STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	543 MAPLE AVENUE REIDSVILLE, NC 27320

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 4/17/2023 through 4/20/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZDNU11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 4/17/2023 through 4/20/2023. Event ID# ZDNU11. The following intakes were investigated NC00192007, NC00193026, NC00193780, NC00194415, NC00190534, NC00194693, NC00194751, NC00195675, NC00196605, NC00196692, NC00199011, NC00199367, NC00199512, NC00199529, NC00199531, NC00199535, and NC00200943. 27 of the 66 complaint allegations resulted in deficiencies.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		5/19/23

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

Electronically Signed | 05/15/2023

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F 550	Continued From page 1 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 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 staff and resident interviews, observations, and, record review, the facility failed to provide a dependent resident incontinence care after a bowel movement which caused the resident to feel embarrassed and angry (Resident #30), failed to provide a dependent resident incontinence care at breakfast time with urine soaked through to the mattress which caused the resident to feel horrible and cry (Resident #41), and failed to provide a dependent resident incontinence care when requested which made	F 550	F550 Incontinent care was provided immediately if it had not already been completed and concerns were discussed with the affected residents. 1-1 counseling and education was given to the identified staff by the Director of Nursing to include timely answering of call lights, and timely incontinent care. All incontinent residents have the potential to be affected. Interviews of all alert and	

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F 550	Continued From page 2 the resident feel horrible and neglected while waiting for care (Resident #245) for 3 of 5 residents reviewed for dignity. Findings included: 1. Resident #30 was admitted to the facility on 5/26/21 with the diagnoses of convulsions and chronic pain syndrome. Resident #30's quarterly Minimum Data Set dated 3/15/23 documented the resident had an intact cognition. The resident required 1-person physical assist for toileting/incontinence care. The resident was frequently incontinent of urine and always incontinent of bowel. Resident #30's care plan dated 1/20/23 documented an activities of daily living deficit with extensive assistance of 1 staff for toileting, personal care, and bowel and bladder incontinence. On 04/18/23 at 11:20 am Resident #30 was interviewed. He stated that "this past Sunday (4/16/23) there were only 3 Nursing Assistants (NA) for the whole building, and I was not assisted to the bathroom in the afternoon and had a bowel movement in my brief." No one assisted me for more than 2 hours. My roommate called his spouse around dinner time to call the facility and ask staff to help us, they were not answering the call light all afternoon. An NA would arrive, turn the light off and not return. Resident #30 stated It was embarrassing to be sitting in stool and stink. My roommate had to deal with that. "I was angry. The NA finally provided care after dinner." On 4/20/23 at 9:40 am an additional interview	F 550	oriented residents and non-alert and oriented residents responsible parties were conducted by Social Worker, Unit Managers and Administrator and completed on 5/11/23 with no concerns identified related to dignity for incontinence care. The Staff Develop Coordinator will educate staff on resident rights and promoting of dignity. The education included answering call lights, calling out for assistance, seeking assistance for a resident when asking for incontinent care and completing incontinent care thoroughly. Any staff member who does not receive this education by 5/19/23 will not be able to work until completed. New hires will receive this education in orientation. The Administrator or designee will conduct 10 resident and/or responsible party interviews weekly times 4 weeks, then 5 interviews times 4 weeks, then 2 interviews monthly time one month for validation of dignified care for the incontinent. Interviews will be conducted weekly or until discharge for resident #31, #41 and #245 by the Administrator or designee to ensure dignity is maintained. These audits will continue for 12 weeks. The Director of Nursing or designee will randomly audit 10 residents weekly for weeks then 5 residents for 4 weeks, the 2 residents monthly for one month for care of the incontinent resident in a timely manner and completion of tasks. The Administrator or designee will bring these audits to the Quality Assurance	

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was conducted with Resident #30. "I realize it was not the staff's fault, it was management, because there were not enough staff to help me. I felt embarrassed that I had odor and did not like to be soiled, but there was no major harm to me other than the embarrassment and anger."

On 4/20/23 at 10:40 am an interview was conducted NA #4. She stated that on Sunday 4/16/23 there were several NA call outs for evening shift. "I was not able to complete my assignment, which included incontinence care. We did as much as we could." She stated she had about 30 residents in her assignment and many residents complained about answering the call lights for assistance. NA #4 could not remember if she was assigned to Resident #30 but covered the hall the resident was on. Each resident received care as soon as possible.

On 4/20/23 at 9:55 am an interview was conducted with Nurse #1 who was assigned to Resident #30 during the evening shift on 4/16/23. Nurse #1 stated there were 3 NAs available for the building and incontinence care was delayed. Nurse #1 stated she was aware that incontinence care was delayed for all the residents in the building and assisted to answer call lights. Nurse #1 stated she had not remembered if she answered Resident #30's call light and received no phone calls from resident's family.

On 4/20/3 NA #5 was not available for interview (scheduled evening shift 4/16/23).

On 4/19/23 at 1:40 pm the Director of Nursing (DON) was interviewed. The DON stated that there were 4 or 5 NA call outs for evening shift on Sunday, 4/16/23. The DON stated she was not

Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.

Date of Compliance: May 19, 2023

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F 550	Continued From page 4	F 550		

aware that the staff was not able to complete their assignment and what happened to Resident #30.

2. Resident #41 was admitted to the facility on 06/06/22.

A review of the quarterly Minimum Data Set (MDS) dated 01/14/23 revealed that Resident #41 was cognitively intact and was able to understand others. Resident #41 had adequate vision and required extensive assistance with one-person physical assist for toilet use.

On 4/19/23 at 9:11 am an observation was made of Resident #41's call light on. At 9:14 am the Activity Coordinator entered the room and asked the Resident what she needed. Resident #41 informed Activity Coordinator she needed to be changed and stated she had asked to be changed before breakfast. The Activity Coordinator left the room and stated she was going to get materials to change the Resident's brief.

An interview was conducted with Resident #41 on 4/19/23 at 9:17 am and Resident stated she had asked to be changed before breakfast, she stated "I turned on my call light at 7:20 am and a staff member came in my room and told her it was too close to breakfast to be changed. Resident #41 indicated she looked at the clock on her wall to see what time it was.

On 4/19/23 at 9:20 am the Activity Coordinator returned to the room and an observation was made of incontinent care on Resident #41. The Activity Coordinator removed the old brief off Resident and the brief was observed to be saturated with urine. The incontinent pad under

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Resident was also soaked with urine, and the fitted sheet under the incontinent pad was wet with a brown ring. The Activity Coordinator had to leave the room to retrieve extra items. While the Activity Coordinator was out of the room Resident #41 stated she was last changed about 3:00 am. She stated, "it makes me feel horrible to sit in wet, cold urine, one night I laid in my urine/waste all night, I just cried, it happened when I first got here" Activity Coordinator reentered room at 9:26 am with the linen and continued to provide incontinent care on Resident #41. Resident's posterior thigh and inner thighs was observed to be excoriated. The Activity Coordinator applied a barrier cream to inner thighs and posterior thighs.

During an interview with the Activity Coordinator on 4/19/23 at 9:37 am she stated, she is a Nursing Assistant and answered the call light because she walked by and saw it on, she was not sure who the Resident's NA was. She verified the brief; incontinent pad and the sheet was soaked with urine. She stated the incontinent pad under Resident was soaked with urine and heavy, and the fitted sheet had a brown ring around it.

On 4/19/23 at 11:33 am an interview was conducted with NA #14 who was assigned to Resident #41. She indicated she was not aware Resident needed to have her brief changed and had not seen Resident's call light on. She stated Resident likes to sleep and will put the call light on when she is ready to be changed.

During an interview on 4/19/23 at 2:51pm with the Director of Nursing (DON) and she indicated staff was expected to provide care to residents when they ask or when they need to have their brief changed. The DON indicated her expectation was

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F 550	Continued From page 6	F 550		

for all residents in the facility to be treated with dignity and respect and no resident should have to wait over 30 minutes for care and treatment.

3. Resident #245 was admitted to the facility on 04/07/23.

A review of the admission Minimum Data Set (MDS) dated 04/11/23 revealed that Resident #245 was cognitively intact. Resident #245 required supervision with one-person physical assist for toilet use.

A review of a concern form dated 4/12/23 for Resident #245, indicated Nursing Assistant (NA) #12 mistreated Resident #245. The resolution was that NA #12 would no longer care for Resident #245.

On 04/18/23 at 1:30 pm during an interview with Resident #245, she stated she had to wait for two hours during the evening shift on 4/12/23 to get assisted to the bathroom. Resident #245 indicated she activated her call light, and the Nursing Assistant (NA) came in the room, turned off the call light and never returned. She explained she knew what time it was because she had called her daughter and she had a cell phone with the time on it. She indicated she then got up unassisted and helped herself to the bathroom. Resident #245 indicated that she was afraid but did not want to "wet" on herself nor have a fall. The resident stated that this made her feel neglected. Resident #245 indicated that once the NA came back to the room the NA was very rude and rough to her and this made her "very upset". Resident #245 indicated this information was reported to the staff at the facility. She was

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F 550	Continued From page 7 unable to recall which staff member. Resident #245 indicated that NA #12 made her feel horrible, bad, and neglected. A phone interview was attempted on 04/19/23 at 10:00 am with NA #12 who worked with Resident #245 on the evening shift on 04/12/23. An interview was conducted with the Director of Nursing on 04/20/23 at 12:53 pm, and she indicated the Nursing Department was staffing challenged. The DON indicated her expectation was for all residents in the facility to be treated with dignity and respect and no resident should have to wait over 30 minutes for care and treatment. An interview was conducted with the Administrator on 04/20/23 at 12:54 pm. He indicated that his expectation was for staff to always treat residents with respect and dignity.	F 550		
F 584 SS=E	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	F 584		5/19/23

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F 584	Continued From page 8 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); §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 observations and staff interviews, the facility failed to clean and maintain the floors, walls, ceiling, window sills/trim, and the exterior surfaces of the PTAC units (individual heating and air conditioning units) and tray tables in the resident rooms in good repair on 3 of 3 hallways observed (C Hallway, A Hallway and B Hallway). The findings included: 1. An observation of Room C27 was conducted on 4/17/23 at 12:25 PM. The trim around the	F 584	F584 Housekeeping and the Maintenance Director addressed the concerns in the indicated rooms upon notification of the issues. All residents have the potential to be affected by this deficient practice. The Administrator, Maintenance Director and Housekeeping Supervisor rounded all resident rooms to determine cleanliness and repair concerns. The results of the audit were used as a base line for	

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F 584	Continued From page 9 room's PTAC unit had a thick layer of a grayish brown substance on it. There was also a dark brown substance observed on the flooring around the perimeter of the PTAC unit. An observation of Room C29 conducted on 4/18/23 at 8:50 AM revealed the PTAC unit was dirty with multiple brown spots on the outside of the unit. The trim above the PTAC unit had a 12-inch-long brown stain on it. The trim under the window and above the PTAC unit also had a 9-inch-long scrape where the paint and part of the wood trim was missing. The electrical outlet used for the PTAC unit was covered with a gray-brown dusty-appearing substance. The floor around the sink in the room and on the adjacent wall had a thick brown-gray substance on it. The wall next to the bed closest to the door (Bed A) had several deep scrapes running the entire length of the bed with paint missing from these areas. Bed A's tray table had a gray-brown dusty-appearing substance covering its base. On 4/19/23 from 1:30 PM to 2:00 PM, a tour of each of the residents' rooms on the C Hallway was conducted with the facility's Maintenance Director and Housekeeping Director. Concerns related to the cleanliness and condition of the rooms observed during this tour included the following: --Room C10: The base of the residents' tray tables each had a dark brown/black substance covering them. The floor tiles under Bed A were observed to be stained or discolored brown. At the time of this observation, the Maintenance Director reported Room C10 was scheduled to be renovated the following week. --Room C12: Twenty-four (24) floor tiles were observed from the doorway of the room to have	F 584	measuring housekeeping outcomes. Room C27 PTAC unit and perimeter was cleaned by Maintenance/Housekeeping. Ceiling Tiles were replaced. Sink & perimeter cleaned Room C29 PTAC cleaned, trim repaired, electrical outlet cleaned. The sink and perimeter was cleaned. Floor tiles were repaired. Over the bed table cleaned. C10 The Over the Bed table was cleaned. Floor tiles replaced C12 The total floor was replaced C26 Naked telephone wires were covered. dead bugs were removed from ceiling C28 Over the bed table cleaned. Decorative window trim replaced. Dust and webs were removed. C29 The PTAC was cleaned. Sink and perimeter area were cleaned. A21 The floor was cleaned B18 The floor was cleaned B19 The Floor was cleaned. The sink and perimeter were cleaned B20 Baseboard and floor were cleaned B21 The floor was cleaned	

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F 584	Continued From page 10 small raised/warped areas on the flooring. --Room C26: Telephone wires were observed to be exposed on the wall between Bed A and Bed B (the bed placed nearest to the window). Both the Maintenance Director and Housekeeping Director reported these wires needed to be covered. Two dead bugs were observed lying in the ceiling light panel. --Room C27: The observation revealed the trim and flooring around the PTAC unit continued to have a gray-brown and dark brown substance on them. During the tour of the C-Hall residence hall, additional concerns for this room were noted to include one ceiling tile with water damage and the baseboard/flooring by the sink had approximately 1/8-inch of a brown/black substance around the perimeter of the floor. --Room C28: The base of the residents' tray tables had a dark brown/black substance on them. Two dust webs were observed on the wall above Bed B, and one dust web was hanging approximately three inches down from the ceiling. A corner decorative block from the window trim was observed lying on the floor next to the PTAC unit. Two ceiling tiles were observed to have brown water spots on them. --Room C29: A tour of this room revealed none of the concerns previously identified on 4/18/23 had been corrected. The PTAC itself, electrical outlet, trim, and flooring around the PTAC unit remained dirty, stained, or damaged. The flooring around the room's sink, walls, and tray table were also observed to be dirty and/or damaged during the tour conducted with the Maintenance and Housekeeping Directors on 4/19/23. As the tour of the residents' rooms on the C Hallway was conducted on 4/19/23, the Maintenance Director reported the facility had	F 584	B22 The floor and toilet area were cleaned B25 The room was remodeled. The floor was stripped and waxed. The Regional Housekeeping Director completed education with housekeeping staff on proper cleaning of rooms. The Administrator educated the Maintenance Director on timely repairs in rooms. The Administrator educated staff members on how to report maintenance needs/requests to the Maintenance Director. The Administrator and Department Heads will complete assigned room rounds 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks and then weekly ongoing. These rounds will focus on cleanliness and any repair needs. The Administrator will gather concerns identified during these rounds and assign concerns to the appropriate person. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed. Date of Compliance: May 19, 2023	

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been prioritizing the renovation of two residents' rooms per week. The Maintenance Director stated the C-Hall resident rooms had not yet been renovated. When asked, the Housekeeping Director reported the residents' tray tables, the outside housing of the PTAC units, windowsills, and trim should all be cleaned and dusted on a daily basis. Also, she noted the floor should be swept and mopped daily with the flooring near the baseboard and around the walls scraped and cleaned as needed.

An interview was conducted on 4/19/23 at 3:34 PM with the facility's Administrator. During the interview, concerns identified in the resident rooms on the C Hallway were discussed. The Administrator reported two rooms per week were being renovated and deep cleaned. However, he expressed concern that all issues identified during the tour conducted with the Maintenance and Housekeeping Directors would take a while to fix as the facility's maintenance and repair had been "neglected" for quite some time.

2. a. Observation was conducted on 4/18/23 at 7:45 AM, Room A21 the floor was very sticky, there was left over paper cups and trash on the floor, base board area had brown matter and old food crumbs encrusted in the corners around the bed and base board. The bathroom floor was sticky with a strong urine odor present.
b. Observation was conducted on 4/18/23 at 8:00 AM, Room B18 the floor had brown dried stain spots throughout the room, the floor was sticky and underneath both beds had dried fluid stain and matted food on the floor. The bathroom had

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a strong urine, fecal odor and dried urine around the front and back of toilet and base board area had a large volume of brown mattered encrusted in the seams.
c. Observation was conducted on 4/18/23 at 8:15 AM, Room B19, the floor was very sticky, heavily stained and a very strong urine odor was present. There was stained dried liquids and old food under resident beds and around dresser and closet area. The base board around resident beds and sink area was very brown and dirty with large amounts of pushed dirt in the creases of the trim. The bathroom floor was very sticky with dried urine and brown matter encrusted around the toilet base and wall splatters of some unknown substance.
d. Observation was conducted on 4/18/23 at 9:30 AM, Room B20, the base board and floor was severely stained with unknown substances, old paper products and food were under resident bed. Around the toilet there were dried brown matter and under the sink at the base board there was also brown matter and dirt on into the floor and base board area throughout the bathroom and the floor was very sticky.
An interview was conducted on 4/19/23 at 9:05 AM, Housekeeper #4 stated inside of each cart there was a cleaning checklist for all the responsibilities and task that needed to be done in each resident room. She reported sweeping/mopping, empty trash, dust, wipe down window ceils, wipe down the front grates on the heating system, clean bathrooms completely. HK#4 stated she cleans the rooms in accordance with the daily cleaning schedule.
e. Observation was conducted on 4/19/22 at 9:30 AM, Room B21, the floor was very stained with dried brown and yellowish liquid on the floor under resident beds, around dresser and closet

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area. Old food products were under the sink area and there were large amounts of dirty pushed toward the base boards of the bedroom and in the bathroom. The bathroom walls had some brown matter on them at the back of the toilet area.
f. Observation was conducted on 4/19/22 at 9:45 AM, Room B22, the bathroom floor was very sticky and dirt and brown matter was encrusted around the toilet base, base board under sink and surrounding walls of the bathroom. There was a strong fecal/urine odor embedded in the room and bathroom. The floor around the resident's dresser and under bed had old paper products and previous meal on the floor.
g. Observation was conducted on 4/19/22 at 9:50 AM, Room B25, the bedroom floor was very sticky had paper products, food, used wipes and tissues under beds, left over trash bags of soiled briefs under sink. The room had a strong urine odor, old dirt and food products were pushed toward the base boards of the corners of the room. The bathroom floor was heavily stained with unknown substance.

An observation and interview were conducted on 4/19/23 at 11:45 AM. The Housekeeping Supervisor (HKS) observed the identified rooms and confirmed additional cleaning needed to be done. The HKS stated each housekeeper was provided with a daily assignment to thoroughly clean resident rooms, bathrooms, sweep mop, empty trash and the assigned rooms would be deep cleaned weekly. The Housekeeping Supervisor acknowledged some rooms had not been cleaned in accordance with the cleaning checklist.

A follow-up observation was conducted on

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F 584	Continued From page 14 4/20/23 at 8:54 AM, with the Administrator of the identified rooms and confirmed that additional cleaning, floor stripping and waxing for all resident rooms in addition to painting and replacing any broken items in the room were necessary to improve the appearance of the facility. The Administrator stated he had received several concerns regarding the cleanliness of the facility from families and residents. The concerns included resident floors, bathrooms, and condition of the tiles throughout the facility. The Administrator stated the floors were stained and needed repairs/replacements in several areas in the facility. Staffing had been an issue, resulting in hiring additional staff for housekeeping/laundry to improve the quality of the facility's appearance. The Administrator further stated he met with the housekeeping team to increase the cleaning schedule of resident rooms to include deep cleaning, stripping/waxing floors to 2- 3 resident rooms daily.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of dental for 1 of 4 residents reviewed for resident assessments (Resident #84). Findings included:	F 641	F641 On 4-19-2023 the MDS coordinator modified the 5-day admission assessment for resident #84 to include obvious cavities or broken natural teeth. Other new admissions have the potential to have dental coded incorrectly on their 5- day Minimum Data Set (MDS) admission assessment. The Minimum	5/19/23

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F 641	Continued From page 15 Resident #84 was admitted to the facility on 2/23/23 with the most recent readmission date of 3/18/23. Review of Resident 84's admission minimum data set assessment (MDS) dated 2/26/23 revealed she was cognitively intact. Obvious or likely cavity or broken natural teeth was not marked. During an interview on 4/17/23 at 1:05 PM with Resident #84, she was observed to have brown, missing, and broken upper and lower teeth with some broken at the gum line. During the interview a piece of one of her back teeth broke off as she was talking. She explained her teeth had gotten worse over the last few years and she was concerned that the newly broken tooth could cause her pain. She denied having pain during the interview and stated she had not had a dental assessment since admission. In an interview on 4/17/23 at 12:32 PM the Director of Nursing stated she was unaware of the condition of Resident #84's teeth. On observation of Resident 84's teeth, she said she would inform the social worker that a dental consultation was needed for the Resident. An interview with the MDS Nurse was conducted on 4/19/23 at 11:41 AM. She revealed she assessed new admissions for dental concerns. She stated the MDS guidelines instructed her to look at a resident's teeth and mouth during her MDS assessment. She explained she had not marked Resident #34's MDS for obvious or likely cavity or broken natural teeth and she had miscoded the MDS. During an interview on 4/19/23 at 11:57 AM the	F 641	Data Set coordinator and Assistant Coordinator will complete a 100% audit of the 5 -day Minimum Data Set (MDS) admission assessments regarding dental coding for new admissions from the past 30 days. All oral evaluations matched the MDS and 5 five dental referrals were made. The Minimum Data Set coordinator will address any concerns and notify the Director of Nursing of the need to modify any assessment. The Regional Minimum Data Set Coordinator will educate the Minimum Data Set Coordinator and Assistant Coordinator on Minimum Data Set (MDS) accuracy with an emphasis on the dental coding of the assessment. This education will be completed by 5-15-2023. Any new MDS coordinators will be educated during orientation before working. The Regional Minimum Data Set Coordinator will audit 5 new admissions a week for 4 weeks, then 3 new admissions a week for 4 weeks and then 2 new admissions a week for 4 weeks. The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: May 19, 2023	

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F 641	Continued From page 16 Administrator stated his expectation was that the MDS Nurse would ensure that the minimum data set assessments were correct and if inaccurate documentation was identified then it should be corrected.	F 641		
F 677 SS=E	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 staff and resident interviews, observations and record review, the facility failed to provide dependent residents assistance with incontinence care (Resident #s 30 and 41), showers and hair wash (Resident #21), nail care (Resident #80), and empty the urinal (Resident #3) for 5 of 9 residents reviewed for activities of daily living. Findings included: 1. Resident #30 was admitted to the facility on 5/26/21 with diagnoses of convulsions and chronic pain syndrome. Resident #30's quarterly Minimum Data Set dated 3/15/23 documented the resident had an intact cognition. The resident required 1-person physical assist for toileting/incontinence care. The resident was frequently incontinent of urine and always incontinency of bowel. Resident #30's care plan dated 1/20/23 documented an intact cognition and activities of daily living deficit with extensive assistance of 1	F 677	F-677 Residents #30 and #41 were provided incontinent care and were allowed to discuss their concerns with the Director of Nursing. Resident #21 was provided a shower and to have his/her hair washed. Resident #80 had nail care completed. Resident# 30s urinal had been emptied and he was allowed to discuss his concerns with the Director of Nursing. All residents have the potential to be affected by the same deficient practice regarding ADL Care. An audit was completed by the Director of Nursing and Unit Managers on all residents checking to ensure that no other resident had concerns with ADL concerns. All ADL/nail care concerns were immediately corrected. The Staff Development Coordinator will provide education to nursing staff on ADL Care with a focus on incontinence care, showers, documentation of showers and	5/19/23

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F 677	Continued From page 17 staff for toileting and personal care, and bowel and bladder incontinence. The resident had a history of moisture associated skin damage to his left buttock. There was no care refusal. On 4/20/23 at 9:40 am an interview was conducted with Resident #30. He stated on 4/16/23 there were only 3 Nursing Assistants (NA) in the building on evening shift (census 97). The NA told me there were only 3 NAs in the building and that was why they could not answer the call light and assist me. "I waited to receive incontinence care for over 2 hours, I was wearing my watch (pointed to a watch on his wrist). I realized there were not enough staff to help me. After 2 hours of waiting to be cleaned of stool, my roommate called his spouse to call the facility and send help to our room." On 4/20/23 at 9:55 am an interview was conducted with Nurse #1 who was assigned to Resident #30 on the evening shift 4/16/23.. Nurse #1 stated on 4/16/23 evening shift there were 3 NAs scheduled for the building and incontinence care was delayed (census 97). On 4/20/23 at 10:40 am an interview was conducted NA #4. She stated that on Sunday 4/16/23 there were several NA call outs. "I was not able to complete my assignment, which included incontinence care. We did as much as we could." She stated she had about 30 residents in her assignment, including Resident #30's hall. Resident #30 required incontinence care that was delayed and that was all the NA could recall. On 4/20/23 at 11:55 am an interview was conducted with NA #6. She stated that on	F 677	baths, nail care and documentation of nail care and rounding on rooms to be aware of urinals that need to be emptied. Nursing staff not receiving the education by May 19, 2023 will not be able to work until the education is completed. Newly hired staff will complete education in orientation. Observations will be made by the Unit Managers or designee for 10 residents a week for 4 weeks, then 5 residents a week for 4 weeks, and then 2 residents a week for 4 weeks. Observations will include incontinence care, shower, hair care and nail care. In addition, the Director of Nursing or designee will conduct a weekly audit on 4 residents who use urinals for 3 months to ensure that urinals are being emptied timely. The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: May 19, 2023	

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Sunday 4/16/23 there was a shortage of NAs on evening shift. NA #6 stated she completed the medication pass and was not aware that residents complained the call lights were not answered and incontinence care was not completed. NA #6 stated she had limited time to provide care during medication pass.

2. Resident #21 was admitted to the facility on 1/27/23 with the diagnosis of chronic obstructive pulmonary disease (COPD).

Resident #21 had a care plan dated 1/27/23 which included a mobility deficit for staff to provide assistance as needed. There was no care refusal.

Resident #21's admission Minimum Data Set dated 2/3/23 documented the resident had a moderately impaired cognition, understood, and understands. The resident required 1 extensive assistance of one staff member for incontinence care and bathing. The resident's diagnoses were heart failure, COPD, and respiratory failure and oxygen treatment.

A review of the bathing/shower activity of daily living documentation revealed Resident #21 had not had a bath or shower for the past 4 days, 4/16/23 - 4/19/23. The resident was scheduled for Tuesday and Thursday showers. A review back to 3/1/23 of the bathing documentation revealed the resident had 1 shower in March when her hair was washed.

On 04/18/23 at 11:43 am an interview was conducted and concurrent observation with Resident #21. Resident #21 stated she has not

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had a shower in over a week. Her hair appeared dirty/greasy and stuck in segments (matted). The resident was aware and able to verbalize her hair was dirty and she wanted a shower (hair was washed during the shower).

On 4/19/23 at 10:10 an interview was conducted with Resident #21. Resident #21 stated she had not received a shower, only morning care and her hair was not washed.

On 4/19/23 at 10:10 an observation was completed of Resident #21. Her hair appeared combed but not washed. The hair was less matted but still appeared greasy.

On 4/19/23 at 10:30 am an interview was conducted with Nurse #1. Nurse #1 stated she was not aware that Resident #21 was not receiving her scheduled showers. Nurse #1 checked the shower schedule and commented that the resident was scheduled for Tuesday and Thursday showers. The resident would receive a shower tomorrow (Thursday). Nurse #1 stated resident's hair would be washed during the shower, not during a bed bath.

4/19/23 at 12:53 pm an interview and observation concurrently was completed with Nursing Assistant (NA) #2. NA #2 stated Resident #21 had not received a shower yesterday (Tuesday), for hair wash, she was not scheduled and could not wash her hair today because there was not enough time on day shift. She had to pass lunch trays. The resident was scheduled for a shower tomorrow (Thursday) and NA #2 stated she would make sure the resident had a shower and not a bed bath. Observation of the resident in her room with NA #2 revealed the resident's hair was dirty

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and the resident stated she wanted a shower. NA #2 stated that the resident can have a shower and did not know why staff were giving her a bed bath instead of a shower.

4/19/23 at 12:45 pm interview with NA #1. She stated Resident #21 was having a bed bath and hair was not washed in the bed. NA #1 commented she was not aware of the shower schedule and had not known when Resident #21 last had a shower.

On 4/20/23 at 2:10 pm an interview and observation was conducted concurrently with Nurse #1. Nurse #1 stated she was not aware that Resident #21 had not received a shower on day shift today. Nurse #1 observed the resident state she wanted a shower.

On 4/20/23 at 3:30 pm an interview was conducted with the Administrator. He stated Resident #21 would receive a shower and hair wash this afternoon and was not aware the resident wanted a shower.

3. Resident #80 was admitted to the facility on 11/12/22 with the diagnosis of stroke.

Resident #80's care plan dated 11/16/22 documented an activities of daily living deficit from left-sided weakness. The resident required extensive assistance with bathing and personal hygiene and to clean and cut nails when he received his bath/shower.
There was no refusal of care.

Resident #80's quarterly Minimum Data Set dated 4/4/23 documented the resident had an intact cognition and required extensive assistance of 1

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for personal care, bathing, and dressing.

A review of Resident #80's bathing documentation documented the resident received a shower twice a week during April 2023. There was no documentation of nail care/trim.

On 04/18/23 at 11:10 am an observation was completed of Resident #80 while sitting in his wheelchair in the hall. His nails were long and dirty (all nails were long and right-hand nails were dirty underneath). During concurrent interview, the resident stated he would like his nails cut. He further stated staff had not offered to cut his nails.

On 4/19/23 at 10:30 am an observation was completed of Resident #80 sitting in his wheelchair at the nurses' station. He remained with long and dirty nails. A concurrent interview was conducted with Nursing Assistant (NA) #8. She stated that residents were to have their nails cut when they received their shower, and she did not know why the resident's nails were not cut. NA #8 stated NA staff could cut resident's nails if they were not a diabetic (Resident #80 was not a diabetic).

On 4/19/23 at 10:40 am an interview was conducted with Nurse #1. Nurse #1 stated she was regularly assigned to Resident #80. She did not know why the resident's nails were not cut, NA staff were required to cut the resident's nails when showered or inform the nurse if not able. The resident was not a diabetic and had not refused care. Nurse #1 stated she was not informed by the NA the resident needed his nails cut.

On 4/20/22 at 2:40 pm an interview was

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conducted with the Director of Nursing. She stated that resident nails were to be cleaned and cut by the NA when showers or bathes were received. If the NA was not able to cut the resident's nails, the NA was required to inform the assigned nurse.

4. On 2/3/22 Resident #3 was admitted to the facility with the diagnosis of neurological deficit.

Resident #3's quarterly Minimum Data Set dated documented an intact cognition and activities of daily living required assistance of 1 staff.

Resident #3's care plan dated documented the resident had an activity of daily living deficit and required extensive assistance of one staff with personal care.

On 04/18/23 at 11:20 am an interview was conducted with Resident #3. He stated that this past Sunday (4/16/23) there were only 3 Nursing Assistants (NA) for the whole building, and I was not assisted to empty my urinal for hours. The urinal was full and when I tried to use the urinal it spilled in the bed. After hours of no staff help, I called my spouse to call the facility and ask staff to help us (roommate). "I just wanted help with my urinal and for staff to answer the call light." He stated my spouse called back to tell me no one answered the phone. When the NA finally arrived after dinner, the NA stated there were only 3 of them for all the residents this evening. He stated my sheets had to be changed from the urine and my roommate was wearing his watch and upset because he was waiting for help also.

On 4/19/23 at 1:40 pm the Director of Nursing

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stated that there were 4 or 5 call outs for evening shift on Sunday, 4/16/23. The staffing was 4 NAs for the building (census 97).

On 4/20/23 at 2:10 pm an interview was conducted with NA #4. She stated that on Sunday 4/16/23 evening shift there were NA call outs. "I was not able to complete my assignment including incontinence care and bathing/showers. We did as much as we could." She stated she had about 30 residents in her assignment including Resident #3's hall. Resident #3 required assistance that was delayed and that was all the NA could recall. If linen was soiled, it would have been changed during care/assistance.

On 4/20/23 at 2:55 pm an interview was conducted with NA #6. She stated that on Sunday 4/16/23 evening shift there was a shortage of NAs on evening shift. NA #6 stated she completed the medication pass and was not aware that residents complained the call lights were not answered and they waited to receive incontinence care. NA #6 stated she had limited time to provide care during medication pass.

On 4/20/22 at 2:40 pm an interview was conducted with the Director of Nursing. She stated staff were expected to provide dependent residents care and if unable to report to the nurse.

5. Resident #41 was admitted to the facility on 06/06/22 with diagnoses of type 2 diabetes and fibromyalgia.

Resident #41's quarterly Minimum Data Set dated

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01/14/23 documented the resident had an intact cognition. The resident required 1-person physical assist for toileting/incontinence care. The resident was frequently incontinent of urine and of bowel and was on diuretics.

On 4/19/23 at 9:11 am an observation was made of Resident #41's call light on. At 9:14 am the Activity Coordinator entered the room and asked the Resident what she needed. Resident #41 informed Activity Coordinator she needed to be changed and stated she had asked to be changed before breakfast. The Activity Coordinator left the room and stated she was going to get materials to change the Resident's brief.

An interview was conducted with Resident #41 on 4/19/23 at 9:17 am and Resident stated she had asked to be changed before breakfast, she stated "I turned on my call light at 7:20 am and a staff member came in my room and told her it was too close to breakfast to be changed." Resident #41 indicated she looked at the clock on her wall to see what time it was.

On 4/19/23 at 9:20 am the Activity Coordinator returned to the room and an observation was made of incontinent care on Resident #41. The Activity Coordinator removed the old brief off Resident and the brief was observed to be dark yellow in color and bulging with urine. The incontinent pad under Resident was also soaked with urine, and the fitted sheet under the incontinent pad was wet with a brown ring. The Activity Coordinator had to leave the room to retrieve extra items.

While the Activity Coordinator was out of the

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F 677	Continued From page 25 room Resident #41 stated she was last changed about 3:00 am. She stated, "it makes me feel horrible to sit in wet, cold urine, one night I laid in my urine/waste all night, I just cried, it happened when I first got here" Activity Coordinator reentered room at 9:26 am with the linen and continued to provide incontinent care on Resident #41. Resident's posterior thigh and inner thighs were observed to be excoriated. The Activity Coordinator applied a barrier cream to inner thighs and posterior thighs. During an interview with the Activity Coordinator on 4/19/23 at 9:37 am she stated she was a Nursing Assistant and answered the call light because she walked by and saw it on, she was not sure who the Resident's NA was. She verified the brief; incontinent pad and the sheet was soaked with urine. She stated the incontinent pad under Resident was soaked with urine and heavy, and the fitted sheet had a brown ring around it. On 4/19/23 at 11:33 am an interview was conducted with NA #14 who was assigned to Resident #41. She indicated she was not aware Resident needed to have her brief changed and had not seen Resident's call light on. She stated Resident likes to sleep and will put the call light on when she is ready to be changed. During an interview on 4/19/23 at 2:51pm with the Director of Nursing (DON) she indicated staff were expected to provide care to residents when they ask or when they need to have their brief changed. She stated staff were expected to provide dependent residents care and if unable to report to the nurse.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		5/19/23

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F 695	Continued From page 26 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 staff interview, observation and record review, the facility failed to provide humidified oxygen as ordered for 1 of 1 resident reviewed for respiratory care (Resident #21). Findings included: Resident #21 was admitted to the facility on 1/27/23 with the diagnosis of chronic obstructive pulmonary disease (COPD). Resident #21 had a care plan dated 1/27/23 which included a mobility deficit for staff to provide assistance as needed and oxygen therapy for COPD and congestive heart failure. Resident #21 had a physician order dated 1/27/23 for oxygen 3 liters by nasal cannula as needed for shortness of breath and oxygen saturation less than 90%. Resident #21's admission Minimum Data Set dated 2/3/23 documented the resident required extensive assistance for activities of daily living of one staff and had oxygen therapy. The resident's diagnoses were heart failure, COPD, and respiratory failure.	F 695	F695 Humidity was applied to concentrator for Resident #21 on 4-19-2023. 1-1 counseling and education was provided to the identified staff by the Director of Nursing. Residents on oxygen have the potential to be affected by the same alleged deficient practice. A room audit of all other residents on oxygen was completed by the Unit Managers to ensure humidity was available if ordered with Audit results showing no concerns identified. The Staff Development Coordinator educated nursing staff including agency on Oxygen use to include providing humidity, changing tubing and humidity bottles, and monitoring humidity each shift. Newly hired staff will receive this education in orientation. Any staff that has not received an education by May 19, 2023 will be required to do so prior to the next scheduled shift. The Administrator or designees will audit residents on oxygen during room rounds 5 times a week for 4 weeks, then 3 times a	

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F 695	Continued From page 27 Resident #21 had a physician order dated 3/30/23 to change oxygen tubing and oxygen humidification every Thursday by night shift. A review of Resident #3's documented vital sign sheet for oxygen saturation documented 96% and 97% from 3/1/23 to 4/20/23 with oxygen administration. On 04/18/23 at 11:47 am an observation and interview was done of Resident #21 in her room. The resident was wearing a nasal cannula attached to an oxygen concentrator running 3 liters of oxygen. There was no bottle of sterile water attached for humidification. Interview of the resident revealed the oxygen concentrator was changed and no water bottle was replaced. Staff informed the resident they were out of sterile water bottles. The resident stated her nose was dry and she would like to have the water. On 4/19/23 at 10:10 am an observation was done of Resident #21's oxygen concentrator. There was no humidification water bottle in place. Concurrent observation and interview was conducted with Nurse #1 who was assigned to Resident #21. She stated night shift staff were responsible for changing the oxygen tubing and humidification water bottle each week. She stated during the morning medication pass she would check the oxygen tubing, flow rate, and water bottle. She had not noticed the water bottle for humidification was missing this morning. She replaced the water bottle. Nurse #1 stated she was not aware the humidification water bottle for oxygen administration was missing on 4/18/23 and 4/19/23.	F 695	week for 4 weeks, then 2 times a week for 4 weeks to ensure humidity is in place when ordered. The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.	

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F 695	Continued From page 28 Night shift Nurse #4 was not available for interview. On 4/20/22 at 2:40 pm an interview was conducted with the Director of Nursing. She stated that oxygen orders were expected to be followed as written and all nursing staff should check the oxygen flow rate and equipment each shift.	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725		5/19/23

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F 725	Continued From page 29 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents and staff, the facility failed to provide sufficient nursing staff to meet the needs of two of six sampled dependent residents. Resident #30 reported he remained in a stool soiled brief for more than two hours. Resident #3 reported there were not enough staff to answer call lights and assist. Findings included: On 04/18/23 at 11:20 am Resident #30 was interviewed. He stated, "This past Sunday (4/16/23) evening shift there were only three nursing assistants (NAs) for the whole building." He shared he was not assisted for incontinence care and sat in bowel movement for more than two hours. Resident #30's quarterly Minimum Data Set dated 3/15/23 documented the resident had an intact cognition. The resident required 1-person physical assist for toileting/incontinence care. The resident was frequently incontinent of urine and always incontinent of bowel. On 04/18/23 at 11:20 am an interview was conducted with Resident #3. He stated that this past Sunday (4/16/23) evening shift there were only three nursing assistants for the whole building. During that evening, the nursing assistants did not answer the call light or they would answer without providing help and say they would come back. The NA told him there were only three NAs working. The NA had not returned for hours and was not assisted to empty my urinal.	F 725	F725 The facility failed to ensure that sufficient staff were available to assist residents with incontinent care. All residents have the potential to be affected by this practice. Licensed staff, medication aides, and certified nursing assistants will be in-serviced by the Staff Development Coordinator in assisting with incontinent care as deemed necessary. Licensed staff, medication aides and certified nursing assistants will be in-serviced on notifying the Director of Nursing if the need is unable to be met with the current daily staffing. The facility will take corrective action to enhance staffing and to ensure deficient practice does not recur. The staffing coordinator will utilize nurses and certified nursing assistants with all shifts from nursing agencies, offering overtime, clinical management assistance and continuation of hiring practices until the facility has completed their interview, orientation and training process to ensure sufficient nursing staff to provide residents with incontinent care as needed. Monitoring will consist of daily audits for 4 weeks, then weekly for 4 weeks and then monthly for one moth to ensure residents ADL needs are being met. These audits will be conducted by the Director of Nursing or designee. The Administrator will bring the results of these audits to the Quality Assurance	

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F 725	Continued From page 30 Resident #3's quarterly Minimum Data Set dated 3/17/23 documented the resident had an intact cognition. The staffing schedule for Sunday, 4/16/23, evening shift had 4 four NAs scheduled between 3:00 pm and 11:00 pm. The resident census was 97. One NA was assigned to pass medication as the Certified Medication Aide from 3:00 pm to 7:00 pm. Time records for Sunday, 4/16/23, were reviewed and verified the NAs present were 4 NAs from 3:00 pm to 7:00 pm and 3 NAs from 7:00 pm to 11:00 pm. On 4/20/23 at 10:40 am an interview was conducted NA #4. She stated on Sunday, 4/16/23, evening shift, there were NA callouts. There were 4 NAs from 3:00 pm to 7:00 pm then 3 NAs from 7:00 pm to 11:00 pm. She said, "I was not able to complete my assignment. We did as much as we could." She stated she had about 30 residents on her assignment. NA#4 stated she was responsible for Resident #30 and #3 for the evening shift. On 4/20/23 at 11:55 am an interview was conducted with NA #6. She stated on Sunday, 4/16/23, there was a shortage of NAs on evening shift. NA #6 stated she completed the medication pass, had limited time to provide resident care, and was not aware that residents complained the call lights were not answered and incontinence care was not completed. On 4/20/23 at 9:55 am an interview was conducted with Nurse #1. She was assigned to	F 725	Committee for 3 consecutive months at which time the determination to further monitoring will be determined. Compliance Date: May 19, 2023	

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F 725	Continued From page 31 Residents #30 and #3. She stated on 4/16/23 evening shift there were 3 NAs scheduled for the building due to 4 NA call outs. She stated that medication was administered, and she had to assist with resident needs which caused tasks to be completed late or assignments not completed. The NAs had approximately 30 residents each for their assignment. When fully staffed, the NA assignment would be 10 to 15 residents per nurse aide. She added the response to call lights and incontinence care was delayed. On 4/19/23 at 1:40 pm the Director of Nursing (DON) was interviewed. She stated that there were four or five call outs for evening shift on Sunday, 4/16/23 and the census was 97. The DON called staff that were off but could not find replacements. She said the staffing agency was not open on Sunday. The DON further stated she thought there were four NAs working on the 4/16/23 evening shift. The typical staffing pattern for evening shift was 6 to 8 NAs.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		5/19/23

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F 761	Continued From page 32 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to: 1) Store medications in accordance with the manufacturer's storage instructions; and 2) Discard a single-use vial of sterile water after opening. This occurred for 1 of 2 medication carts observed (Upper B Hall Medication Cart). The findings included: 1a) Accompanied by Nurse #1, an observation of the Upper B Hall Medication Cart was conducted on 4/19/23 at 11:50 AM. The observation revealed one unopened Humalog insulin Kwikpen dispensed for Resident # 17 was not dated when it was put on the medication cart. A blue auxiliary sticker placed on the insulin pen by the pharmacy read, "Refrigerate until opened." An interview was conducted on 4/19/23 at 12:05 PM with Nurse #1. During the interview, the nurse reported the insulin pen was likely delivered on an evening shift and put directly into the medication cart at that time. When asked, the nurse stated unopened insulin pens should be	F 761	F761 Corrective action has been accomplished for the alleged deficient practice- failed to store medications in accordance with the manufactures instructions(unopened insulin pen stored on the cart) and failed to discard a single use vial of sterile water after opening. The pen and sterile water were removed immediately from the cart and destroyed. 1-1 Education and counseling were provided to the identified staff by the Director of Nursing (DON) The Pharmacy Customer Service Manager inspected all carts for deficient practice and no concerns were identified. Measures put in place to ensure the alleged deficient practice doesn□t recur: Unit Managers (UM) and Staff Development coordinator (SDC) to audit all med carts for medications not stored correctly and one time use medications not discarded. This audit will be completed by 5-19-23. The DON will address any concerns.	

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F 761	Continued From page 33 refrigerated until opened (put into use). A review of Resident #17's medication orders revealed he had a current order for Humalog insulin. According to Lexi-Comp (a comprehensive electronic medication database), unopened prefilled pens of Humalog insulin may be stored under refrigeration until their expiration date or at room temperature if used within 28 days. An interview was conducted on 4/19/23 at 3:51 PM with the facility's Director of Nursing (DON). During the interview, the results of the Medication Storage facility task were discussed. The DON stated she would have expected unopened insulin pens to have been stored in the refrigerator until put into use. 1b) Accompanied by Nurse #1, an observation of the Upper B Hall Medication Cart was conducted on 4/19/23 at 11:50 AM. The observation revealed one unopened Novolog insulin pen dispensed for Resident #14 was not dated when it was put on the medication cart. A blue auxiliary sticker placed on the pen by the pharmacy read, "Refrigerate until opened." An interview was conducted on 4/19/23 at 12:05 PM with Nurse #1. During the interview, the nurse reported the insulin pen was likely delivered on an evening shift and put directly into the medication cart at that time. When asked, the nurse stated unopened insulin pens should be refrigerated until opened (put into use). A review of Resident #14's medication orders revealed he had a current order for Novolog	F 761	The Staff Development Coordinator (SDC) will educate all nurses and CMAs on medication storage and single use medications. This education will be completed by 5-19-23. Any unavailable staff or newly hired staff will be educated before the next worked shift. Unit Managers and third shift charge nurses will audit med carts 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then 2x weekly for 4 weeks. The Director of Nursing (DON) will analyze the information collected from these audits and report patterns and trends to the Quality Assurance Performance Committee(QAPI) every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan and will add interventions and additional monitoring as needed to ensure continued compliance.	

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F 761	Continued From page 34 insulin. According to Lexi-Comp (a comprehensive electronic medication database), unopened prefilled pens of Novolog insulin may be stored under refrigeration until their expiration date or at room temperature if used within 28 days. An interview was conducted on 4/19/23 at 3:51 PM with the facility's Director of Nursing (DON). During the interview, the results of the Medication Storage facility task were discussed. The DON stated she would have expected unopened insulin pens to have been stored in the refrigerator until put into use. 2) Accompanied by Nurse #1, an observation of the Upper B Hall Medication Cart was conducted on 4/19/23 at 11:50 AM. The observation revealed an opened 10 milliliter (ml) vial of sterile water for injection labeled for "single use only" was stored on the med cart. An interview was conducted on 4/19/23 at 12:05 PM with Nurse #1. During the interview, the nurse reported the single use vial of sterile water should have been discarded after being used one time. Nurse #1 was observed to discard the opened vial of sterile water. An interview was conducted on 4/19/23 at 3:51 PM with the facility's Director of Nursing (DON). During the interview, the results of the Medication Storage facility task were discussed. The DON confirmed the opened vial of "single use" sterile water stored on medication cart needed to be discarded after it was used one time.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		5/19/23

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F 812	Continued From page 35 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to maintain a clean oven, conveyor toaster and stove. The facility also failed to maintain clean nourishment room refrigerators, label and date food for 1 of 1 nourishment refrigerators reviewed (A hallway nourishment room). The dietary aide failed to change gloves during dishwashing while handling dirty and clean dishes when observed during dishwashing process. The facility failed to ensure the commercial dishwasher was maintaining the rinse temperatures according to the manufacturer's recommendations. These practices had the potential to affect food being served to residents. Finding included:	F 812	F812 The toaster, oven and stove were cleaned upon notification. The food found in the nourishment room refrigerator was discarded upon discovery. The refrigerator inside was cleaned immediately and continues to be on our routine cleaning schedule. The dietary aide was educated on the proper procedure for when to change gloves when handling clean and dirty items. The dishwasher was serviced during survey and temperatures were maintained. All residents have the potential to be affected by the deficient practice. Dietary consultant and Administrator	

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F 812	Continued From page 36 1 a. During an observation on 4/17/23 at 9:55 AM, the oven had a large volume of grease buildup inside of the oven. The grease buildup was encrusted on doors and on shelves where food would be cooked. The stand on which the oven was placed had white stains on its legs. 1 b. During an observation on 4/17/23 at 9:58 AM, the stove had a large brown burnt grease spot on one side of the splash guard. During an interview with the Dietary Manager on 4/17/23 at 10:00 AM, she indicated the staff were assigned to clean the large equipment like the stove and the oven, every other week. The Dietary Manager stated that the oven was cleaned the previous week. 1c. During a tray line observation on 4/18/23 at 11:50 AM, the conveyor toaster was observed to be having dark brown grease with breadcrumbs sticking to the toaster roller and on the floor of the toaster. During an interview with the Dietary Manager on 4/20/23 at 11:20 AM, she indicated the staff were assigned to clean the toaster daily. Most of the parts were removable and placed in the dishwasher. The belt was not removable, and it was hard to remove the crumbs and degrease it. The Dietary Manager further stated the grease on the stove backsplash was hard to remove and multiple attempts have been made to remove the it. 2. An observation of the nourishment refrigerator on A hallway nourishment room on 4/17/23 at 10:10 AM, revealed two take out containers with	F 812	provided education to the dietary staff regarding cleaning of the oven, stove and conveyor toaster. Education included the daily monitoring of nourishment rooms to ensure no food is stored in the refrigerator without proper labeling including the date. In addition, education was provided on donning and doffing of gloves when going from clean to dirty areas. The Administrator educated facility staff on proper labeling, including the date, of items stored in the nourishment room refrigerator. The Administrator or designee will audit the nourishment room refrigerators to ensure items are labeled and dated five times a week for 4 weeks, then 3 times a week for 4 weeks and then 2 times a week for 4 weeks. The Administrator or designee will conduct random observations for proper glove use in the kitchen between clean and dirty five times a week for 4 weeks, then 3 times a week for 4 weeks and then 2 times a week for 4 weeks. The Administrator or designee will audit the cleaning of the stove, conveyor toaster and oven ensuring cleanliness and logs are completed five times a week for 4 weeks, then 3 times a week for 4 weeks and then 2 times a week for 4 weeks. The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.	

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resident name on it. There was no date as to when the food was placed in the refrigerator. There was one take out container with no name or date on it. One 8-ounce milk carton with expiration date 4/8/23. The nourishment refrigerator had a large yellowish-brown stain on the floor.

During an interview with the Dietary Manager on 4/17/23 at 10:13 AM, she indicated she was responsible for cleaning the nourishment refrigerator. The Dietary Manager stated she usually checks the refrigerator and discards any food that was not labelled and dated. She further stated all resident's food placed in the refrigerator should be labeled with resident's name and date by the nursing staff.

3 . During an observation of dishwashing process on 4/19/23 at 2:30 PM, there was one dietary aide running the dishwasher. The Dietary aide was observed to be using the same gloves between the dirty and clean dishes.

During an interview with the dietary aide on 4/19/23 at 2:33 PM, he indicated he was usually assigned to wash dishes in the dishwasher after lunch. He indicated he had forgotten to change his gloves from dirty to a clean dish.

During an interview with the Dietary Manager on 4/20/22 at 11:20 AM, stated the dietary aide needed some education. The dietary aide was a slow learner and needed constant education. The Dietary Manager stated staff should be washing hands and changing gloves between tasks.

4. An Observation of the dishwashing machine revealed " NSF Machine operation requirement

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as Manufactured by CMA Dishwasher". These instructions were mounted on the side of the machine. The instructions stated the wash temperature requirement was minimum 155 degrees Fahrenheit (F) and a wash cycle time of 49 seconds. The rinse temperature requirement was minimum180 degrees F and a rinse cycle time of 12 seconds.

During an observation on 4/19/23 at 2:20 PM, the dietary aide was observed washing dishes after lunch meal in the dishwasher. Observation also revealed the rinse cycle gauge read 170 degrees F during use. The dietary aide was observed placing dishes in the dish washer and continued washing dishes even when the rinse temperature did not reach 180 degrees (F) as per manufacture recommendations.

During an interview on 4/19/23 at 2:22 PM, the dietary aide stated the dishwasher temperature was 170 degrees F rinse cycle. He indicated that the temperature should be 180 degrees F. The dietary aide continued to wash the dishes even when the rinse temperature of 180 degrees F was not reached. The aide was asked to stop washing dishes and the Dietary Manager was notified.

During an interview with the Dietary Manager on 4/19/23 at 2:26 PM, she stated the rinse gauge was not always accurate and she would run a dish thermometer to check the temperature of the rinse cycle. She further stated the rinse temperature should be 180 degrees F and usually reached that temperature when the dishwasher ran empty multiple times.

The dishwasher was run multiple times with the thermometer in the dishwasher; however, the

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rinse temperature of 180 degrees F was not reached.

Observation of the dishwasher on 4/20/23 at 9:30 AM, revealed the wash and rinse cycle temperatures were reached. The rinse cycle was between 180- 190 degrees F. The Dietary Manager indicated that the dishwasher was serviced by a local contractor.

During an interview on 4/20/23 at 11:20 AM, the Dietary Manager stated she usually runs the empty dish washer multiple times to ensure that temperatures for wash and rinse cycle were reached per manufacturer recommendations. The dishwasher was serviced last evening, and the rinse temperature was now reaching 180 degrees F.

During an interview on 4/20/23 at 12:30 PM, the Administrator stated the dishwasher was serviced on 4/19/23 and the rinse temperature was now above 180 degrees. The Administrator stated the staff should stop the dish washing process and should notify the Dietary Manager. The Dietary Manager should notify the Maintenance staff if the temperature was not within manufacturing recommendations. Staff should observe the temperatures multiple times when the dishes were washed in the dishwasher to ensure the wash and rinse cycle temperatures were maintained. The Administrator further stated dietary staff would be working on cleaning the kitchen equipment and refrigerator. The Maintenance staff would be helping dietary staff to clean the equipment as needed. The Administrator indicated nursing staff need to label and date residents food brought in by the family before it was placed in the nourishment

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F 812	Continued From page 40 refrigerator.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to	F 867		5/19/23

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adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse

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F 867	Continued From page 42 resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility's Quality Assessment	F 867	F-867	

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F 867	Continued From page 43 and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification and complaint survey in December 2021 and subsequently recited in April 2023 on the current recertification and complaint survey. The recited deficiency was in the area of food safety requirements and store, prepare, distribute and serve food in accordance with professional standards for food service safety. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: The tag was cross referenced to: F 812 Based on observations, and staff interviews the facility failed to maintain a clean oven, conveyor toaster and stove. The facility also failed to maintain clean nourishment room refrigerators, label, and date food for 1 of 1 nourishment refrigerators reviewed (A hallway nourishment room). The dietary aide failed to change gloves during dishwashing while handling dirty and clean dishes when observed during dishwashing process. The facility failed to ensure the commercial dishwasher was maintaining the rinse temperatures according to the manufacturer's recommendations. These practices had the potential to affect food being served to residents. During the previous survey on 12/02/21, the facility had failed to maintain dinnerware in clean and good condition.	F 867	The facility□s Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the facility put into place following the recertification survey and complaint survey in December 2021 in regard to food safety requirements and store, prepare, distribute and serve food in accordance with professional standards for food service safety. Plan of correction was put in to place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Administrator initiated in-service to all administrative staff on 5-15-2023 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as	

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F 867	Continued From page 44 On 04/20/23 at 3:04 PM, during an interview, the Administrator indicated the QAA committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits and monitors that plan and 4) discusses the outcome. The Administrator indicated QAA was a work in progress.	F 867	necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education. The Quality Assurance Performance Improvement Committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction. Date of Compliance: May 19, 2023	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at 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,	F 880		5/19/23

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staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 46 §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 staff interviews, observation, and record review, the facility failed to don personal protective equipment (PPE) before providing care to a resident with ESBL (extended-spectrum beta-lactamases) urine infection (Resident #7) for 1 of 2 residents reviewed for contact precautions. Findings included: Resident #7 was admitted to the facility on 3/18/20 with the diagnosis of urinary retention. The facility transmission-based precautions updated on 1/20/22 documented in part "contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or resident's environment. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or the resident's environment. Donning personal protective equipment upon room entry and discarding before exiting the room ..." Resident #7 had a physician order dated 3/17/23 for contact isolation (contact precautions) for ESBL (extended-spectrum beta lactamase producing bacteria which can be resistant to	F 880	F 880 Corrective action has been accomplished for the alleged deficient practice the facility failed to don Personal Protective Equipment (PPE) before providing care to a resident with ESBL (extended spectrum beta-lactamases) urine infection Resident #7 on 4/18/2023. 1:1 Staff education provided by the Director of Nursing (DON) and Staff Development Coordinator (SDC) with the staff member identified violating the policy/procedure for infection control. Education included observing the signage and wearing proper PPE when entering an isolation room. Proper PPE is specifically outlined on the signage at each isolation doorway. Other residents who are on isolation have the potential to be affected by the same alleged deficient practice. On 4-19-2023 the Staff Development Coordinator (SDC) completed education with staff regarding Personal Protective Equipment(PPE) and isolation signage. The Director of Nursing	

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F 880	Continued From page 47 antibiotics) of the urine. Resident #7's quarterly Minimum Data Set dated 3/30/23 documented the resident had a urinary catheter and urinary tract infection. On 4/18/23 at 9:45 am an interview was conducted with Nurse #4. She stated Resident #7 had contact precautions for ESBL urinary tract infection and all staff that provided care were required to don PPE before care. On 04/18/23 at 10:10 am Resident #7 was observed to have signage on the wall next to her room door for contact precautions for staff to wear a gown and gloves. The PPE was available in a set of drawers below the sign. NA #7 did not don a gown or gloves and was observed to enter the resident's room with towels and stated she was getting ready to bathe and provide urinary catheter care. NA #7 was stopped and interviewed. She stated she was not aware of the contact precautions and was observed to exit the room and look at the wall and read the contact precaution signage. The NA stated she did not see the signage upon entering the room. On 4/19/23 at 3:15 pm an interview was conducted with the Infection Preventionist. The Infection Preventionist stated PPE should be donned for contact precautions before any care provided. The Infection Preventionist stated she completed regular surveillance on the halls to ensure staff compliance with infection control practices.	F 880	completed an audit and monitoring of residents on isolation to ensure all PPE was available and signage was in place. Measures put into place to ensure that the alleged deficient practice does not recur include: Director of Nursing (DON) and Staff Development Coordinator (SDC) are SPICE certified. The Staff Development Coordinator (SDC) began observation/surveillance rounds on 5/08/2023 to ensure proper donning and doffing of Personal Protective Equipment, and proper use. The Staff Development Coordinator (SDC) began reeducation for all staff related to the Center for Disease Control (CDC), State guidelines and company policy and expectations related to Infection Prevention and Control. This reeducation and continued education included: proper use of Personal Protective Equipment (PPE) and understanding of isolation signage and instructions. Education will be completed by the Staff SDC by 5/19/2023 and any unavailable staff will receive this education as well as new employees during orientation. Increased Surveillance Rounds and Room round audits 5 times a week to include a weekend day will be completed by the Director of Nursing(DON), Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. BUILDING _____ B. WING _____	C 04/20/2023

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F 880	Continued From page 48	F 880	Development Coordinator(SDC), and Unit Managers(UM) for 4 weeks; then 3x a week for 4 weeks and then 2x a week for 4 weeks to identify any variance from policy and protocol. The Director of Nursing(DON) will address any concerns identified. Signage will be placed on the door rather than beside the door and the facility will put in place the use of door PPE hangers to make isolation rooms more visible to staff. This is ongoing. Directed Plan of Correction(DPOC) steps are being implemented by the facility as recommended and will be completed by the Director of Nursing and the Regional Director of Clinical Operations. Part of the DPOC includes education in the form of the following training/education. https://youtu.be/1W8Ai1avL7A - signage video SPICE Video Library - Statewide Program for Infection Control & Epidemiology (unc.edu) □ 1. How to handwash 2. How to hand rub 3. Donning & Doffing PPE Facility held an impromptu QA meeting to conduct a Root Cause Analysis on 5-9-23 with the Medical Director, Administrator, DON/IP, Staff Development Coordinator, and select members of the QAPI committee. The Director of Nursing (DON/IP) and Staff Development Coordinator(SDC) will	

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F 880	Continued From page 49	F 880	review data obtained during rounds, analyze the data and report patterns/trends to the QAPI committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions, based on identified outcomes to ensure continued compliance. Date of compliance 5-19-23	