointment on 1/14/2022 in Rocky Mount and so she had not been present at this appointment. She stated she would have gone if she had been notified of the appointment date and time. She stated Resident #89 had dementia

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representative to include new diagnosis, medication orders, outside physician consult appointments, injury, decline and or room changes, etc as part of the orientation packet for new hires for the Licensed Nursing staff.
The DON and or Administrative Nurses will review resident's orders 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure if there are residents with new diagnosis, medication orders and outside physician consult appointments, injury, decline and or room change that the resident and the resident's representative was notified in a timely manner, utilizing the QA monitoring tool for Notification of changes.

Quality Assurance
The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review by the Interdisciplinary Team members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed.

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F 580	Continued From page 22	F 580		

and was not capable of making her needs known, understanding information given to her, or consenting to any treatments. The RP stated the facility was aware that she wanted to be notified of any outside consult appointments so she could be present with her family member.

On 10/12/22 at 11:16 AM an interview with the Schedular indicated she scheduled the 1/14/22 orthopedic consult for Resident #89 to see the physician in Rocky Mount who originally did Resident #89's left knee surgery in response to the physician's order dated 12/22/21 for an orthopedic consult. She stated she would have been responsible for notifying Resident #89's RP of the appointment location, date, and time. She went on to say after Resident #89 went to this appointment, her RP called the facility upset because she had not been made aware of the appointment and had not been present. The Schedular stated she apologized to Resident #89's RP. She went on to say while she would have been responsible for notifying Resident #89's RP of the appointment when she arranged it, she thought Nurse #4 notified Resident #89's RP.

On 10/12/22 at 12:37 PM an interview with Nurse #4 indicated Resident #89's RP had been upset that she was not notified of Resident #89's 1/14/22 orthopedic consult. She stated she had apologized to Resident #89's RP. Nurse #4 went on to say she did not think it had been her responsibility to make Resident #89's RP aware as she had not scheduled the appointment. She stated it was usually the person scheduling the appointment who made the RP aware. In a follow-up interview on 10/13/22 at 12:10 PM Nurse #4 indicated she did receive information

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F 580	Continued From page 23 about the location, date, and time of Resident #89's orthopedic consult from the Schedular via a text message prior to the 1/14/22 appointment when Resident #89's RP was in the facility, however, had not passed the information on to Resident #89's RP because she had gotten busy with an emergency. On 10/13/22 at 4:15 PM an interview with the Director of Nursing (DON) indicated while there may have been some miscommunication between Nurse #4 and the Schedular, Resident #89's RP should have been immediately made aware of any change in her condition, her new physician's order for eye drops and her consult appointment.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		11/16/22

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F 583	Continued From page 24 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to protect resident medical information for 1 of 1 resident (Resident #250) when a Nursing Assistant (NA) #11 left Resident #250's medical information up on a computer screen located on hall 200 east. Findings included: Resident #250 was admitted to the facility on 9-12-22. The admission Minimum Data Set (MDS) revealed Resident #250 was severely cognitively impaired. Observation of the computer on hall 200 east occurred on 10-10-22 at 12:23pm. The computer monitor was observed to have Resident #250's medical information on the screen. During an interview with NA #11 on 10-10-22 at 12:25pm, the NA said she had Resident #250	F 583	Corrective Action for the Resident Affected On 10/10/2022, the NA # 11 logged of the Kiosk screen showing resident #250's personal records. On 10/10/2022, the Director of Nursing (DON) provided a 1:1 in-service to NA #11 on personal privacy/confidentiality of records. Corrective Action for the Residents Potentially Affected On 10/10/2022 Administrator assessed the Kiosk system and reset the system to ensure the system timed out in a timely manner in privacy mode. All residents have the potential to be affected. The Administrator and the Director of Nursing assessed all Kiosk on 10/10/2022, to ensure that when staff was not using them that they were placed in privacy mode.	

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pulled up on the screen charting on him when the lunch trays arrived on the unit, and she did not log off. NA #11 stated "I don't understand what the problem is." The NA logged off the computer and walked away.

Nurse #7 was interviewed on 10-10-22 at 12:35pm. The nurse stated it was a privacy violation to leave resident information visible to the public. She said if she would have seen Resident #250's medical information on the computer screen when she would have logged NA #11 out of the system, so the resident information was no longer visible.

An interview with the Director of Nursing (DON) occurred on 10-10-22 at 9:20am. The DON stated all staff had training on keeping resident information private on 5-4-22 and expected all staff to keep resident information private. She also stated she thought NA #1 was charting and when the lunch trays arrived, the NA forgot to log out.

The Administrator was interviewed on 10-13-22 at 3:58pm. The Administrator stated the computers had been set to power down after one minute but said "somehow" the computer NA #11 was using became programmed to never time out or power down. The Administrator stated he expected all resident information to remain confidential and for staff to log out of the system if they are leaving the area.

F 583

Systemic Changes
On 11/2/2022, the Staff Development Coordinator began in-servicing the Licensed Nursing staff and Certified Nursing Assistants on personal privacy/confidentiality of records, specifically ensuring that after using the Kiosk/computer that the information is closed so that records cannot be accessed by others. Agency staffing was included on this in-service. Any staff including agency staff not available for the in-service, will be educated prior to their next scheduled shift.
On 11/7/2022, the Staff Development Coordinator added the education to the orientation packet for new hires to include Personal privacy/confidentiality of records, specifically ensuring that after using the Kiosk/computer that the information is closed so that records cannot be accessed by others.
The DON and or Administrative Nurses will monitor the facility computers when staff have completed their assignment to ensure that staff has closed out the residents' records 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents personal privacy/confidentiality of records are kept private, utilizing QA monitoring tool for Personal Privacy/Confidentiality of Records.

Quality Assurance
The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review by the

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F 583	Continued From page 26	F 583	Interdisciplinary Team members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		11/16/22

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F 584	Continued From page 27 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to (1) maintain resident walls and heating/air units in good repair and the facility failed to (2) maintain a clean-living environment for 1 of 5 halls (hall 200 west) reviewed for environment. Findings included: 1a. Observation of room 223 occurred on 10-10-22 at 11:06am. The observation revealed the wall beside bed B had the paint removed allowing the plaster to show. The area measured approximately 2.5 feet by 1.5 feet. A second observation of room 223 occurred on 10-13-22 at 8:27am with the Environmental Manager and the Maintenance Director. The observation revealed the wall beside bed B had the paint removed allowing the plaster to show. The area measured approximately 2.5 feet by 1.5 feet. During an interview with the Maintenance Director on 10-13-22 at 8:46am, the Maintenance Director stated he had placed putty on the wall last week. He explained he had to return to room 223 to	F 584	Corrective Action For Affected Residents The carpet in room 221 was cleaned, the privacy curtain in room 222 was replaced, the wall in room 223 was painted, and the PTACH cover was repaired on 10-13-22. Systemic Changes Housekeeping staff were in-serviced on cleaning procedures for curtains and carpets on 10-17-2022. A 100% audit of curtains was completed on 10-24-2022. Any soiled curtains were taken down and washed. If stains persist, curtains will be replaced as soon as they are available. They were ordered on 10-31-22. According to the vendor it could take 3-4 weeks for delivery due to supply chain difficulties. A 100% audit of carpets was completed on 11-3-22. Any carpets that showed soil were cleaned by 11-4-22. If stains were not removable, carpet will be replaced by 11-16-2022. A 100% audit of PTACH units was completed on 11-3-22. Any PTACH covers that were loose were repaired by 11-4-2022.	

F 584

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sand and paint the area but stated he did not have a timeline on when the work would be completed.

b. Room 225 was observed on 10-10-22 at 11:20am. The observation revealed the cover to the rooms heat/air wall unit was loose from the unit allowing the left side of the cover to be partially off the heat/air unit.

A second observation of room 225 occurred on 10-13-22 at 8:30am with the Environmental Manager and the Maintenance Director. The observation revealed the cover to the rooms heat/air wall unit was loose from the unit allowing the left side of the cover to be partially off the heat/air unit.

The Maintenance Director was interviewed on 10-13-22 at 8:50am. The Maintenance Director stated staff could report issues in the maintenance book located at each nursing station or by verbally telling him in person. He stated staff had not reported the cover to the heat/air unit being loose or partially coming off. The Maintenance Director commented the covers often became loose and just needed to be pushed back on to the unit. The Maintenance Director discussed making walk around rounds every morning but stated he had not noticed the issues brought to his attention.

2a. Observation of room 221 occurred on 10-10-22 at 11:00am. The observation revealed 2 circular brown stains the size of the bottom of a glass on the resident's carpet.

During a second observation of room 221 on 10-13-22 at 8:33am with the Environmental

F 584

A 100% audit of rooms for wall repair needs was completed on 11-3-2022. Any necessary repairs or paint was completed by 11-16-2022.

Quality Assurance
Carpets and privacy curtains will be audited by the housekeeping manager weekly x 6 weeks, then monthly x 3 months to ensure compliance. Results will be submitted to the QAPI committee for review and evaluation.
Room audits for wall repair and PTACH covers will be completed by the Maintenance Director weekly x 6 weeks, then monthly x 3 months to ensure compliance. Results will be submitted to the QAPI committee for review and evaluation.

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Manager and the Maintenance Director. The second observation revealed 2 circular brown stains the size of the bottom of a glass on the resident's carpet.

The Environmental Manager was interviewed on 10-13-22 at 8:40am. The Environmental Director stated the carpets in the resident rooms were cleaned weekly and was not aware there were brown stains in room 221.

b. Room 222 was observed on 10-10-22 at 11:03am and revealed black and brown marks on the privacy curtain separating bed A from bed B.

A second observation of room 222 was completed on 10-13-22 at 8:35am with the Environmental Manager and the Maintenance Director. The observation revealed black and brown marks on the privacy curtain separating bed A from bed B.

The Environmental Manager was interviewed at 8:43am. The Environmental Manager stated the housekeeping staff should be observing the privacy curtains daily and if the housekeeping staff noticed the privacy curtains were dirty, the housekeeping staff should take down the curtain and have the curtain cleaned.

c. Observation of room 227 occurred on 10-10-22 at 11:16am. The observation revealed brown, yellow and black marks on the wall next to bed B and the privacy curtain separating bed A from bed B was observed to have rust-colored circles and splashes present.

During a second observation of room 227 occurred on 10-13-22 at 8:37am with the

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F 584	Continued From page 30 Environmental Manager and the Maintenance Director. The observation revealed brown, yellow and black marks on the wall next to bed B and the privacy curtain separating bed A from bed B was observed to have rust-colored circles and splashes present. The Environmental Manager was interviewed on 10-13-22 at 8:45am. The Environmental Director discussed making rounds every morning but stated he had not noticed the issues brought to his attention. The Administrator was interviewed on 10-13-22 at 3:58pm. The Administrator stated he understood the Maintenance Director and the Environmental Director missing the issues brought to their attention but stated he expected the residents to have a safe and clean environment.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		11/9/22

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F 657	Continued From page 31 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and facility staff interviews and record review the facility failed to have a cognitively intact resident participate in the care plan meetings. This was for 1 of 2 residents reviewed for care plans (Resident #72). The findings included: Resident #72 was admitted to the facility on 7/29/16. She had reentries on 8/2/22 and 8/30/22. Her diagnoses included diabetes, peripheral vascular disease, bilateral lower extremity amputations and a fracture of the right femur. The quarterly Minimum Data Set (MDS) assessment dated 6/22/22 indicated Resident #72 was cognitively intact. The admission and significant change MDS dated 8/9/22 indicated Resident #72 was readmitted to the facility on 8/2/22 from an acute care hospital. Resident #72 was cognitively intact. Her quarterly MDS dated 9/16/22 indicated Resident #72 was cognitively intact.	F 657	Corrective Action for the Resident Affected Resident #72 has been scheduled for a care plan meeting on 11-9-2022. Systemic Changes All cognitively intact residents have the potential to be affected. Cognitively intact residents will be invited to attend their care plan meetings and encouraged to participate in the development or review of their care plan. The Social Services Director will deliver 2 copies of a care plan invitation to all cognitively intact residents. The resident will sign 1 copy for the facilities records and they will retain the other copy. On the day and time of the scheduled care plan meeting, the Social Services Director will record whether or not the resident attended the care plan meeting. Both forms will be placed in the resident's chart. This process will begin on 11/4/2022. Quality Assurance	

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F 657	Continued From page 32 On 10/10/22 at 12:04 PM Resident #72 stated she was not aware of being invited and had not attended a meeting about her care. She said she had not participated in the development or review of her plan of care. On 10/12/22 at 1:15 PM Social Worker (SW) #1 said the residents who are capable of understanding are invited to the care plan meeting. SW #1 said she had spoken to Resident #72 in the past about attending the care plan meeting. She said Resident #72 told her in the past that she did not need to come to the meeting. She said she had verbally communicated with Resident #72 but had not provided written information to the resident about the care plan meetings. SW #1 said she did not remember when she had last spoken to Resident #72 about the care plan meetings. A review of the Care Plan Participation Record provided by SW #1 for Resident #72 revealed the interdisciplinary team members participated in the care plan development on 3/9/22, 6/8/22,7/6/22, 8/24/22 and 9/21/22. The area of these forms for documentation of resident/representative included 1) participated by telephone, 2) participated by videotelephony or 3) declined to participate. On each of the forms this area was not completed. On 10/13/22 at 2:15 PM SW #1 said she was not aware of the need to document if Resident #72 attended the meeting or chose not to attend the meeting. She said she had developed a new form since the previous conversation with the surveyor on 10/12/22 to make the cognitively intact residents a sign to remind the residents of their meetings.	F 657	A member of the care plan team including the Social Services Director, ADON, Activities Director, Therapy Manager, and Dietary Manager will review each scheduled resident's chart weekly for completion of both forms for 90 days until a quarterly cycle is complete. Results of these audits will be submitted to the facility QAPI team for review and evaluation.	

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F 657	Continued From page 33 On 10/13/22 at 3:40 PM the Director of Nursing reported she was not aware Resident #72 was not participating in the care plan development meetings and that there should be documentation of her invitation and declination to participate.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, and facility staff interviews the facility failed to provide incontinent care for 1 of 7 residents (Resident #16) reviewed for activities of daily living (ADLs). The findings included: Resident #16 was admitted to the facility on 4/2/22. His diagnoses included hemiplegia of the right dominant side, speech deficit, diabetes, and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated 7/8/22 indicated he was moderately cognitively impaired. He required extensive assistance with all activities of daily living including toileting, bathing, and personal hygiene. He was always incontinent of bowel and bladder. The care plan for Resident #16 indicated he had impaired mobility related to right sided	F 677	Corrective Action for the Resident Affected On 10/10/2022, Residents #16 was given incontinence care by his assigned nursing assistant #8. On 10/10/2022, the Director of Nursing (DON) provided a 1:1 in-service to NA #8 on incontinent care and frequency of care. Corrective Action for the Residents Potentially Affected All residents that are incontinent of their bladder have the potential to be affected. On 11/2/2022, the Director of Nursing (DON) and Administrative Nursing reviewed resident□s charts and identified 81 residents with a diagnosis of incontinence. Of the 81 residents, it was determined that 35 residents require increase monitoring for their incontinence needs. Systemic Changes	11/16/22

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hemiplegia. The approaches included assist with ADLs to completion and assist resident with toileting needs PRN (as needed).

On 10/10/22 at 2:22 PM Resident #16 reported the last time he had received incontinent care was on the 11:00 PM to 7:00 AM shift. He acknowledged he was soiled and had been wet for a long time.

On 10/10/22 at 2:55 PM an observation of incontinent care was completed with Nurse Aide (NA) #8 and revealed his adult brief was saturated with a dark dry ring on the inside. The Resident's under pad was noted to be wet with a dark dry ring around the edges. The Resident's gown was noted to be wet.

On 10/10/22 at 3:18 PM NA #8 said she and NA #9 worked together to meet the residents' needs but she was assigned to Resident #16. She said she provided incontinent care to Resident #16 between 8:00 and 9:00 AM that morning. She said the resident's pad was dirty when she provided care, but there were no clean pads available, so she used a folded sheet instead of a pad. When asked about the resident having a soiled pad, she stated there were no pads in the clean utility room. She said she was told by the 11:00 PM - 7:00 AM shift that Resident #16 received a partial bath that morning so she did not provide a bath for Resident #16.

On 10/11/22 at 3:00 PM NA #10 reported she worked on the 11:00 PM to 7:00 AM shift on 10/10/22 and was assigned to Resident #16. She reported she provided incontinent care to him between 12:30 AM and 1:00 AM then again at 4:00 AM and around 6:00 AM. She said she did

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On 11/2/2022, the Staff Development Coordinator initiated an in-service with the licensed nurses and nursing assistants on incontinent care needs. Any nurse or nurse assistant that did not received the in-service will not work until they have received the in-service. The in-service included how often a resident is to be monitored for incontinent care, as well as monitoring residents that require increased monitoring. This in-service will be a part of the facilities orientation process for training of new licensed and unlicensed staff as well as include Agency staff.
On 11/4/2022, the DON and or Administrative Nurses made corrections in the electronic health record to increase monitoring on the activities of daily living flow sheet.
The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with a diagnosis of bladder incontinence are assisted with their incontinent needs every two hours or sooner by utilizing the QA monitoring tool for ADL Care.

Quality Assurance (QA)
The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed.

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F 677	Continued From page 35 not provide a full bath. On 10/13/22 at 3:30 PM the Director of Nursing (DON) stated the NA should be checking the residents more frequently as least every 2-3 hours and a resident should not remain in wet briefs for an entire shift.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff and Nurse Practitioner interviews the facility failed to perform blood glucose monitoring as ordered for 1 of 4 residents (Resident #77) reviewed for medication administration. Findings included: Resident #77 was admitted to the facility on 3/21/2017 with a diagnosis of diabetes mellitus. A review of her quarterly Minimum Data Set (MDS) assessment dated 8/31/22 revealed she was cognitively intact. She received insulin injections on 7 of 7 look back days of the assessment.	F 684	Corrective Action for the Resident Affected On 11/2/2022, the Director of Nursing, (DON) met with Resident #77 and re-educated her about the importance of checking resident's FSBG and taking her insulin as prescribed. The resident was given the choice of getting her FSBG and receiving her insulin as prescribed or speaking to the Provider to have it changed. The resident chose to speak to Provider. Corrective Action for the Residents Potentially Affected All residents with a diagnosis of Diabetes Mellitus have the potential to be affected.	11/16/22

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A review of the current comprehensive care plan for Resident #77 revealed a focus area last reviewed on 9/14/22 of insulin dependent diabetes with risk for hypo/hyper glycemia (low/high blood glucose). The goal was for Resident #77 to have any signs or symptoms of hypo/hyper glycemia detected, treated, and resolved early. An intervention was to check blood glucose and administer medication as ordered.

A review of her active October 2022 physician's orders revealed the following:

Finger Stick Blood Glucose (FSBG) before meals (AC) and at hour of sleep (HS)
Insulin Aspart (a short acting injectable insulin to treat diabetes) inject 5 units (U) subcutaneously (SUB-Q) before meals. Hold for blood glucose less than 180.
Insulin Aspart Sliding Scale for blood glucose greater than 270 give additional 1 U, greater than 300 give additional 2 U, greater than 350 give additional 3 U, greater than 400 give additional 4 U.

On 10/11/22 at 5:51 PM an observation of medication administration with Nurse #5 revealed she did not check Resident #77's blood glucose before her dinner meal. Resident #77 was observed to have already eaten her dinner meal which was still present on her bedside table when Nurse #5 checked Resident #77's FSBG. The result was 137.

An interview with Nurse #5 at that time indicated she cared for Resident #77 before and was familiar with her. She stated Resident #77 liked to

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the potential to be affected. On 11/2/2022, the Director of Nursing (DON) and Administrative Nursing reviewed resident's charts and identified 30 residents with a diagnosis of Diabetes Mellitus.

Systemic Changes
On 11/2/2022, the Staff Development Coordinator initiated an in-service with the licensed nurses on following MD orders, specifically on residents with a diagnosis of Diabetes Mellitus and has an order for FSBG and with a sliding scale with coverage prior to meals. Any nurse that did not received the in-service will not work until they have received the in-service prior to their scheduled shift. This in-service will include Agency staff. On 11/7/2022, the Staff Development Coordinator added to the orientation packet for education to the License Nursing Staff to follow MD orders, specifically residents with a diagnosis of Diabetes Mellitus that has an order for FSBG and sliding scale. If the resident request FSBG and sliding scale to be different from the order, the provider is to be contacted.

The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with a diagnosis of Diabetes Mellitus receive FSBG and their sliding scale and insulin coverage as ordered from the MD, by utilizing the QA monitoring tool for Diabetes Mellitus.

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take her insulin and have her FSBG taken after she ate because her blood glucose levels were unpredictable. Nurse #5 went on to say Resident #77 told her she was afraid if she took her insulin before she ate and then didn't eat her blood glucose level would drop. Nurse #5 stated she had educated Resident #77 on the reason she should have her blood glucose taken and her insulin given before her meals and Resident #77 told her she understood this but liked to be in control of her care and still wanted this done after she ate. Nurse #5 stated she did it this way when she cared for Resident #77. She further indicated she had last cared for Resident #77 on 10/5/22. She went on to say she had not documented this anywhere and had not shared the information with the Assistant Director of Nursing (ADON), the Director of Nursing (DON) or Resident #77's medical provider.

On 10/11/22 at 5:53 PM an interview with Resident #77 indicated she understood the physician's order was for her to have her blood glucose checked and insulin given before her meals but she knew her body and preferred this be done after she ate. She stated her blood glucose was very unpredictable and she was afraid if she did this before her meal and then didn't eat her blood glucose level would drop too low. She stated she had not spoken about this to her medical provider.

On 10/11/22 at 6:17 PM an interview with the Assistant Director of Nursing (ADON) indicated she was familiar with Resident #77. She stated Resident #77 was alert and oriented and liked to be involved with her care. She went on to say she had not been made aware Resident #77 had expressed a desire to have her blood glucose

F 684

Quality Assurance (QA)
The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed.

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checked and her insulin administered after her meals instead of before like the physician ordered. The ADON further indicated this was important information that needed to be communicated to the provider so the provider was aware that the documented blood glucose results reflected Resident #77's blood glucose after her meals. She stated the provider could then have changed the order if it was appropriate. She went on to say this was also something that that needed to be reflected in Resident #77's plan of care so everyone was doing things consistently. The ADON stated if the physician's order was for Resident #77 to have her blood glucose taken and her insulin given before her meals then that is what should be happening unless there was communication with Resident #77's medical provider and an order was given for something else.

On 10/13/22 at 3:37 PM a telephone interview with Resident #77's medical provider Nurse Practitioner (NP) #1 indicated the physician's order was for Resident #77 to have her blood glucose checked and her insulin given before her meals. He went on to say he was not aware this was being done after her meals. He stated Resident #77 was very involved in her care and it was important for her to have some control. He further indicated knowing whether the blood glucose result reflected Resident #77's status after her meal rather than before would be important information. He went on to say he would expect the nurses to be communicating with him and documenting in the progress notes if Resident #77 was expressing the desire and having her blood glucose taken and her insulin given after her meals rather than before so he could address the issue with Resident #77,

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F 684	Continued From page 39 monitor trends and change the order if appropriate. On 10/13/22 at 4:15 PM an interview with the Director of Nursing (DON) indicated if Resident #77 was expressing the desire to do something other than the provider ordered, nurses should be communicating with the provider so the provider could have a discussion with Resident #77 and address the issue with her. She stated checking Resident #77's blood glucose after her meals would not be following the physician's order.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent 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 observations, record review and staff interviews the facility failed to apply a protective boot in accordance with the physician's order for 1 of 4 residents (Resident #37) reviewed for pressure ulcers. Findings included:	F 686	Corrective Action for the Resident Affected On 10/14/22, the Director of Nursing, (DON) observed Resident #37 to ensure that the Prevalon boot was in place per MD orders.	11/16/22

F 686 Continued From page 40

Resident #37 was admitted to the facility on 2/1/2019 with diagnoses of dementia, chronic kidney disease and muscle weakness.

A review of the quarterly Minimum Data Set (MDS) assessment for Resident #37 dated 8/2/2022 revealed she was severely cognitively impaired. She required the extensive assistance of one person for bed mobility. Resident #37 was at risk for pressure ulcers and had one unstageable pressure ulcer that was not present on her admission to the facility. She had a pressure reducing device to her bed, nutrition, or hydration interventions to manage her skin problem and pressure ulcer care in place.

A review of the current comprehensive care plan for Resident #37 revealed a focus area dated 8/2/22 of at risk for pressure ulcers related to impaired mobility. It further revealed Resident #37 had an unstageable pressure ulcer to her left foot that had healed on 9/7/22. The goal was the risk of new skin breakdown would be minimized through the next review. Interventions included administer treatments as ordered by the physician and use pillows, pressure reducing mattress and other supportive/protective devices to assist with positioning.

A review of Resident #37's October 2022 Treatment Administration Record (TAR) on 10/12/202 revealed an active physician's order for Prevalon to be always in place except during ADL care. The information regarding the Prevalon boot placement was noted to be for your information (FYI).

On 10/12/22 at 6:45 AM an observation of

F 686

Corrective Action for the Residents Potentially Affected
All residents have the potential to be affected. On 11/2/2022, the Director of Nursing (DON) and Administrative Nursing reviewed resident’s charts and identified 10 residents with an order to use a Prevalon boot/boots. Of the 10 residents, it was determined that 8 residents had the Prevalon boot/boots in place as ordered. 1 resident did not due to refusals/non-compliance and order is PRN.

Systemic Changes
On 11/2/2022, the Staff Development Coordinator initiated an in-service with the licensed nurses and unlicensed staff on following when to use prevalon boots per MD orders. Any nurse or nurse assistant that did not received the in-service will not work until they have received the in-service. This in-service will be a part of the facilities orientation process for training of new licensed nurses, unlicensed staff, as well as include Agency staff.
The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with an order to utilize prevalon boots have them on as prescribed by the MD, by utilizing the QA monitoring tool for alteration in skin integrity.

Quality Assurance (QA)
The results of these reviews to be submitted to the Quality Assurance

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F 686	Continued From page 41 Resident #37 with Nurse Aide (NA) #3 revealed she was in bed. No Prevalon boot was observed to be in place. An interview with NA #3 at that time indicated the nurse would usually let her know if a resident needed a Prevalon boot. She stated she was not aware of Resident #37 having Prevalon boot that needed to be in place. She went on to say she had been caring for Resident #37 from 11PM on 10/11/22 and Resident #37 had not had a protective boot on all night. On 10/12/22 at 6:49 AM an interview with Nurse #2 indicated she took over the care of Resident #37 at 6:00 AM that morning from Nurse #3. She stated Nurse #3 gave her a report regarding Resident #37's status but had not said anything about Resident #37 needing a protective boot. She went on to say if a resident needed a protective boot, it would normally be on the TAR. Nurse #2 further indicated she had not checked the TAR when she took over the care for Resident #37 at 6:00 AM that morning. She stated if Resident #37 had a physician's order for a Prevalon boot to be always in place except during ADL care then she should have had it on. On 10/12/22 at 3:55 PM an observation of Resident #37 with the facility Treatment Nurse revealed Resident #37 was in bed. A protective boot was observed on Resident #37's left foot. The skin to Resident #37's left foot was observed to be intact without any breakdown. An interview with the Treatment Nurse at that time indicated Resident #37 had a deep tissue injury to her left foot that had healed. She went on to say Resident #37 currently had an active physician's order for her boot to be always in place except during ADL care to prevent any further skin breakdown.	F 686	Performance Improvement (QAPI) Committee by the DON for review by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed.	

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On 10/13/22 at 8:29 AM a telephone interview with Nurse #3 indicated she cared for Resident #37 from 11:00 PM on 10/11/22 until 6:00 AM on 10/12/22. She stated this was her first time ever caring for Resident #37. She went on to say she was not aware Resident #37 needed to have a protective boot on. Nurse #3 stated she had access to Resident #37's care plan and TAR which were at the nurse's station but she was used to having access to these things on a computer. She further indicated she would not realistically review a resident's care plan in a paper chart. She stated Resident #37 did not have any wound care due on her shift so she had not checked the TAR.

On 10/13/22 at 3:37 PM a telephone interview with Resident #37's Nurse Practitioner (NP #1) indicated at one time Resident #37 had a bad wound to her left foot from constant pressure. He stated this had healed. He went on to say the physician's order for the Prevalon could probably have been discontinued. He further indicated staff should either be following the physician's orders or communicating with the provider to have the order discontinued and something else put in place.

On 10/13/22 at 4:15 PM an interview with the Director of Nursing (DON) indicated if Resident #37 had an active physician's order for a Prevalon boot to be always in place except during ADL care then she should have had it on. She stated NAs did not have access to TARs. She went on to say nurses should be checking resident's TARs and care plans when caring for residents to be sure they weren't missing anything and communicating needed information to NAs.

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with the resident, facility staff, and physician the facility failed to provide a safe transfer of a resident using a mechanical lift which caused a resident (Resident #72) to fall and fracture her right upper leg. This was for 1 of 3 residents reviewed for accidents. The findings included: Resident #72 was admitted to the facility on 7/29/16. Her diagnoses included diabetes, peripheral vascular disease, bilateral lower extremity amputations and a fracture of the right femur. The quarterly Minimum Data Set (MDS) assessment dated 6/22/22 indicated Resident #72 was cognitively intact. She required extensive assistance with bed mobility, dressing, toilet use ad personal hygiene. She was totally dependent with the assistance of 2 staff for transfers. She required supervision for locomotion off the unit and used a wheelchair for locomotion. She had range of motion impairment of both lower extremities.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 44	F 689		

A nursing note dated 7/29/22 documented at 8:45 AM Nurse #4 was called to Resident #72's room by the Nursing Aide (NA) who stated she was transferring Resident #72 by mechanical lift to her wheelchair when the lift pad snapped/broke. Nurse #4 observed Resident #72 sitting upright on the floor in front of her wheelchair. The note documented Nurse #4 asked Resident #72 what was different, and the resident's response was "pad." Nurse #4 documented the resident's right below knee amputation (BKA) was leaning on the foot of the mechanical lift.

A review of the hospital discharge summary dated 8/2/22 documented Resident #72 was admitted on 7/30/22 for a fracture of the right femoral shaft (straight part of the long bone from the hip to the knee). The resident had surgical repair of the right leg fracture on 7/31/22 with intramedullary nailing of the right femur (a metal rod is inserted inside the bone and across the fracture to provide a solid support for the fractured bone). She was discharged back to the facility on 8/2/22

A review of the physician's progress note dated 8/2/22 revealed Resident #72 was admitted to a medical center on 7/30/22 and was discharged back to the facility on 8/2/22 for management of a right femoral shaft fracture after a fall. His note documented the resident was being transferred in a mechanical lift, which resulted in her sustaining a fracture. She was sent to the local hospital emergency department and was transferred to the medical center. She had surgical repair of the right femur with nailing on 7/31/22.

The admission and significant change MDS dated 8/9/622 indicated Resident #72 was readmitted to the facility on 8/2/22 from an acute care hospital.

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F 689	Continued From page 45 Resident #72 was cognitively intact. She required extensive assistance with bed mobility, dressing, and personal hygiene. She was totally dependent for transfers and locomotion off the unit in a wheelchair which required 2 or more staff. She was totally dependent with assistance of 1 staff for toilet use. She had range of motion impairment of both lower extremities. The care plan last updated 8/9/22 revealed Resident #72 was at risk for falls related to impaired mobility due to left AKA (above knee amputation) and right BKA (below knee amputation). The approaches included name brand mechanical lift +2 for transfers was documented below the approach of "s/p fall 7/29/22. ED (Emergency Department) visit for right hip pain." On 10/10/22 at 12:10 PM Resident # 72 stated she broke her right hip when she fell while being transferred from the bed to her wheelchair using a mechanical lift. She said she tried to tell the NA that something was not right, and she was leaning too far over. She was not able to state which NA it was. On 10/11/22 at 9:00 AM Nurse #4 stated she remembered Resident #72 fell from the mechanical lift when the lift pad broke. Nurse #4 said she was not present in the room when it happened there was 1 NA present when that happened. She said she did not remember which NA was present. Nurse #4 said she saw Resident #72 on the floor and the NA told her she was had the resident up in the lift. Nurse #4 assessed Resident #72 and called the physician to have her sent to the hospital due to severe pain in her right hip. She said the lift pad was not	F 689		

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the correct pad for the resident's weight.

The fall investigation report was reviewed. This report documented on 7/29/22 at 8:45 AM the NA was transferring the resident via mechanical lift to the wheelchair when the lift pad snapped and broke. The nursing assistant was documented as NA #5. The report documented the fall huddle (team meeting to review the fall) revealed the resident had leg pain of 8-9 (on a pain scale of 1-10), hit leg on lift, and the resident was sent to the hospital.

Attempts to contact NA #5 were unsuccessful.

On 10/11/22 at 10:50 AM Physician #1 stated he was aware of the fall and broken right femur of Resident #72. He stated she had surgery to repair the fracture and she currently self-propels in her wheelchair daily.

On 10/12/22 at 11:45 AM Resident #72 was observed out in the hall propelling her wheelchair.

An interview with the Director of Nursing (DON) on 10/11/22 at 4:00 PM revealed the facility conducted a complete investigation with a root cause analysis and implemented a plan of correction. She said NA #5 used the wrong lift pad. The DON explained the lift pads have weight requirements and NA #5 used the wrong pad for Resident #72's weight so the strap on the pad broke which caused Resident #72 to fall from the lift onto the floor. The DON said NA #5 did not use 2 staff which was the protocol for all mechanical lifts. The DON provided the documentation of the plan of correction.

The facility provided the following corrective

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F 689	Continued From page 47	F 689		

action plan with a completion date of 7/30/22.

Allegation of Compliance for mechanical lift Incident F689

On 7/29/22 at 8:50 am resident #72, who has a diagnosis of End Stage Renal Disease, Type 2 Diabetes, and congestive heart failure fell from the mechanical lift about 3 feet onto the floor as NA #5 was moving her from the bed to a wheelchair. Emergency care was provided, and the resident was transferred to the Emergency Room.

Resident #72 has a BIMS score or 15 and is her own responsible party. Physician was notified of fall at 9:00am by charge nurse on the hall. EMS (Emergency Medical Services) was called, and resident was transferred to the local hospital at 9:15am. Resident's husband, who is her only family, was in facility for respite care. He was notified at 2:00pm once facility was able to get more information about resident #72's status.

Upon investigation, the following was determined:
a. Aide (NA#5) did not follow facility protocol of having 2 people involved on every mechanical lift.
b. Aide (NA#5) did not use the correct pad.
c. NA's who were working at the time were interviewed and NA #5 had not asked anyone to assist her with lift use.
d. Staffing levels were appropriate and another NA was available to assist but was not asked.

Root cause analysis revealed the cause of the fall to be a combination of the aide not following facility protocol and using the incorrect pad.

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F 689	Continued From page 48 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. NA#5 was terminated on 7/29/2022 at 10 am for failure to follow facility protocols. 2. Use of mechanical lifts was suspended for all residents until all investigations complete. a. All residents using a mechanical lift have the potential to be affected. b. 100% of NAs and Nurses were in-serviced on facility policy regarding mandatory use of two people for all mechanical lifts, what correct lift pads look like, where to locate the pads and how to use them. Staff then showed understanding through return skills demonstration. Any staff member that was not able to be in-serviced on this date will not be allowed to return to work until they have received their education. Completed 7/29/22 c. All lift pads were inspected and found to be appropriate in size/fit for the Facility's mechanical lifts. Completed 7/30/22 d. Maintenance Director inspected all lifts for proper function and found that all mechanical lifts are in proper working order and have been routinely inspected and found to be in working order per Facility policy and/or manufacturer's recommendations. Completed 7/29/22 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. 100% of NAs and Nurses were in-serviced on facility policy regarding mandatory use of two people for all mechanical lifts, what correct pads look like, where to locate them and how to use them. Any staff member that was not able to be in-serviced on this date will not be allowed to return to work until they have received their	F 689		

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F 689	Continued From page 49 education. Completed 7/29/22 b. All lift pads were inspected and found to be appropriate in size/fit for the Facility's mechanical lifts. Completed 7/30/22 c. Maintenance Director inspected all lifts for proper function and found that all mechanical lifts are in proper working order and have been routinely inspected and found to be in working order per Facility policy and/or manufacturer's recommendations. Completed 7/29/22 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. a. Nursing Administration staff will conduct random skills checks on 10% of NAs for proper use of lifts and pads weekly x4 weeks, monthly x 2 months, and quarterly x3 or until such time as no incidents of failure to comply with Facility policy are noted. b. Mechanical lifts will be checked monthly by Maintenance Director and lift pads will be checked monthly by Central Supply. c. The QA committee will review all results monthly and implement or modify actions as need. This corrective action plan was in place on 7/30/22 by the Administrator. The corrective action plan was verified through record review of the education and monitoring of mechanical lift transfers, interviews with facility staff, observation of a mechanical lift transfer and observations of Resident #72. Based on observations, interviews, and record reviews the facility's compliance date of 7/30/22 was verified.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		11/16/22

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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 observations, staff interviews, and record review the facility failed to provide tracheostomy care following sterile technique when a nurse did not don sterile gloves prior to suctioning a resident's tracheostomy (Resident #45) and failed to set oxygen as ordered (Resident #30) for 2 of 4 residents reviewed for tracheostomy and respiratory care.

Findings included:

1. Resident #45 was admitted to the facility on 6/29/18. Her active diagnoses included chronic respiratory failure with hypoxia, alveolar hypoventilation (a disorder where a person does not take enough breaths per minute), and tracheostomy.

Resident #45's minimum data set assessment dated 8/4/22 revealed she was assessed as severely cognitively impaired. She required extensive assistance with personal hygiene. She was documented to receive tracheostomy care in the facility.

Review of Resident #45's care plan dated 8/4/22

F 695

Corrective Action for the Resident Affected
On 10/11/2022, the Director of Nursing, (DON) provided 1:1 re-education to Nurse #1 on proper procedure for tracheostomy care with return demonstration.
On 10/12/2022, the DON reviewed the MD oxygen orders for resident #30 to ensure the oxygen concentrator to the prescribed dosage.

Corrective Action for the Residents Potentially Affected
All residents with tracheostomies have a potential to be affected. On 10/11/2022, the Director of Nursing (DON) and Administrative Nursing reviewed resident's charts and identified 5 residents with tracheostomies. The DON and or Administrative Nurses observed 1:1 tracheostomy care on each resident to ensure proper technique was performed.
All resident's with orders for oxygen therapy have the potential to be affected. On 10/15/22, the DON and or Administrative Nurses reviewed all

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revealed she was care planned for respiratory risk related to the presence of a tracheostomy.

Review of Resident #45's orders revealed on 10/1/22 she was ordered to have tracheostomy care to be done every shift.

During observation on 10/11/22 at 8:07 AM Nurse #1 was observed providing tracheostomy care to Resident #45 in the resident's room. The nurse performed hand hygiene, donned clean gloves, and opened the tracheostomy supplies for care. With the same gloves, she removed the tracheostomy suctioning catheter from the packaging and attached it to the bedside suctioning device. Sterile gloves were observed left in the tracheostomy kit package. Continuing to use the clean gloves, the nurse suctioned Resident #45's tracheostomy.

During an interview on 10/11/22 at 10:48 AM Nurse #1 stated she did not remember tracheostomy suctioning was a sterile procedure and she should have donned sterile gloves prior to completing preparation of her sterile field and suctioning of the resident's tracheostomy.

During an interview on 10/11/22 at 11:15 AM the Director of Nursing stated sterile technique should be followed by staff during tracheostomy suctioning.
2. Resident #30 was admitted to the facility on 5/30/21 with a diagnosis of seizures.

A review of her quarterly Minimum Data Set (MDS) assessment dated 8/3/22 revealed she was severely cognitively impaired. She required the extensive assistance of one person for bed mobility, transfers and locomotion and the total

F 695

residents charts going back for 30 days, to ensure any resident receiving oxygen therapy was receiving the correct amount of oxygen per MD orders. The DON and or Administrative Nurses observed 6 out of 6 no changes were needed. There were 6 PRN noted as well for no changes needed.

Systemic Changes
On 11/2/2022, the Staff Development Coordinator initiated an in-service with the licensed nurses on following proper technique on tracheostomy care. Any Licensed nurse that did not received the in-service will not work until they have received the in-service. This in-service will be a part of the facilities orientation process for training of new licensed nurses, as well as include Agency staff.
On 11/2/2022, the Staff Development Coordinator initiated an in-service with the licensed nurses on following MD orders for oxygen therapy. Any Licensed nurse that did not received the in-service will not work until they have received the in-service. This in-service will be a part of the facilities orientation process for training of new licensed nurses, as well as include Agency staff.
The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with a tracheostomy will have their tracheostomy cleaned using proper sterile technique, by utilizing the QA monitoring tool for trach care.
The DON and or Administrative Nurses

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assistance of one person for personal hygiene. She received tracheostomy (a hole in the front of the neck where a tube is inserted to help with breathing) care and oxygen therapy.

A review of the current comprehensive care plan for Resident #30 revealed a focus area last updated on 8/3/22 of respiratory risk related to tracheostomy on 2 liters (L) of oxygen (O2) via tracheostomy collar. The goal was for respiratory risks to be minimized with interventions. Interventions included notify the physician or nurse practitioner (NP) of change in status and monitor O2 saturations.

The October 2022 active physician's orders for Resident #30 included O2 2L via tracheostomy.

A review of Resident #30's Medication Administration Record (MAR) for October 2022 revealed an order for O2 at 2L via tracheostomy. There were initials present on the MAR on 10/11/22 for the 7AM-3PM shift indicating staff verified this flow rate. It further revealed initials present on 10/11/22 for the 11PM-7AM shift indicating staff verified this flow rate.

On 10/11/22 at 8:26 AM an observation of Resident #30 revealed her O2 flow rate was set to 4.5 L which she was receiving via her tracheostomy. Resident #30 was in bed, smiling and did not appear to be in any distress.

On 10/12/22 at 6:38 AM an observation of Resident #30 revealed she was in bed. Her O2 flow rate was set to 4.5 liters which she was receiving via her tracheostomy. She was smiling and did not appear to be in any distress.

F 695

will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with orders for oxygen are receiving the prescribed oxygen, by utilizing the QA monitoring tool for oxygen orders.

Quality Assurance (QA)
The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed.

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On 10/12/22 at 6:41 AM an observation of Resident #30 with Nurse #2 revealed her O2 flow rate was set at 4.5L. An interview with Nurse #2 at that time indicated Resident #30's physician's order for O2 was 2L via tracheostomy. Nurse #2 stated she took over the care of Resident #30 at 6:00 AM that morning from Nurse #3. She stated she did look in on Resident #30 at 6:00 AM when she assumed her care but did not specifically check her O2 flow rate. She went on to say Nurse #3 had not reported any changes in Resident #30's respiratory status. Nurse #2 further indicated she had not changed Resident #30's O2 flow rate from 2L to 4.5L and did not know why it would be at 4.5L. Nurse #2 was observed to change Resident #30's O2 flow rate from 4.5L to 2L.

A review of Resident #30's O2 saturations monitoring documented on her October 2022 MAR revealed the following:
10/11/22 7AM-3PM 95% on O2 2L
10/11/22 3PM-11PM 96% on O2 2L
10/11/22 11PM-7AM 96% on O2 2L

On 10/12/22 at 6:44 AM an interview with Nurse Aide (NA) #3 indicated she provided care to Resident #30 since 11PM on 10/11/22. She stated NAs did not change the O2 flow rates. She went on to say only nurses could do that. NA #3 stated she did not think Resident #30 would be able to reach her O2 or change the settings herself. She further indicated she provided Resident #30 with a bath that morning about 6:00 AM but had not noticed what her O2 flow rate was set at.

On 10/13/22 at 8:29 AM a telephone interview with Nurse #3 indicated she cared for Resident

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F 695	Continued From page 54 #30 from 11PM on 10/11/22 until 6AM on 10/12/22 when she reported off to Nurse #2. She stated she did not know why Resident #30's O2 flow rate would be set at 4.5 liters. She went on to say Resident #30's physician's order was for O2 at 2L. Nurse #3 further indicated she checked Resident #30's O2 flow rate that morning when Resident #30 was receiving her bath and it was set at 2L. On 10/13/22 at 10:45 AM an interview with NA #4 indicated she was familiar with Resident #30 and cared for her often. She stated Resident #30 required total assistance. She went on to say she did not think there any way Resident #30 could change her O2 settings herself. On 10/13/22 at 4:15 PM an interview with the Director of Nursing (DON) indicated Resident #30 should be receiving O2 at the flow rate ordered by her physician.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		10/13/22

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F 812	Continued From page 55 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure (1) 16 of 22 dishware were dry before being stacked and ready for use and (2) 2 of 10 dented cans were removed from the cart ready for use. The facility also failed to ensure 6 of 20 plates and bowels were clean prior to placing them on the tray line ready to use. These practices had the potential to affect food served to the residents. Findings included: 1.The initial tour of the kitchen was conducted on 10-10-22 at 10:05am with the Dietary Manager. The tour revealed the following: a. One 3-inch steam table pan was stacked wet on the rack labeled ready for use. b. one large flat metal pan was stacked wet and placed on a rack labeled ready for use. c. One 6 pound can of tropical fruit salad and one 6 pound can of pineapple tidbits were dented around the rim of the cans and placed on the rack ready for use. The Dietary Manager was interviewed on 10-10-22 at 10:20am. The Dietary Manager stated the pans, and the cans were ready to be used. She explained she was unaware of the pans being stacked wet or the cans being dented. The Dietary Manager explained the pans were to	F 812	Corrective Action Dishes/Pots/Pans and dome plate lids that were found with food debris and/or stacked wet were immediately removed from rotation, sanitized, and stored properly to allow proper air drying. 10-12-2022 Dented cans were immediately removed and discarded. 10-10-2022 Systemic Changes The Dietary Manager and dietary staff were in-serviced by the District Manager on air drying/storage dishes including dishes, pots, pans, and dome plate lids properly and cleanliness of kitchen bowls, plates, and cookware on 10-12-2022. The Dietary Manager and dietary staff were in-serviced by the District Manager on proper storage of dented cans on 10-12-2022. Quality Assurance Monitoring tools will be utilized proper drying, storage, and cleanliness of bowls, plates, dishes, pots, pans, and dome plate lids. Audits will be conducted daily x 4 weeks, weekly x 3 months. All results will be presented to the QAPI team for review. Monitoring tools will be utilized to ensure proper storage of dented cans. Audits will be conducted daily x 4 weeks, weekly x 3 months. All results will be presented to	

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F 812	Continued From page 56 be left separated during the drying process on the shelf and the cans should have been removed from the rack and placed on the shelf marked dented cans. 2. A second observation of the kitchen occurred on 10-12-22 at 11:30am with the Dietary District Manager. The second tour revealed the following: a.14 of 30 plastic dome plate lids on the tray line ready for use were observed to be stacked wet. b. 3 of 15 meal plates on the tray line ready for use were observed to have dried food particles. c. 3 of 10 small bowls on the tray line ready for use were observed to have dried food particles. The Dietary District Manager was interviewed on 10-12-22 at 11:45am. The Dietary District Manager stated she was unaware of the issues with the plate lids, plates and bowls. She explained staff were to inspect the dishes for cleanliness prior to placing them on the tray line and stated the kitchen did not have enough rack space for the plate lids to be separated so they could dry and so staff were stacking the plate lids wet and placing them on the tray line. The Administrator was interviewed on 10-13-22 at 3:58pm. The Administrator stated the dirty bowls and plates should not have been placed on the tray line and that he had already spoken with the Dietary District Manager.	F 812	the QAPI team for review.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment.	F 838		11/16/22

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The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);

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F 838	Continued From page 58 (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to review and annually update the Facility Assessment. Findings included: Review of the Facility Assessment revealed the assessment was last updated in September 2022. The document indicated the facility had a facility based and community-based risk assessment utilizing an all-hazards approach however there was not a risk assessment completed in the document. The Facility Assessment also indicated the facility had an Emergency Preparedness Plan that was up to date however the Emergency Preparedness Plan that was present was not complete.	F 838	Corrective Action The facility's Hazard Vulnerability Assessment (HVA) was updated to reflect a facility based and community-based risk assessment utilizing an all-hazards approach on 10-13-2022. The facility's Emergency preparedness plan was updated on 11-16-2022. Systemic Changes The facility safety committee met on 11-3-2022 to review the HVA and discuss corrections/updates to the Emergency Preparedness Plan. The changes/updates were completed and reviewed by the safety committee on 11-16-22.	

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F 838	Continued From page 59 The Administrator was interviewed on 10-13-22 at 5:07pm. The Administrator stated he was not able to produce a facility based and community-based risk assessment. He explained he thought it was completed but said he was unable to locate the assessment. The Administrator also discussed not being aware the Emergency Preparedness plan was not complete at the time the Facility Assessment was updated.	F 838	Quality Assurance The changes/updates to the HVA and Emergency Preparedness plans will be reviewed by the QAPI committee at their next scheduled meeting. The HVA and Emergency Preparedness Plan will be reviewed annually by the facility safety committee.	
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;	F 842		11/16/22

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(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

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F 842	Continued From page 61 Based on record review and staff interviews the facility failed to accurately document the administration of Sliding Scale Insulin coverage (Resident #77) and failed to accurately document when a medication was not administered (Resident #17) for 2 of 5 residents whose medications were reviewed. Findings included: 1.Resident #77 was admitted to the facility on 3/21/2017 with a diagnosis of diabetes mellitus. A review of her active October 2022 physician's orders revealed the following: Finger Stick Blood Glucose (FSBG) before meals (AC) and at hour of sleep (HS) Insulin Aspart Sliding Scale for blood glucose greater than 270 give additional 1 U, greater than 300 give additional 2 U, greater than 350 give additional 3 U, greater than 400 give additional 4 U. A review of Resident #77's October 2022 Medication Administration Record (MAR) revealed the following documentation: On 10/1/22 at 11:30 AM Resident #77's FSBG was 310. On 10/2/22 at 11:30 AM Resident #77's FSBG was 328. On 10/5/22 at 4:30 PM Resident #77's FSBG was 278. No documentation was present on Resident #77's MAR on these instances to indicate Sliding Scale insulin coverage was provided. On 10/11/22 at 5:51 PM an interview with Nurse #5 indicated she cared for Resident #77 on 10/5/22 at 4:30 PM when her FSBG result was	F 842	Corrective Action for the Resident Affected On 10/12/2022, 10/11/2022 and 10/15/2022, the Director of Nursing, (DON) provided 1:1 re-education to Nurse #1, Nurse 6, and Nurse#5 on proper documentation when giving medications and the procedures when the medication is not given. Corrective Action for the Residents Potentially Affected All residents have the potential to be affected. On 11/4/2022, the Director of Nursing (DON) and Administrative Nursing reviewed Resident's Medication Administration Records (MAR) and Treatment Administration Records (TAR) going back for the last 30 days to ensure that medications given were documented timely. All resident's receiving medications have the potential to be affected. On 11/4/2022, the DON and or Administrative Nurses reviewed all residents' orders going back for the last 30 days to ensure that if a resident had an order for a medication that the medication was in the medication cart and or in the facility to be given. If found medication was not available, a call was made to the MD to notify in case new orders were needed and sent to pharmacy. Those not available, pharmacy was notified to send medications the same evening. Systemic Changes On 11/4/2022, the Staff Development Coordinator initiated an in-service with the	

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documented as 278. She stated she did administer the additional 1 U of insulin per the Sliding Scale insulin coverage but must have forgot to document it. She went on to say she knew she should have documented this on Resident #77's MAR but must have gotten distracted and forgot.

On 10/13/22 at 1:04 PM a telephone interview with Nurse #6 indicated she cared for Resident #77 on 10/1/22 at 11:30 AM when her FSBG result was documented as 310. She stated she did administer the additional 2 U of insulin per the Sliding Scale insulin coverage but forgot to document it. She went on to say she knew she should have but it was an oversight on her part. Nurse #6 further indicated she also cared Resident #77 on 10/2/22 at 11:30 AM when her FSBG result was documented as 328. She stated she did administer the additional 2 U of insulin per the Sliding Scale insulin coverage but forgot to document it. She went on to say she knew she should have but this was also an oversight on her part.

On 10/13/22 at 4:15 PM an interview with the Director of Nursing (DON) indicated nurses should be accurately documenting the medication they administered on the resident's MAR.

2. Resident #17 was admitted to the facility on 7/7/21. His active diagnoses included vitamin D deficiency.

Review of Resident #17's orders revealed on 9/20/22 he was ordered ergocalciferol vitamin D2 50,000 units per 1.25 milligrams take one capsule by mouth every month on the 28th.

Review of Resident #17's medication

F 842

licensed nurses on failure to properly document when giving a medication. Any Licensed nurse that did not received the in-service will not work until they have received the in-service. This in-service will be a part of the facilities orientation process for training of new licensed nurses, as well as include Agency staff. The DON and or Administrative Nurses will conduct random audits on the medication and monitoring the nurses passing medications 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure medications are available by utilizing the QA monitoring tool for medication administration and proper documentation.

On 11/4/2022, the Staff Development Coordinator initiated an in-service with the licensed nurses on notifying the MD when medications are not available in case an order needs to be given for a medication exchange. The in-service also included to notify the DON and the family if medications are not available and how to properly inventory the medication carts to ensure medications are always available. Any Licensed nurse that did not received the in-service will not work until they have received the in-service. This in-service will be a part of the facilities orientation process for training of new licensed nurses, as well as include Agency staff. The DON and or Administrative Nurses will conduct random assessments of the medication and treatment carts, 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure medications are available by utilizing the

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F 842	Continued From page 63 administration record for October 2022 revealed on 10/1, 10/2, 10/3, 10/4, 10/5, 10/6, 10/7, 10/9, and 10/10 at 8:00 AM ergocalciferol vitamin D2 50,000 units per 1.25 milligrams was initialed by the nurse. During an interview on 10/12/22 at 8:49 AM Nurse #1 stated if a medication is initialed on the medication administration record on a day, then the medication was given that day. The nurse showed the surveyor the medication in question was not available on the cart to be given yet in October 2022. She continued and stated their pharmacy sent resident medications weekly and the medication would not be in the cart for this month until Monday 10/24/22 as the medication was due on Friday 10/28/22. Upon review of the medication administration record, the nurse stated she did not have a reason she initialed the medication administration record as she did not give the medications those days. During an interview on 10/12/22 at 8:50 AM the Director of Nursing stated initials on the medication administration record indicated the medication would have been given, however, the medication would not have been available on the cart to have been given on the dates in question. The Director of Nursing concluded the medication administration record had been marked in error and should not have been initialed.	F 842	QA monitoring tool for medication availability. Quality Assurance (QA) The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed.	
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	F 880		11/16/22

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, 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

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F 880	Continued From page 65 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Physician interviews the facility failed to follow infection control practices when 2 of 2 nursing assistants (NA) (NA #11 and NA #12) failed to perform hand hygiene between resident contact while passing meal trays. Findings included: Review of the facility's "Hand Washing" policy and procedure dated October 2014 revealed in part all personnel shall follow established hand washing procedures to prevent the spread of infection and disease. Alcohol based sanitizers may be used instead of soap and water if hands are not visibly dirty. Hand washing is performed before and after	F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10/10/2022 and 10/11/2022, the NA #11 and NA# 12 were re-educated on the facilities policy for infection control on performing hand hygiene between resident contact while passing meal trays. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be	

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resident contact.

Review of the "Hand Hygiene: Why, How and When" education revealed all staff received education on hand washing 9-14-22. The education included when to use alcohol-based sanitizer and when to use soap and water.

a.A continuous observation of lunch trays being passed occurred on 10-10-22 from 12:17pm through 12:20pm. NA #11 was observed in resident room 229 touching the resident's silverware, the drinking glasses and holding the resident's hand. NA #11 walked out of room 229 without performing hand hygiene, opened the meal cart, retrieved another lunch tray off the meal cart and entered resident room 226, approaching the resident in bed "A". NA #11 was observed touching the resident's silverware and drinking glasses then holding the resident's hand. She exited room 226 without performing hand hygiene, walked to the meal cart, obtained a meal tray and walked into resident room 230. She approached the resident in bed "A" touching the resident's tray table and removing the lid off the resident's meal. NA #11 exited room 230 without performing hand hygiene.

NA #11 was interviewed on 10-10-22 at 12:20pm. The NA stated she had received education on hand hygiene last month but stated she thought she only had to perform hand hygiene when her hands were visibly dirty. NA #11 commented she did not think she had to perform hand hygiene between resident interactions if her hands were not dirty. NA #11 was observed to perform hand hygiene before continuing to provide lunch trays to the residents.

F 880

affected by the alleged deficient practice.
From 10/10/2022 to 11/9/2022, staff received a copy of the infection control policy relating to performing hand hygiene.
On 10/10/2022 to 11/9/2022, Licensed Nurses and Certified Nursing Assistants provided return demonstration of proper hand washing technique to the DON and or Administrative Nurses.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Staff Development Coordinator was re-educated by the Director of Nursing on 10/10/2022, on the facility□s policy for Infection Control Practices as it relates to hand washing hand hygiene between resident contact while passing trays.

On 10/10/2022 through 11/9/2022 all staff has been re-educated on the facility policy titled Infection Control Hand Hygiene, indicating proper hand hygiene when passing meal trays between residents.

Staff that did not receive the education before midnight of 11/9/2022, will not be able to work until they do so.

New hires, including any new agency staffing will not be permitted to start an assignment until they have been educated on the facility policy titled Infection Control Hand Hygiene.

The Director of Nursing and or

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On 10-10-22 at 12:35pm, Nurse #7 was interviewed who stated she was responsible for supervising the NAs but said she cannot monitor them closely when she was trying to pass medications. The nurse discussed NA #11 needing to perform hand hygiene between each resident encounter and stated she would discuss hand hygiene with the NA.

b. On 10-11-22 from 9:16am to 9:18am, a continuous observation of delivery of breakfast trays occurred. NA #12 was observed entering resident room 222 and approaching the resident in bed "B" with the breakfast tray. She was observed touching the resident's tray table, silverware and drinking glasses. NA #12 exited room 222 without performing hand hygiene and walked to the meal cart to retrieve another breakfast tray. She entered room 222 and approached the resident in bed "A", touching the residents tray table, silverware and drinking glasses. NA #12 exited room 222 without performing hand hygiene, walked to the meal cart and retrieved another breakfast tray. The NA entered resident room 224 and approached the resident in bed "A". She was observed touching the resident's tray table and the lid to the resident's meal. NA #12 exited room 224 without performing hand hygiene.

NA #12 was interviewed on 10-11-22 at 9:19am. The NA stated she had received education on hand hygiene yesterday (10-10-22). The NA retrieved a bottle of hand sanitizer from her pocket and stated "I am supposed to be sanitizing my hands between each resident encounter. I just forgot." NA #12 was observed to perform hand hygiene before continuing to provide breakfast trays to the residents.

administrative staff will complete an audit on during each meal 3 times a week for 6 weeks, then weekly times 4 weeks, then monthly. Results of the audit will be reported to the Administrator. Any staff found not to be following infection control protocols will have progressive disciplinary action.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The Director of Nursing will present the results of these audits to the Administrator at the Monthly Quality Assurance Performance Improvement (QAPI) Meeting times 6 months, for further problem resolution if needed.

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The Assistant Director of Nursing (ADON) was interviewed on 10-10-22 at 1:15pm. The ADON stated staff had received education on hand hygiene but could not remember when the education occurred. She stated she expected staff to perform hand hygiene between each resident encounter.

During an interview with the Infection Preventionist (IP) Nurse on 10-10-22 at 1:47pm, the IP nurse discussed the staff had received education on hand hygiene last month. She stated the education included washing hands between each resident encounter and that she expected staff to perform hand hygiene between each resident encounter. The IP nurse stated she did not know why staff was not performing hand hygiene but planned on providing further education.

The Director of Nursing (DON) was interviewed on 10-11-22 at 9:20am. The DON discussed staff receiving education on hand hygiene last month and stated management had started re-educating staff on hand hygiene yesterday (10-10-22). The DON said she thought NA #12 had not performed hand hygiene between each resident contact because she was nervous but expected staff to perform hand hygiene between each resident encounter.

A telephone interviewed with the facility Physician occurred on 10-13-22 at 3:15pm. The Physician discussed the recommendation for hand hygiene was to be completed between each resident contact and stated staff should be performing hand hygiene between residents. The Physician also stated there could be a possibility of

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F 880	Continued From page 69 infections to be spread from one resident to another when hand hygiene was not performed. The Administrator was interviewed on 10-13-22 at 3:58pm. The Administrator discussed hand hygiene education was provided to staff almost monthly and did not know why staff were not completing hand hygiene between each resident contact.	F 880		