STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION	1000 COLLEGE STREET WILKESBORO, NC 28697

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted on 10/11/21 through 10/12/21. Additional information was obtained offsite on 10/13/21. A survey team returned to the facility on 10/14/21 through 10/15/21 due to additional complaint allegations. Therefore, the exit date was changed to 10/15/21. Event ID# JJ3711. 33 of the 53 complaint allegations were substantiated and cited.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		11/15/21

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

Electronically Signed | 11/11/2021

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family and staff interviews, the facility failed to treat residents in a dignified manner by not providing incontinence care prior to a resident (Resident #17) wetting through her brief onto her draw sheet. In addition, the facility failed to provide incontinence care to a resident (Resident #2) who had a bowel movement prior to dinner and she and her roommate (Resident #1) ate dinner while smelling the bowel movement for 3 of 6 residents reviewed for dignity and respect. The findings included: 1. Resident #17 was admitted to the facility on 10/19/12 and readmitted on 03/16/19 with diagnoses which included Alzheimer's disease, dementia, seizure disorder and anxiety disorder. Resident #17"s Care Area Assessment summary completed with her annual Minimum Data Set (MDS) assessment dated 12/16/20 revealed she	F 550	F550 Resident Rights 1. Resident #17 and #2 will continue to be monitored for and provided with incontinence care assistance per residents' plan of care. Monitoring and care continues to be provided routinely and as needed including before meals to maintain resident dignity. 2. Residents' incontinence care needs as identified per ADL care plan and Kardex will continue to be monitored for and provided by direct care staff routinely, as needed and before meals to maintain resident dignity. ADL care plans and Kardex updated by MDS Coordinator as appropriate for current facility residents on 11/10/2021. 3. Education completed 10/18/21 – 11/12/21. The Director of Nursing provided education to current licensed nurses, nurse aides and direct care agency staff on monitoring for and	

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F 550	Continued From page 2 was incontinent of bowel and bladder due to decreased mobility and cognitive impairment. Resident was at risk for developing pressure ulcer and urinary tract infection (UTI) related to her incontinence. Resident was totally dependent on nursing staff for incontinence care. Resident #17's most recent quarterly Minimum Data Set assessment dated 08/20/21 revealed she was severely impaired for daily decision making and required extensive to total assistance of 1 to 2 staff with all activities of daily living and was totally dependent on 1 staff member for toileting. Resident #17's care plan dated 09/15/21 revealed a plan of care for her incontinence of bowel and bladder related to her confusion and impaired mobility. The goal was for Resident #17 to remain free from infection, skin breakdown due to incontinence and brief use through the review date of 11/20/21. The interventions included check for incontinence prn (as needed), wash, rinse and dry perineum, change clothing prn after incontinent episodes, notify nursing if incontinent during activities, use disposable briefs per manufacturer's recommendation and change when soiled, encourage fluids during the day to promote prompted voiding responses, ensure resident has unobstructed path to the bathroom (resident does not use bathroom), establish voiding patterns, monitor/document for signs and symptoms of UTI such as burning, pain, blood tinged urine, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior or change in eating habits, monitor/document/report to MD prn possible medical causes of incontinence, bladder	F 550	providing incontinence care to residents per residents' plan of care to maintain dignity. Newly hired licensed nurses, nurse aides and direct care agency staff will receive education upon hire. Direct care nursing staff will determine and provide resident incontinence needs as needed or requested and prior to delivering meal trays. 4. The Director of Nursing will oversee and delegate to clinical nursing to complete an audit of incontinent residents to ensure care and dignity is being provided. Monitoring will be completed for five (5) residents via rounding observations at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with residents right to dignity with incontinence. Compliance date of 11/15/2021	

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infection, constipation, loss of bladder tone, weaking of control muscles, decreased bladder capacity, diabetes, stroke, and medication side effects, and obtain labs/tests as ordered and report abnormal to the MD.

Interview on 10/11/21 at 2:30 PM with family member of Resident #17 in conference room revealed she had just gotten to the facility and "smelled strong odor of urine as soon as walked in the door." The family member stated she had spoken with the Nurse Aide (NA) caring for the resident and NA #11 told her she had not been able to change the resident since around 9:00 or 9:30 AM after breakfast. NA #11 had been into Resident #17's room around 2:20 PM to change the resident and the family member told her no and came to find one of us so we could see her incontinence care and "see the condition the resident was in." The family member further stated when she comes to the facility if the resident is soiled, she usually changed her and bathed her and cut and cleaned her fingernails because otherwise it was not done. She indicated this was nothing new and had been going on for some time.

Interview on 10/11/21 at 3:00 PM with NA #12 revealed she was assigned to Resident #17 for the 3:00 PM to 11:00 PM shift and would change the resident as soon as she was able to get supplies for her incontinence care.

Observation on 10/11/21 at 3:06 PM of Resident #17's incontinence care revealed the resident had wet her brief all the way up her back, to all four corners of the plastic border around the brief and the cotton layer in between the layer next to the resident on the front and the plastic outer layer

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was balled up in the center of the brief. Resident #17 had wet through her brief onto the draw sheet under her on the bed. Resident #17 was cleaned by NA #12 and new clean brief applied and clean draw sheet was placed under her on top of her sheet. An interview conducted with NA #12 revealed she did not think the resident had been checked or changed for several hours due to the amount of urine in the brief and the draw sheet under the resident being wet.

Interview on 10/11/21 at 3:18 PM with NA #11 who had taken care of Resident #17 on the 7:00 AM to 3:00 PM revealed she had only been able to change the resident once today. NA #11 stated she had changed Resident #17 after breakfast and went in to change her around 2:00 to 2:30 PM and the family member told her no that she wanted the surveyors to see her changed. NA #11 stated she had not been able to get back to the resident prior to 2:00 PM due to all the feedings, lifts, and everything else she had to do today. NA #11 further stated this was her first week off orientation and she was "overwhelmed with the workload when there was only 3 NAs in the building." NA #11 indicated she was "overwhelmed with the number of residents she was assigned to care for" and said there was not enough time to get everything done. She further indicated Resident #17 was supposed to get a shower today but there was no one doing showers and said she had not even had time to give her a bed bath due to her workload. According to NA #11, "it was pretty normal lately for the NAs to have 20 or more residents to care for and there was no way to get everything done in 8 hours."

Interview on 10/12/21 at 4:45 PM with the interim

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Director of Nursing (DON) revealed there were staffing challenges at the facility. The DON stated there was only 1 full time employed nurse on day shift and 1 full time employed nurse on evening shift and the rest of the nurses were PRN (as needed) or were agency nurses. She further stated they recently had increased their base salary to be more competitive with hiring but still had quite a few open positions. The DON indicated she expected residents to be checked and changed as needed or at least every 2-3 hours and would not expect residents to go for over 4 hours without being checked for incontinence.

2. Resident #2 was admitted to the facility on 11/25/16 and readmitted on 08/31/20 with diagnoses which included Alzheimer's disease, dementia, osteoarthritis, and anxiety disorder among others.

Resident #2's most recent Minimum Data Set (MDS) assessment dated 09/10/21 revealed she required extensive to total assistance of 1 to 2 staff with most activities of daily living (ADL). The MDS further revealed she required extensive assistance of 1 staff with toileting and wore briefs.

Resident #2's care plan dated 10/12/21 revealed there was a plan of care for being incontinent of bowel and bladder due to diagnosis of dementia and was at risk of UTI and pressure ulcer development. The goal was for the resident to remain free from skin breakdown due to incontinence and brief use through the review date of 01/20/22. The interventions included barrier cream as ordered, use of disposable briefs according to manufacturer's recommendation, check during care rounds when

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soiled and prn, clean peri-area when soiled and prn, clean peri-area with each incontinence episode, encourage adequate fluid intake with meals and between with med pass, observe for signs and symptoms of UTI including pain, burning , blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating habits, observe/report prn any possible causes of incontinence, bladder infection, constipation, loss of bladder tone, weakening o control muscles, decreased bladder capacity, diabetes, stroke and medication side effects.

Interview on 10/11/21 at 4:00 PM with family members visiting Resident #2 revealed they were not pleased with the resident's care. One of the family members further revealed they were blessed to have Resident #1 as their family member's roommate because she looked out for Resident #2. The other family member described an incident recently in which Resident #2 had sat in her own poop for over 4 hours because the NA assigned to her had not come in and changed her as requested by the roommate, Resident #1. The family member stated Resident #1 had realized when she smelled it that Resident #2 had a bowel movement and when she rang the call light they had not come and changed Resident #2 for over 4 hours. The family member further stated there was no excuse for allowing an elderly person who could not care for herself to sit in poop for that long at a time. She indicated it was not good for her skin to go that long without being changed. The family member indicated they had complained to the Director of Nursing about the care and were told "we are short staffed and

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F 550	Continued From page 7	F 550		

doing the best we can." The family member further indicated "that is not what you want to hear when you are concerned about the care your loved one was receiving in the nursing home."

Interview on 10/11/21 at 4:30 PM with Resident #1 who is the roommate of Resident #2 revealed on Saturday, 10/09/21, at 4:00 PM she rang her call light for Resident #2. Resident #1 stated Resident #2 had a bowel movement and she could smell it, so she rang her light for a NA to come in and change Resident #2. Resident #1 further stated NA #7 answered the call light and stated she had just changed Resident #2. Resident #1 indicated she told NA #7 she had had a bowel movement and she could smell it and NA #7 said again she had just changed the resident. Resident #1 further indicated it was 8:45 PM before NA #7 came in and changed Resident #2. Resident #1 explained that she and Resident #2 had to eat their dinner while smelling her bowel movement. Resident #1 further explained that she informed Resident #2's family about the incident and complained about it and was told (could not remember by whom) that "it was being addressed." Resident #1 advised that she knew the specific times because she had looked at her watch when she called out for assistance for Resident #2 and looked at her watch again when they came in and changed her. Resident #1 stated she wears her watch every day.

Interview on 10/12/21 at 3:15 PM with NA #7 revealed she was working on 10/09/21 and was assigned to Resident #1 and Resident #2. NA #7 stated there were good days and bad days with staffing just like any other place you work and said it was difficult to get everything done for

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F 550	Continued From page 8 every resident on days they were short staffed. She stated lately there were more days than not they worked without an adequate number of staff for the workload. NA #7 further stated it was impossible to get incontinence rounds done every 2 hours and they were lucky to get 2 rounds done on every resident. NA #7 indicated if she didn ' t change Resident #2 when Resident #1 rang the bell for her it was probably because she was cleaning another resident and then supper trays came out and she had to pass trays and feed residents that need to be fed and then after all trays are collected you can then start your second round. NA #7 further indicated they don ' t purposely leave someone wet or messed up but sometimes it was "impossible to get everything done for everybody and you just had to do the best you can." Interview on 10/12/21 at 4:45 PM with the interim Director of Nursing (DON) revealed there were staffing challenges at the facility. The DON stated there was only 1 full time employed nurse on day shift and 1 full time employed nurse on evening shift and the rest of the nurses were PRN (as needed) or were agency nurses. She further stated they recently had increased their base salary to be more competitive with hiring but still had quite a few open positions. The DON indicated she expected residents to be checked and changed as needed or at least every 2-3 hours and would not expect residents to go for over 4 hours without being checked for incontinence.	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F 561		11/15/21

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F 561	Continued From page 9 The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family and staff interviews, the facility failed to honor the residents ' preferences regarding preferred number of showers or bed baths per week for 3 of 3 residents (Resident #1, Resident #6, and Resident #9) reviewed for choices. The findings included: 1. Resident #1 was admitted to the facility on	F 561	F561 Self-Determination 1. On October 21st, the Administrator completed an updated bathing type and frequency preference assessment for Resident #1, #6 and #9. Unfortunately, Resident #6 expired on 10/30/21. ADL care plans, POC tasks and Kardex's updated as indicated to honor residents' right to self-determination. 2. On November 10th, the interdisciplinary	

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F 561	Continued From page 10 07/02/18 and readmitted on 04/28/21 with diagnoses which included end stage renal disease, diabetes mellitus type II, hypertension, and chronic obstructive pulmonary disease among others. Resident #1's Care Area Assessment (CAA) summary completed 11/09/20 with her annual Minimum Data Set assessment revealed she was able to make her needs known, used the call bell for assistance, was bed to wheelchair bound and was incontinent of bowel and bladder at times. The CAA summary further revealed Resident #1 was on dialysis Monday, Wednesday, and Friday of each week. Resident #1's most recent quarterly Minimum Data Set (MDS) assessment dated 07/28/21 revealed she was cognitively intact for daily decision making and required total dependence of 1 staff member for bathing. Resident #1's care plan dated 08/11/21 revealed she had a care plan for requiring physical assistance daily due to decreased mobility. The goals were for the resident to participate in activities of daily living (ADL) as she was able through the next review date of 11/18/21 and not have any significant decline in ADL through the next review date of 11/18/21. The interventions included bathing/showering: dependent on 1-2 nursing staff, personal hygiene: extensive dependence of at least 1 nursing staff, praise all efforts at self-care and resident was non-ambulatory and used wheelchair for locomotion for supervision with no more than 1 nursing staff, among others. The shower schedule provided by the facility	F 561	team (Administrator, Director of Nursing, Activity Director, MDS coordinator, wound care nurse, social worker, and Director of Rehabilitation) completed an updated bathing preference assessment for current facility residents to ensure preferences for bathing type and frequency are identified. Care plans, POC tasks, Kardex's and facility bathing schedule updated accordingly. 3. Education completed 10/18/21 – 11/12/21. The Director of Nursing and/or Social Services Director educated current facility licensed nurses, nurse aides and direct care agency staff on honoring residents right to self-determination with bathing type and frequency preferences. Newly hired licensed nurses, nurse aides and direct care agency staff will receive education upon hire. Resident preferences for bathing type and frequency will be assessed upon admission and as needed by the licensed nurse and care provided by the nurse aide as reflected per the care plan, POC tasks, Kardex and facility bathing schedule. 4. The Director of Nursing and/or nurse designee will complete an audit of resident bathing preferences to ensure proper care and self-determination. Monitoring will be completed for five (5) random residents for bathing preference at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes	

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F 561	Continued From page 11 indicated Resident #1 was scheduled for showers only once per week on Monday. There was no indication on the schedule as to what shift the resident's shower was to be provided. Interview on 10/11/21 at 4:30 PM with Resident #1 in the activities room revealed she was not getting her showers as scheduled as well as other residents. Resident #1 stated there was a problem at the facility with Nurse Aides (NAs) calling in and when they called in the NA assigned to showers was pulled to work on the floor and unable to do showers. She further stated she had gone 2 weeks recently without getting a shower because the NA scheduled for showers was pulled to work the floor due to another NA calling out. Resident #1 indicated her last shower had been 11/05/21. She further indicated she was supposed to get a shower on 11/08/21 but there was no one at the facility to do showers that day. The shower NA was pulled to work the floor. According to Resident #1, she preferred her showers on Tuesday and Friday and stated she had requested a shower every other day but was told (could not remember by whom) that she would get "two showers per week." She explained she was used to "showering every day" prior to coming to the facility and said she preferred showers over bed baths or partial baths because she felt cleaner. Resident #1 further explained she liked to be clean because she went out in public to dialysis 3 times a week and did not want to smell or not appear clean at the dialysis center. Interview on 10/12/21 at 11:27 AM with Nurse Aide (NA) #14 revealed on day shift for at least 4 hours of the day, NAs had 20 to 25 residents and there was no way to get everything done with that	F 561	to the plan as necessary to maintain compliance with residents right to self-determination with bathing. Compliance date of 11/15/2021	

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many residents to care for. NA #14 stated bathing and showers were often not done because there was not enough help to get showers done.

Interview on 10/12/21 at 12:07 PM with NA #1 revealed she usually did showers if showers were done. She stated recently (the past 3-4 weeks) she had been pulled to the floor to fill in for call outs and showers were not done as scheduled. NA #1 further stated there were usually about 10 to 16 showers scheduled per day and there were only 2 shower rooms. She indicated on a good day she could probably get 10 to 12 showers done unless there were residents that required 2 person lifts. On the days there were a lot of lifts, NA #1 said she could only get about 8 to 10 showers done in a day. NA #1 shared bed baths were done sometimes on shower days, but it was difficult to wash resident ' s hair because their green tray for washing hair in the bed had disappeared and had not been replaced by the facility.

Interview on 10/12/21 at 3:15 PM with NA#7 revealed there were good days and bad days at the facility. NA #7 indicated the NA to resident ratio was sometimes crazy and the NAs were not able to complete all the assigned work. She stated on bad days they were lucky to get 1 shower completed as scheduled and sometimes they were not able to get even one done.

Interview on 10/12/21 at 3:55 PM with NA #16 revealed she and NA #17 were doing showers on the 3:00 PM to 11:00 PM shift. She stated there was usually only one NA assigned to showers but since they were not able to get any showers done on the 7:00 AM to 3:00 PM shift there were 2 NAs assigned to showers.

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Interview on 10/12/21 at 4:45 PM with the interim Director of Nursing (DON) revealed there were staffing challenges at the facility. The DON stated there was only 1 full time employed nurse on day shift and 1 full time employed nurse on evening shift and the rest of the nurses were PRN (as needed) or were agency nurses. She further stated they recently had increased their base salary to be more competitive with hiring but still had quite a few open positions. The DON explained that if the residents wanted their showers on certain days then they should get them, and it was her expectation that the residents receive their showers when they wanted their showers. The DON also added that if the showers were not documented then they were not done.

2. Resident #9 was admitted to the facility on 01/06/21 with diagnoses that included heart failure and renal insufficiency.

The quarterly Minimum Data Set (MDS) assessment dated 08/17/21 revealed Resident #9 was cognitively intact for daily decision making and required supervision assistance of one staff for bathing.

A review of the Shower Schedule revealed Resident #9's shower was scheduled for Monday and Friday.

A review of Resident #9's Bathing record for October 01, 2021 through October 12, 2021 revealed the Resident received a shower on Monday October 4th and Monday October 11th.

A review of the Daily Staffing record revealed

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there was no staff scheduled to give showers on Friday October 1st or Friday October 8th for the morning or evening shifts.

An interview conducted with Resident #9 on 10/12/21 at 11:00 AM revealed the Resident explained he was scheduled for two showers a week, but he was "lucky" if he received one shower a week. The Resident stated before last night (10/12/21) he had not received a shower for 7 days and that was not okay with him because his skin itched him all the time and he looked forward to his showers. Resident #9 stated that on some days the staff "wiped" him off, but it was not as thorough as a shower bath which he preferred. The Resident continued to explain that when he does not receive his showers the staff tell him that they do not have enough staff to give showers.

During an interview with Nurse Aide (NA) #1 on 10/11/21 at 2:58 PM the NA confirmed she cared for Resident #9 on 10/08/21 on morning shift and provided a partial bath for the Resident because there was not a person scheduled to give showers that day.

Attempts were made to interview Nurse Aide #9 who worked on 10/08/21 evening shift but the attempts were unsuccessful.

During an interview with the Director of Nursing (DON) on 10/12/21 at 4:30 PM she reviewed Resident #9's Bathing record since October 1st, 2021 and acknowledged that the Resident had not received his two scheduled showers a week for at least two weeks. The DON explained that if the residents wanted their showers on certain days then they should get them, and it was her

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expectation that the residents receive their showers when they wanted their showers. The DON also added that if the showers were not documented then they were not done.

An interview was conducted with Nurse Aide (NA) #2 on 10/13/21 at 2:10 PM who confirmed she worked with Resident #9 on 10/01/21 morning shift. The NA explained that the Resident did not received a shower that shift because there was not a staff person scheduled to give showers that shift.

An interview was conducted with Nurse Aide (NA) #3 on 10/13/21 at 2:20 PM who confirmed she cared for Resident #9 on 10/01/21 evening shift. The NA explained there was no person scheduled to give showers that day because they had to be pulled to the floor therefore, Resident #9 did not receive his scheduled shower.

3. Resident # 6 was readmitted to the facility on 10/07/21 with diagnoses that included paranoid schizophrenia, major depression, moderate intellectual disabilities, anxiety disorder, epilepsy, suicidal ideations, diabetes, chronic obstructive pulmonary disease, congestive heart failure, atrioventricular block, and morbid obesity.

Resident # 6's quarterly Minimum Data Set (MDS) assessment dated 08/17/21 revealed the resident was cognitively intact for daily decision making and was extensive assistance with 1-person assist for bed mobility, toilet use and personal hygiene and total dependence with 2-person assist for bathing.

Review of the care plan dated 12/20/20 with a review date of 11/29/21 revealed an activity of

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daily living (ADL) self-performance deficient with a goal to remain at current level of functioning.

A review of the shower schedule revealed Resident # 6 was to receive showers every Monday and Thursday.

A review of the Documentation Survey Report v2, type: bathing schedule, indicated Resident # 6 did not receive bed baths daily for the months of June 2021 through October 10, 2021.

An interview with Resident # 6 on 10/11/21 at 12:23 PM revealed he did not want to have showers but only wanted a bed bath daily. Resident # 6 further revealed he'd had no bed bath today and he never refused bed baths. He stated sometimes he would get them in the morning, sometimes in the afternoon and sometimes would not get them at all.

An interview with Nursing Assistant (NA) # 5 on 10/11/21 at 3:10 PM revealed she did what she could in the amount of time she had. NA # 5 further revealed she occasionally gave a bed bath but the shower person would give the bed baths and they were done any time throughout the first shift.

An interview with NA #14 on 10/12/21 at 11:27 AM stated the NAs sometimes had 20-25 residents to care for and there wasn't enough time to get everything done. NA # 14 further stated showers and bed baths often were not done because there wasn't enough help.

An interview with the Interim Director of Nursing (DON) on 10/12/21 at 4:45 PM revealed if the residents wanted a shower or bed bath on certain

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F 561	Continued From page 17 days they should get them. The Interim DON further revealed if the resident did not want a shower, they should be getting a bed bath every day. The Interim DON stated if the showers or bed baths were not documented, they were not done.	F 561		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility neglected to provide incontinence care to a resident who was soiled with urine and resulted in a small reddish open area on her buttocks for 1 of 4 (Resident #23) residents reviewed for activities of daily living. The resident stated that her bottom was burning like it was on fire and wished she could care for herself, so she did not have to sit in a soiled brief. The findings included:	F 600	F 600-Free from Abuse and Neglect 1. On October 11th, the nurse aide provided incontinence care and the nurse completed a thorough skin assessment for Resident #23, notified the attending physician of skin concern, obtained treatment orders for reddened area to buttocks and updated skin care plan accordingly. Resident #23 discharged home on 10/29/2021 with no skin concerns. 2. On October 18th, the licensed nurses	11/15/21

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F 600	Continued From page 18 Resident #23 was admitted to the facility on 02/13/21 with diagnoses that included hemiplegia following a cerebral accident affecting her left non-dominate side, contractures, moisture associated dermatitis, urinary incontinence, and anxiety. Resident #23 has a skin care plan revised 5/19/21 which indicated she was at risk for skin breakdown. An incontinence care plan revised 05/25/21 indicated Resident #23 was incontinent of bowel and bladder with a goal of no skin breakdown due to incontinence with interventions that included peri-care after each incontinent episode and total dependance from staff for incontinence care. Resident #23 had a self-care deficit care plan related to total incontinence revised on 07/01/21 with a goal to remain clean, dry and odor free and interventions to include the need for assistance by staff for personal hygiene and grooming and two personal physical assistance for bed mobility. A quarterly Minimum Data Set (MDS) dated 07/07/21 revealed Resident #23 to be require extensive assistance for her bed mobility and personal hygiene needs. The MDS further indicated Resident #23 was always incontinent of bowel and bladder. A Brief Interview of Mental Status (BIMS) dated 10/05/21 indicated Resident #23 was cognitively intact. An observation and interview made on 10/11/21 at 12:45 PM revealed Resident #23 laying on her back in bed yelling for assistance with	F 600	completed skin assessments and incontinence care observations of current cognitively intact and cognitively impaired residents to ensure appropriate care provided to prevent avoidable skin concerns and resident neglect. Resident questionnaire audits were completed by the Social Services Director for cognitively intact residents to further ensure all residents are free from neglect. 3. Education completed 10/18/21 to 11/12/21. The Director of Nursing provided education to nurse aides, licensed nurses, and direct care agency staff on the importance of providing timely incontinence care and prevention of skin breakdown. The Director of Nursing, Administrator and Social Services Director provided abuse and neglect in-service training for current direct and indirect care facility and agency staff. Newly hired licensed nurses, nurse aides and direct care agency staff will receive education upon hire. Direct care nursing staff will monitor and provide incontinence care needs by performing routine room rounds and as needed or requested. Newly identified skin concerns will be communicated to the licensed nurse for assessment then reported to the physician for treatment orders as indicated. 4. The Director of Nursing and/or nurse designee will complete an audit of resident incontinence care and skin condition to ensure residents are free from neglect. Monitoring will be completed for five (5) random residents at a frequency of five (5) times weekly for four	

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F 600	Continued From page 19 incontinence care. Resident #23 was pulling at the blue incontinence brief she wore that was partially covered by a white sheet and she said, "please change me, my bottom it is on fire." There was a strong urine odor in the room during the observation. Resident #23's call light was not on during the observations; however, she was heard requesting assistance from outside of the door by the surveyor who entered. An observation and interview made on 10/11/21 at 1:00 PM revealed Resident #23 continue to lay in her bed still on her back yelling for assistance with incontinence care while staff walked by the room. Resident #23 stated "it is hurting worse; someone please get this off me before I have a hole in my butt. I wish I could just take care of myself, so I didn't need anyone to wipe my butt and sit wet." The surveyor told the resident she would make the nurse aware she needed assistance. The surveyor then told a nurse who was sitting behind the desk at the nurses' station and the nurse said she would have an Nurse Aide (NA) to take care of it. An observation and interview made on 10/11/21 at 3:45 PM revealed Resident #23 was again yelling for assistance requesting incontinence care and when approached became tearful saying her buttocks felt like it was burning like it was on fire and felt like she couldn't barely stand to sit on it any longer. Resident #23 indicated she thought she had a hole on her butt. Resident #23 verbalized staff did not help when she called out. The surveyor approached the nurses' station and notified the oncoming nurse that Resident #23 was requesting assistance with incontinence care and need for observation when it occurred.	F 600	(4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain resident freedom from abuse and neglect. Compliance date of 11/15/2021	

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An observation on 10/11/21 at 3:47 PM of incontinence care provided by Nurse Aide (NA #12) and NA #19 revealed Resident #23 lying in bed with a blue brief heavily saturated with a dark ring of liquid that revealed the interior cotton lining separating and shedding from the brief linings. The bed pad under Resident #23 was visibly wet with a yellow liquid substance present. The brief was discarded and visualization of Resident #23's buttocks revealed a quarter sized red circular area to the left lower buttocks near Resident #23's peri-area. The area was open and non-blanchable approximately 1 inch from the center of her rectum. As NA #12 began to wipe Resident #23's bottom, Resident #23 continued to complain of burning and stinging throughout the procedure. Once the incontinence care was completed with a clean brief and bed pad, then NA #19 covered Resident #23 up with the sheet and the Resident #23 stated she felt better.

An interview with NA #12 and NA #19 on 10/11/21 at 3:53 PM stated they had only been on duty approximately an hour and had not yet provided care to Resident #23 since they arrived for their shift. They stated the day shift should have provided incontinence care to Resident #23 before they left for the day. Both NAs indicated the state of which Resident #23 presented during the incontinence care was not acceptable to be this wet. They felt the open area observed was new to their knowledge as they had cared for Resident #23 before and stated they would let the nurse know.

An interview with Wound Nurse on 10/12/21 at 10:15 AM revealed she was responsible for wounds in the facility; however, she had recently been working as a floor nurse more often than

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being able to assess resident wounds. Wound Nurse indicated she had not been made aware Resident #23 was observed to have a reddened open area visible during incontinence care on 10/11/21 but she would investigate this concern.

An observation and interview with Wound Nurse on 10/12/21 at 11:30 AM revealed Wound Nurse's observation of Resident #23's buttocks. Wound nurse acknowledged a new reddened open area to Resident #23's buttocks. Wound Nurse was unable to determine what caused the area during the observation, stated it was a new area and indicated she would obtain a new order for ointment from the physician.

An interview with NA #11 on 10/12/21 at 3:00 PM revealed she had been assigned to care for Resident #23 on 10/11/21 during day shift. NA #11 indicated she felt overwhelmed with the assignment she was given on 10/11/21 and had only changed Resident #23 before breakfast that morning. NA #11 indicated with all the lifts, feedings, and incontinence care it was more than she was able to get done in a shift and got sidetracked and did not make it back in to change Resident #23 before her shift ended on 10/11/21. NA #11 stated she wants to change residents every two hours, but often it may only be once or twice when the NAs are assigned up to 20 residents on day shift. NA #11 did not recall noticing the red open area noted to Resident #23's buttocks on 10/11/21 when she changed her early that morning. NA #11 also vocalized staff are aware that Resident #23 has a history of hollering out and doesn't always need care, but often just wants someone to come in the room.

An order was obtained from the physician on

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F 600	Continued From page 22 10/12/21 at 3:43 PM for Zinc Oxide to Resident #23's buttocks twice daily on day and evening shifts for redness. An interview with the Director of Nursing (DON) on 10/12/21 at 4:45 PM revealed she expected all residents to be changed every two to three hours regardless of the facility's recent staffing shortages and increase workloads. The DON indicated she Resident #23 should not have went without being checked and incontinence rounds provided from before breakfast until 3:45 PM when second shift staff arrived on duty.	F 600		
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 observations, record reviews, resident, family and staff interviews, the facility failed to provide incontinence care prior to a resident (Resident #17) wetting through her brief onto her draw sheet, failed to provide incontinence care to a resident (Resident #2) who had a bowel movement, failed to provide showers as scheduled for 1 resident (Resident #3), and failed to provide nail care for 2 residents (Resident #18 and Resident #2) for 4 of 4 residents reviewed for activities of daily living for dependent residents. The findings included: 1. Resident #17 was admitted to the facility on 10/19/12 and readmitted on 03/16/19 with	F 677	F677-ADL Care Provided for Dependent Residents 1. Resident #17 and #2 continues to receive assistance with incontinence care, Resident #3 continues to receive assistance with bathing and Resident #2 and #18 continue to receive assistance with nail care per residents plan of care to maintain quality of care for dependent residents. 2. On November 10th, MDS Coordinator and Director of Nursing completed an audit of resident s dependent on staff for assistance with incontinence, bathing and/or nail care. Care needs provided as identified and updates to resident ADL	11/15/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 23 diagnoses which included Alzheimer ' s disease, dementia, seizure disorder and anxiety disorder. Resident #17's Care Area Assessment summary completed with her annual Minimum Data Set (MDS) assessment dated 12/16/20 revealed she was incontinent of bowel and bladder due to decreased mobility and cognitive impairment. Resident was at risk for developing pressure ulcer and urinary tract infection (UTI) related to her incontinence. Resident was totally dependent on nursing staff for incontinence care. Resident #17's most recent quarterly Minimum Data Set assessment dated 08/20/21 revealed she was severely impaired for daily decision making and required extensive to total assistance of 1 to 2 staff with all activities of daily living and was totally dependent on 1 staff member for toileting. Resident #17's care plan dated 09/15/21 revealed a plan of care for her incontinence of bowel and bladder related to her confusion and impaired mobility. The goal was for Resident #17 to remain free from infection, skin breakdown due to incontinence and brief use through the review date of 11/20/21. The interventions included check for incontinence prn (as needed), wash, rinse and dry perineum, change clothing prn after incontinent episodes, notify nursing if incontinent during activities, use disposable briefs per manufacturer's recommendation and change when soiled, encourage fluids during the day to promote prompted voiding responses, ensure resident has unobstructed path to the bathroom (resident does not use bathroom), establish voiding patterns, monitor/document for signs and symptoms of UTI such as burning, pain, blood	F 677	care plans, POC tasks and Kardex□s made as appropriate by the MDS Coordinator and Director of Nursing. 3. Education completed 10/18/21 □ 11/12/21. The Director of Nursing provided education to current facility licensed nurses, nurse aides and direct-care agency staff on providing ADL care for dependent residents per resident care plan, POC tasks and Kardex. Education includes the importance of timely incontinence care and monitoring through routine room rounds as needed or requested providing bathing assistance per resident preference and facility schedule, and providing nail care. Newly hired licensed nurses, nurse aides and direct-care agency staff will receive education upon hire. 4. The Director of Nursing and/or nurse designee will complete an audit of dependent residents for incontinence care, bathing care and nail care to ensure care for residents requiring assistance with ADLs are being met. Monitoring will be completed for five (5) random residents for ADL care at a frequency of five (5) times weekly for (4) four weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the interdisciplinary team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with ADL care for dependent residents. Compliance date of 11/15/2021	

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tinged urine, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior or change in eating habits, monitor/document/report to MD prn possible medical causes of incontinence, bladder infection, constipation, loss of bladder tone, weaking of control muscles, decreased bladder capacity, diabetes, stroke, and medication side effects, and obtain labs/tests as ordered and report abnormal to the MD.

Interview on 10/11/21 at 2:30 PM with family member of Resident #17 in conference room revealed she had just gotten to the facility and "smelled strong odor of urine as soon as walked in the door." The family member stated she had spoken with the Nurse Aide (NA) caring for the resident and NA #11 told her she had not been able to change the resident since around 9:00 or 9:30 AM after breakfast. NA #11 had been into Resident #17's room around 2:20 PM to change the resident and the family member told her no and came to find one of us so we could see her incontinence care and "see the condition the resident was in." The family member further stated when she comes to the facility if the resident is soiled, she usually changed her and bathed her and cut and cleaned her fingernails because otherwise it was not done. She indicated this was nothing new and had been going on for some time.

Interview on 10/11/21 at 3:00 PM with NA #12 revealed she was assigned to Resident #17 for the 3:00 PM to 11:00 PM shift and would change the resident as soon as she was able to get supplies for her incontinence care.

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Observation on 10/11/21 at 3:06 PM of Resident #17 ' s incontinence care revealed the resident had wet her brief all the way up her back, to all four corners of the plastic border around the brief and the cotton layer in between the layer next to the resident on the front and the plastic outer layer was balled up in the center of the brief. Resident #17 had wet through her brief onto the draw sheet under her on the bed. Resident #17 was cleaned by NA #12 and new clean brief applied and clean draw sheet was placed under her on top of her sheet. An interview conducted with NA #12 revealed she did not think the resident had been checked or changed for several hours due to the amount of urine in the brief and the draw sheet under the resident being wet.

Interview on 10/11/21 at 3:18 PM with NA #11 who had taken care of Resident #17 on the 7:00 AM to 3:00 PM revealed she had only been able to change the resident once today. NA #11 stated she had changed Resident #17 after breakfast and went in to change her around 2:00 to 2:30 PM and the family member told her no that she wanted the surveyors to see her changed. NA #11 stated she had not been able to get back to the resident prior to 2:00 PM due to all the feedings, lifts, and everything else she had to do today. NA #11 further stated this was her first week off orientation and she was "overwhelmed with the workload when there was only 3 NAs in the building." NA #11 indicated she was "overwhelmed with the number of residents she was assigned to care for" and said there was not enough time to get everything done. She further indicated Resident #17 was supposed to get a shower today but there was no one doing showers and said she had not even had time to

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give her a bed bath due to her workload. According to NA #11, "it was pretty normal lately for the NAs to have 20 or more residents to care for and there was no way to get everything done in 8 hours."

Interview on 10/12/21 at 4:45 PM with the interim Director of Nursing (DON) revealed there were staffing challenges at the facility. The DON stated there was only 1 full time employed nurse on day shift and 1 full time employed nurse on evening shift and the rest of the nurses were PRN (as needed) or were agency nurses. She further stated they recently had increased their base salary to be more competitive with hiring but still had quite a few open positions. The DON indicated she expected residents to be checked and changed as needed or at least every 2-3 hours and would not expect residents to go for over 4 hours without being checked for incontinence.

2. a. Resident #2 was admitted to the facility on 11/25/16 and readmitted on 08/31/20 with diagnoses which included Alzheimer ' s disease, dementia, osteoarthritis, and anxiety disorder among others.

Resident #2's most recent Minimum Data Set (MDS) assessment dated 09/10/21 revealed she required extensive to total assistance of 1 to 2 staff with most activities of daily living (ADL). The MDS further revealed she required extensive assistance of 1 staff with toileting and wore briefs.

Resident #2's care plan dated 10/12/21 revealed there was a plan of care for being incontinent of bowel and bladder due to diagnosis of dementia and was at risk of UTI and pressure ulcer

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development. The goal was for the resident to remain free from skin breakdown due to incontinence and brief use through the review date of 01/20/22. The interventions included barrier cream as ordered, use of disposable briefs according to manufacturer ' s recommendation, check during care rounds when soiled and prn, clean peri-area when soiled and prn, clean peri-area with each incontinence episode, encourage adequate fluid intake with meals and between with med pass, observe for signs and symptoms of UTI including pain, burning , blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating habits, observe/report prn any possible causes of incontinence, bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke and medication side effects.

Interview on 10/11/21 at 4:00 PM with family members visiting Resident #2 revealed they were not pleased with the resident's care. One of the family members further revealed they were blessed to have Resident #1 as their family member's roommate because she looked out for Resident #2. The other family member described an incident recently in which Resident #2 had sat in her own poop for over 4 hours because the NA assigned to her had not come in and changed her as requested by the roommate, Resident #1. The family member stated Resident #1 had realized when she smelled it that Resident #2 had a bowel movement and when she rang the call light they had not come and changed Resident #2 for over 4 hours. The family member further stated there

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was no excuse for allowing an elderly person who could not care for herself to sit in poop for that long at a time. She indicated it was not good for her skin to go that long without being changed. The family member indicated they had complained to the Director of Nursing about the care and were told "we are short staffed and doing the best we can." The family member further indicated "that is not what you want to hear when you are concerned about the care your loved one was receiving in the nursing home."

Interview on 10/11/21 at 4:30 PM with Resident #1 who is the roommate of Resident #2 revealed on Saturday, 10/09/21, at 4:00 PM she rang her call light for Resident #2. Resident #1 stated Resident #2 had a bowel movement and she could smell it, so she rang her light for a NA to come in and change Resident #2. Resident #1 further stated NA #7 answered the call light and stated she had just changed Resident #2. Resident #1 indicated she told NA #7 she had had a bowel movement and she could smell it and NA #7 said again she had just changed the resident. Resident #1 further indicated it was 8:45 PM before NA #7 came in and changed Resident #2. Resident #1 explained that she and Resident #2 had to eat their dinner while smelling her bowel movement. Resident #1 further explained that she informed Resident #2's family about the incident and complained about it and was told (could not remember by whom) that "it was being addressed." Resident #1 advised that she knew the specific times because she had looked at her watch when she called out for assistance for Resident #2 and looked at her watch again when they came in and changed her. Resident #1 stated she wears her watch every day.

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Interview on 10/12/21 at 3:15 PM with NA #7 revealed she was working on 10/09/21 and was assigned to Resident #1 and Resident #2. NA #7 stated there were good days and bad days with staffing just like any other place you work and said it was difficult to get everything done for every resident on days they were short staffed. She stated lately there were more days than not they worked without an adequate number of staff for the workload. NA #7 further stated it was impossible to get incontinence rounds done every 2 hours and they were lucky to get 2 rounds done on every resident. NA #7 indicated if she didn't change Resident #2 when Resident #1 rang the bell for her it was probably because she was cleaning another resident and then supper trays came out and she had to pass trays and feed residents that need to be fed and then after all trays are collected you can then start your second round. NA #7 further indicated they don ' t purposely leave someone wet or messed up but sometimes it was "impossible to get everything done for everybody and you just had to do the best you can."

Interview on 10/12/21 at 4:45 PM with the interim Director of Nursing (DON) revealed there were staffing challenges at the facility. The DON stated there was only 1 full time employed nurse on day shift and 1 full time employed nurse on evening shift and the rest of the nurses were PRN (as needed) or were agency nurses. She further stated they recently had increased their base salary to be more competitive with hiring but still had quite a few open positions. The DON indicated she expected residents to be checked and changed as needed or at least every 2-3 hours and would not expect residents to go for

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over 4 hours without being checked for incontinence.

2. b. Resident #2 was admitted to the facility on 11/25/16 and readmitted on 08/31/20 with diagnoses which included Alzheimer ' s disease, dementia, osteoarthritis, and anxiety disorder among others.

Resident #2's most recent Minimum Data Set (MDS) assessment dated 09/10/21 revealed she required extensive to total assistance of 1 to 2 staff with most activities of daily living (ADL). The MDS further revealed she required extensive assistance of 1 staff with personal hygiene.

Observation and interview on 10/11/21 at 4:00 PM with family members visiting Resident #2 revealed they were not pleased with the resident's care. One of the family members was observed cleaning brown debris from Resident #2's fingernails. The family member revealed they often came in and her hands and fingernails were dirty, so they cleaned them for her instead of waiting for the staff to do it. The other family member stated the care was not what they expected and felt Resident #2 was sometimes ignored because she could not speak up for herself. The family member further stated they were blessed to have Resident #1 as their family member's roommate because she looked out for Resident #2 and kept them informed about her care when she was in the room. The family members indicated they had complained to the Director of Nursing about the care and were told "we are short staffed and doing the best we can."

Interview on 10/12/21 at 11:10 AM with NA #10 revealed she routinely cared for Resident #2 and

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had taken care of her on 10/11/21 and 10/12/21. She stated Resident #2 was totally dependent on staff for all activities of daily living including personal hygiene. NA #10 stated she checked resident fingernails when providing care but said she had not noticed Resident #2's nails being dirty because she had a lot of residents and was in a rush to complete care. NA #10 further stated she performed nail care and trimming unless the resident was diabetic and then she would let the nurse know the resident ' s nails needed to be trimmed.

Interview on 10/11/21 at 12:50 PM with Nurse #6 revealed staff usually performed nail care and trimmed nails on shower days. She stated the staff would perform nail care at other times if requested by the resident or family. Nurse #6 further stated the NAs performed nail care on residents unless they were diabetic and if they were the nurses would clean, trim, and file their nails. Nurse #6 indicated she had not noticed Resident #2's nails being dirty while providing her med pass.

Interview on 10/12/21 at 4:45 PM with the interim Director of Nursing (DON) revealed there were staffing challenges at the facility. The DON stated she expected fingernails to be cleaned, cut, and filed any time they were long, dirty, or anytime the resident or family requested they be done.

3. Resident #3 was admitted to the facility on 02/20/20 with diagnoses that included cerebral vascular accident and dementia.

The quarterly Minimum Data Set (MDS) assessment dated 08/03/21 revealed Resident #3's cognition was severely impaired and

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required extensive assistance of one staff for bathing. The MDS also indicated the Resident was incontinent and had no behaviors of rejection of care.

Resident #3's revised care plan dated 08/16/21 revealed the Resident had a self-care performance deficit related to hemiplegia and dementia. The goals that Resident #3 would remain at her current level of function and would not decline in her activities of daily living (ADL) through the next review would be attained by utilizing interventions such as providing extensive assistance of one staff for her ADL and providing a sponge bath when a full bath or shower cannot be provided.

A review of the Shower Schedule revealed Resident #3 was scheduled for showers on Sunday and Thursday.

A review of Resident #3's Bathing record from October 1, 2021 through October 11, 2021 revealed the Resident had not received a shower during that time period.

A review of Resident #3's Progress Notes from October 1, 2021 through October 11, 2021 revealed no documentation for refusal of showers.

An observation of Resident #3 on 10/11/21 at 10:45 AM revealed the Resident was awake and lying on her already made bed fully dressed in her day clothes. The Resident was neatly groomed and without odors of incontinence. Resident #3 would not make eye contact or respond to questions.

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On 10/11/21 at 1:10 PM an interview was conducted with family member who explained that Resident #3 was scheduled for showers on Sunday and Thursday and had not received a shower for at least 2 weeks. The family member stated the Resident was incontinent and was prone to yeast infection (rash) and needed to be showered when scheduled to help prevent the yeast infection from occurring. The family member added that there was a family member who visited the Resident nearly every day and knew that she had not been given the 2 scheduled showers a week.

During an interview on 10/11/21 at 4:05 PM with Nurse Aide (NA) #4 she confirmed she cared for Resident #3 on 10/03/21 evening shift. The NA explained that she was normally scheduled to give showers but was pulled to the hall to work that day due to call outs. The NA stated Resident #3 did not receive a shower that shift. The NA continued to explain that she was scheduled to care for Resident #3 on 10/07/21 evening shift as well but did not give the Resident her scheduled shower that shift.

An interview was conducted with Nurse Aide (NA) #2 on 10/11/21 at 5:00 PM who confirmed she was scheduled for showers on 10/07/21 evening shift. The NA explained that she approached Resident #3 for her shower and the Resident refused (the refusal was not documented on the Bathing record). The NA stated she reported the refusal to the Nurse but could not remember who the Nurse was.

An interview was conducted with the Director of Nursing (DON) on 10/12/21 at 4:30 PM. The DON was shown Resident #3's Bathing record which

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reflected she had not received her scheduled showers during the month of October 2021. The DON acknowledged the Bathing record and reported that she knew that Resident #3 received a shower on 10/07/21 given by Nurse Aide (NA) #10 because she observed the NA taking the Resident into the shower room and fixing her hair. The DON added, regardless, if the showers were given then the staff should have given a bed bath instead. The DON also added she expected the showers to be given as scheduled and if the showers were not documented then they were not done.

An interview was conducted with Nurse Aide (NA) #10 who confirmed she worked on 10/07/21 evening shift but did not give Resident #3 her scheduled shower. The NA explained there was not a person scheduled to give showers on that shift.

During an interview with Nurse Aide (NA) #7 on 10/12/21 5:00 PM she confirmed she worked with Resident #3 on 10/10/21 evening shift. The NA explained that the person scheduled for showers was pulled to the hall to work therefore, Resident #3's scheduled shower was not given.

An interview was conducted with Nurse Aide (NA) #6 on 10/13/21 at 1:40 PM. The NA confirmed she worked with Resident #3 on 10/10/21 morning shift and explained there was no staff scheduled to give showers that shift therefore, the Resident did not get her scheduled shower.

During an interview with Nurse Aide (NA) #5 on 10/13/21 at 3:35 PM she confirmed she worked with Resident #3 on 10/03/21 morning shift. The NA explained she was not aware that the

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Resident was scheduled for a shower that day and did not give the Resident a shower. The NA continued to explain that they normally did not have a person scheduled for showers on the weekend because they were usually short staffed, and the shower person was almost always pulled to the hall to work.

An interview was conducted with Nurse Aide (NA) #8 on 10/13/21 at 5:30 PM who confirmed she cared for Resident #3 on 10/07/21 morning shift. The NA explained that there was not a staff person scheduled to give showers on the morning shift and she did not give Resident #3 her scheduled shower.

4. Resident #18 was admitted to the facility on 9/13/19 with diagnosis that included cerebrovascular accident (CVA), hypertension, diabetes, non-Alzheimer dementia, hypertension, and anxiety.

Review of the quarterly comprehensive Minimum Data Set (MDS) dated 09/21/21 revealed that Resident #18 was cognitively impaired for daily decision making and required extensive assistance of one staff member with activities of daily living.

Review of care plan dated 10/12/21 revealed Resident #18 required physical assistance with activities of daily living (ADLS) due to decreased mobility and cognitive impairment. The goal was for resident #18 would be clean, dry and odor free with current interventions. Interventions included extensive assist of one person to physically assist resident #18 with personal hygiene.

An observation of Resident #18 was made on

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10/11/21 at 10:47 AM. Resident #18 was observed sitting in her wheelchair in the hallway. All 10 of her fingernails were approximately a quarter inch long and were noted to have dried brown substance under them.

An observation of Resident #18 was made on 10/11/21 at 2:43 PM. Resident #18 was resting in bed. All 10 of his fingernails were approximately a quarter inch long and were noted to have dried brown substance under them.

An interview was conducted with NA #10 on 10/12/21 at 11:10 AM during first shift. NA #10 confirmed that she routinely cared for Resident #18 and had taken care of her on 10/11/21 and 10/12/21. She stated that she assisted resident #18 with getting dressed the morning of 10/11/21. She stated that Resident #18 was dependent on staff for all aspects of activities of daily living including nail care. NA #10 stated she usually checked nails whenever she provided care. NA #10 stated that she performed nail care and trimming unless they were diabetic then the nurse trimmed the nails. NA further stated that she was rushed during morning care and had not noticed the resident's finger nails.

An interview was conducted with Nurse #6 on 10/11/2021 at 12:50 PM. Nurse #6 stated that the NA's usually performed nail care and trimmed nails on shower days. She also stated the staff would perform nail care if requested by a resident. Nurse #6 further stated that the NAs performed nail care on residents unless the resident was a diabetic, then the nurses would perform nail care and trimmed nails.

An interview was conducted with treatment nurse

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F 677	Continued From page 37 #7 on 10/12/2021 at 4:05 PM. She stated that it is the responsibility of the NA to trim and clean residents' nails, unless the residents were diabetic then it was the hall nurse's responsibility to trim the nails. An interview was conducted with the Director of Nursing (DON) on 10/12/21 at 4:14 PM. The DON stated that she expected fingernails to be cleaned and trimmed any time they were long or dirty.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to prevent skin breakdown when incontinence care was delayed resulting in an open area of redness to the buttocks for 1 of 1 resident reviewed for neglect (Resident #23). Findings included: Resident #23 was admitted to the facility on 02/13/21 with diagnoses that included hemiplegia following a cerebral accident affecting her left non-dominate side, contractures, moisture related dermatitis, urinary incontinence, and anxiety.	F 684	F684-Quality of Care 1. On October 11th, the nurse aide provided incontinence care and the nurse completed a thorough skin assessment for Resident #23, notified the attending physician of skin concern, obtained treatment orders for reddened area to buttocks and updated skin care plan accordingly. Resident #23 discharged home on 10/29/21 with no skin concerns. 2. On October 18th, licensed nurses completed skin assessments and incontinence care observations of cognitively intact and cognitively impaired	11/15/21

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F 684	Continued From page 38 A review of Resident #23's physician orders indicated she had no treatments in place for identified skin breakdown to her buttocks. Resident #23 had a self-care deficit care plan related to total incontinence revised on 07/01/21 with a goal to remain clean, dry and odor free and interventions to include the need for assistance by staff for personal hygiene and grooming and two personal physical assistance for bed mobility. A quarterly Minimum Data Set (MDS) dated 07/07/21 revealed Resident #23 required extensive assistance for her bed mobility and personal hygiene needs. A Brief Interview of Mental Status (BIMS) dated 10/05/21 indicated Resident #23 was cognitively intact. A skin assessment dated 10/08/21 indicated Resident #23's skin was intact. A review of nurse progress notes for 10/8/21 to 10/12/21 did not include mention of any new skin breakdown nor an updated skin assessment was completed. An observation and interview made on 10/11/21 at 12:45 PM revealed Resident #23 laying on her back in bed yelling for assistance with incontinence care. Resident #23's door was observed to be open at the time. Resident #23 was pulling at the blue incontinence brief she wore that was partially covered by a white sheet and she said, "please change me, my bottom it is on fire." There was a strong urine odor in the room upon entry.	F 684	residents to ensure appropriate care provided to prevent avoidable skin concerns and resident neglect. Resident questionnaire audits were completed by the Social Services Director for cognitively intact residents to further ensure all residents receive care in accordance with professional standards of practice. 3. Education completed 10/18/21 □ 11/12/21. The Director of Nursing provided education to nurse aides, licensed nurses and direct care agency staff on providing timely incontinence care and prevention of skin breakdown in accordance with professional standards of practice. Newly hired licensed nurses, nurse aides and direct care agency staff will receive education upon hire. Direct care nursing staff will monitor and provide incontinence care needs by performing routine room rounds and as needed or requested. Newly identified skin concerns will be communicated to the licensed nurse for assessment then reported to the physician for treatment orders as indicated. 4. The Director of Nursing and/or nurse designee will complete an audit of resident incontinence care and skin condition to ensure residents receive care in accordance with professional stands of practice. Monitoring will be completed for five (5) random residents at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months	

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F 684	Continued From page 39 An observation and interview made on 10/11/21 at 1:00 PM revealed Resident #23 continued to lay in her bed yelling for assistance with incontinence care while staff walked by the room. Resident #23 stated "it is hurting worse; someone please get this off me before I have a hole in my butt. I wish I could just take care of myself, so I didn't need anyone to wipe my butt and sit wet." During an observation of incontinence care provided by NA #12 and NA #19 on 10/11/21 at 3:47 PM, a quarter sized red circular area to the left lower buttocks near Resident #23's peri-area was seen when her heavily soiled brief was removed. The area was open approximately 1 inch from the center of her rectum. As NA #12 began to wipe Resident #23's bottom, Resident #23 continued to complain of burning and stinging throughout the procedure. After identification, NA #12 ran her fingers across the area and the area did not blanch in color. An interview with NA #12 and NA #19 on 10/11/21 at 3:53 PM stated they felt the open area observed was new to their knowledge as they had cared for Resident #23 before and stated they would let the nurse know. An interview with Wound Nurse on 10/12/21 at 10:15 AM revealed she was responsible for wounds in the facility; however, she had recently been working as a floor nurse more often than being able to assess resident wounds. The Wound Nurse indicated she had not been made aware Resident #23 was observed to have a reddened open area visible during incontinence care on 10/11/21 but she would investigate this concern.	F 684	and will make changes to the plan as necessary to ensure resident care is maintained in accordance with professional standards of practice. Compliance date of 11/15/2021	

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F 684	Continued From page 40 An observation and interview with the Wound Nurse on 10/12/21 at 11:30 AM revealed the Wound Nurse's observation of Resident #23's buttocks. The Wound Nurse acknowledged a new reddened open area to Resident #23's buttocks. During the observation the Wound Nurse stated she was uncertain what caused the open area and stated it was a new area then indicated she would obtain a new order for an ointment from the physician. An interview with NA #11 on 10/12/21 at 3:00 PM did not recall noticing the red open area noted to Resident #23's buttocks on 10/11/21 when she changed her early that morning before breakfast.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff, hospice, and physician interviews, the facility failed to administer pain medications as prescribed by the physician to a hospice resident to treat chronic pain for 1 of 1 resident reviewed for pain management (Resident #15). As a result, Resident #15 reported her pain level was 7 to 9 on a scale of 1 to 10 across all three shifts during her stay in the facility. Findings included:	F 697	F697-Pain Management 1. Resident #15 discharged from the facility on 08/30/21. 2. The Director of Nursing and MDS Coordinator interviewed all residents to ensure pain levels were managed and pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the	11/15/21

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F 697	Continued From page 41 Resident #15's hospital discharge summary included the following order with a fill date of 08/27/21: ·Morphine Sulfate Immediate Release (MSIR) 15 milligram (mg) tabs give 3 to equal 45mg every 4 hours for 15 days for pain. MSIR is controlled substance in the opiate category used to treat moderate to severe pain. Resident #15 was admitted to the facility on 08/27/21 under hospice services following a hospitalization for narcotic medication withdrawal and chronic obstructive pulmonary disease (COPD) and she had a history of a motor vehicle accident (MVA) that resulted in a left above the knee amputation. Review of Resident #15's August 2021 Medication Administration Record (MAR) revealed an order dated 08/27/21 transcribed inaccurately by the Director of Nursing (DON). to include: ·Morphine Sulfate Immediate Release (MSIR) 15 milligram (mg) tabs give 3 to equal 45mg every 4 hours as needed for pain for 15 days A review of the August 2021 MAR also revealed Resident #15 was administered MSIR on 7 occasions. ·Resident #15 received no MSIR on 08/27/21 after her admission to the facility. ·Resident #15 was administered MSIR on 8/28 at the following time: 8:40 AM when her pain was documented to be a 9 on a scale of 1 to 10 and	F 697	residents' goal and preferences. 3. Education completed 10/18/21 – 11/12/21. The Director of Nursing provided education to all licensed nursing staff were educated on documentation of resident's pain levels, every shift pain observation and notification of MD when pain is not managed. All nurse aides and medication aides were educated on notifying licensed nursing staff when residents report pain or display pain indicators. 4. The Director of Nursing and/or nurse designee will complete a pain management audit tool to ensure pain management is provided. Monitoring will be completed for five (5) random residents at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain ADL care for dependent residents. Compliance date of 11/15/2021	

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again at 10:15 PM with pain levels documented at an 8. Based on the original order prescribed Resident #15 missed 4 doses.

·Resident #15 was administered MSIR on 08/29 at the following times: 4:58 AM when her pain was documented to be a 7, 10:57 AM with an unidentified pain level (NA was listed), and again at 11:48 PM with pain level documented to be a 8. Resident #15 missed 3 doses on 08/29/21.

·Resident #15 was administered MSIR on 8/30 at the following times: 4:23 AM when pain was documented to be a 7 and 8:58 AM with pain levels documented at a 3.

The discharge Minimum Data Set (MDS) dated 08/30/21 assessed Resident #15 with intact cognition and noted she received opiates and antianxiety medications on 3 of 7 days during the MDS assessment period. The MDS further indicated under a section titled pain assessment Resident #15 verbalizing a pain level of a 9 of 10 on the pain scale over the last 5 days.

A review of the nursing progress notes dated 08/27/21 through 08/30/21 revealed no documentation related to Resident #15's pain management to include location of pain or notification of the provider.

A facility social worker (SW) note dated 08/30/21 revealed a telephone conversation between the SW and Resident #15's family member about Resident #15's desire for discharge due to believing she will receive better care under hospice services at home and get her medications provided for pain and anxiety on time.

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A review of a hospice note dated 08/30/21 written by Hospice Nurse #1 indicated Resident #15 had expressed being very displeased with her stay at the facility due to not receiving pain medications as prescribed and having to wait 1-2 hours after she requested them before they were administered.

An interview with Med Aide (MA) #1 on 10/13/21 at 3:20 PM revealed she was familiar with Resident #15 and had been responsible for administering her medications on 10/29/21 during the evening shift. MA #1 stated she recalled medicating Resident #15 with controlled substances to include an opiate. MA #1 explained Resident #15 had approached her on one occasion although she was unable to recall the time inquiring why her medications were not being administered routinely and why she had to ask and wait to receive them every time she wanted them. MA #1 elaborated that she told Resident #15 the medications were ordered as needed and she would have to ask for them to receive them. MA #1 indicated Resident #15 frequently complained of experiencing debilitating pain although she was unable to give an exact pain level and she made a nurse aware although she was unable to recall which nurse she notified.

An interview with Nurse Aide (NA) #13 on 10/13/21 at 3:25 PM revealed she had not directly worked with Resident #15; however, did recall being in the room when Resident #15 called her family member who resided in the facility and was complaining of being in pain and not receiving her medications as prescribed. NA #13 stated she overheard Resident #15 tell her brother someone needed to do something to fix this, or she was

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leaving the facility and going home where she could get better care. NA #13 indicated she told Resident #15's nurse that day about what she had overheard; however, she was unable to recall which nurse was assigned to Resident #15 on that date.

An interview with NA #3 on 10/13/21 at 3:29 PM revealed she worked with Resident #15 while in the facility and recalled her constantly complaining of pain in her back and overall generalized pain. At times, Resident #15 stated her pain was excruciating and NA #3 would make Nurse #4 aware, but she was unsure if Resident #15 received pain medications to treat her pain or how long it took to administer the medications requested.

An interview with MA #2 on 10/13/21 at 4:11 PM revealed she was the familiar with Resident #15 and had been responsible for medicating Resident #15 on the date of her discharge of 08/30/21. MA #2 stated she recalled administering controlled substances for pain; however, Resident #15 complained of a lot of pain in her back and abdomen and she made Nurse #4 aware. MA #2 could not recall the names of the medications she administered that day; however, she did recall applying a "pain patch" that was ordered and was clarified to be Fentanyl.

An interview with Nurse #4 (an agency nurse) was attempted three times without success.

An interview with the Hospice Social Worker (HSW) on 10/14/21 at 11:00 AM revealed she had visited Resident #15 in the facility and was familiar with Resident #15's concerns regarding

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her pain management. The HSW stated she had made the medicating staff on the cart on that day (although she could not recall the exact date, she believed it was the day after admission) aware of Resident #15's concerns with pain and her not receiving medications as requested without prolonged delays resulted in unmanaged pain and severe anxiety and had previously had negative effects on Resident #15 but she could not recall the staff member she told.

An interview with Hospice Nurse #1 on 10/14/21 at 11:13 AM revealed she was familiar with Resident #15 and had overseen her hospice care for the last year prior to admission to the facility. Hospice Nurse #1 indicated her hospice records indicated Resident #15 was ordered Fentanyl 75mcg/hr. patches, MSIR 45mg every 4 hours, and Lorazepam 1mg every 4 hours. Hospice Nurse #1 stated she had been present at the hospital with Resident #15 on the day she was discharged to the facility and saw her in the facility shortly after her time of admission to the facility on 08/27/21. Hospice Nurse #1 said she notified the nurse on the cart of the importance of Resident #15 receiving her medications as ordered and not missing or delaying doses due to her history of side effects when the medications are not taken as prescribed but did not recall what the nurses' name she spoke with on that date. Hospice Nurse #1 also revealed she visited Resident #15 at the facility on 08/30/21 when she was planned to discharge home under hospice services. Resident #15 expressed to her that she did not believe her medications had been administered as ordered but Hospice Nurse #1 did not have access to the physician's orders to verify if the medications were administered correctly. Hospice Nurse #1 recalled Resident

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#15 having increase heart rate, decrease oxygen saturations, anxiety, and pain on the date of discharge and felt her to be experiencing some withdrawal symptoms from her medications.

An interview with Nurse #5 on 10/14/21 at 3:12 PM revealed she was no longer employed with the facility however she was familiar with Resident #15. Nurse #5 stated she recalled one day during Resident #15's stay being approached by a staff member (although she was unable to recall the date or the staff member who approached her) about Resident #15's medications. Nurse #5 indicated she was very busy attempting to process an overwhelming number of admissions on that day, she had planned to phone the physician about Resident #15's pain management concerns, but after completing the other tasks that day, she did not remember and therefore she did not look into Resident #15's medication concerns. Nurse #5 mentioned new admission orders were supposed to be verified and clarified during a clinical meeting the following morning after admission; however, she did not recall being involved in the process of verifying Resident #15's admission orders and felt she may have been off duty on that date due to it being a weekend.

An interview with the Director of Nursing (DON) on 10/12/21 at 10:45 AM revealed she was unaware Resident #15's pain had not been managed while in the facility or that Resident #15 did not receive her pain medications as prescribed on the discharge summary. The DON acknowledged she was the nurse who transcribed the medications from the discharge summary and had transcribed them as PRN instead of scheduled doses of the opiates and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 47 antianxiety medications. The DON explained that the facility's typical procedure included herself and another administrative nurse (typically Nurse #5) although at times other administrative nurses were utilized where new admission orders were reviewed for accuracy on the morning following admission. Although she is unsure how these orders were missed if these orders were reviewed the following day. An interview with the Medical Director on 10/12/21 at 3:39 PM revealed he was not aware Resident #15's pain had not been managed during her stay because it was limited in days and he did not see her while in the facility. The MD vocalized the medications should have been administered as ordered on the hospital discharge summary. The MD elaborated that a resident who had opiate dependance who was accustomed to MSIR 6 times a day routine and then receiving less than the prescribed doses may result in adverse side effects.	F 697		
F 725 SS=G	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).	F 725		11/15/21

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F 725	Continued From page 48 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family, and staff interviews, the facility failed to provide sufficient nursing staff for the provision of incontinence care to a resident (Resident #23) who was wet and yelling that it was burning and hurting her skin and as a result ended up with a reddened area on her skin, failed to provide incontinence care to a resident (Resident #17) who was wet through her brief and onto her draw sheet, failed to provide incontinence care to a resident (Resident #2) who had a bowel movement, failed to provide showers as scheduled for 3 residents (Resident #1, Resident #6 and Resident #9) and failed to provide nail care for 2 residents (Resident #18 and Resident #2) for 7 of 7 residents reviewed for sufficient nursing staff. The findings included: This tag is cross referred to: F600: Based on observation, record review and	F 725	F725 Sufficient Nursing Staff- 1. Residents #1, #2, #9, #17, and #18 are continuing to receive care and treatment according to their plan of care. Residents #6 and #23 are no longer current residents of the facility. 2. On 10/17/2021, facility implemented an updated wage scale to recruit and retain additional nursing staff. The Director of Nursing and Administrator implemented additional measures to ensure state regulatory compliance of sufficient staffing by contacting local staffing agencies, offering bonuses for shifts, and incentivizing attendance. Upon hire, appropriate competencies and skill sets are initiated to provide nursing and related services to assure resident safety and attain highest practicable physical, mental, and psychosocial well-being of each resident. 3. The interdisciplinary team discussed	

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F 725	Continued From page 49 staff interviews, the facility neglected to provide incontinence care to a resident who was soiled with urine and resulted in a small reddish open area on her buttocks for 1 of 4 (Resident #23) residents reviewed for activities of daily living. The resident stated that her bottom was burning like it was on fire and wished she could care for herself, so she did not have to sit in a soiled brief. F684: Based on observation, record review, and staff interviews, the facility failed to prevent skin breakdown when incontinence care was delayed resulting in an open area of redness to the buttocks for 1 of 1 resident reviewed for neglect (Resident #23). F 561: Based on observations, record reviews, resident, family and staff interviews, the facility failed to honor the residents' preferences regarding number of showers or bed baths per week for 3 of 3 residents (Resident #1, Resident #6, and Resident #9) reviewed for choices. F677: Based on observations, record reviews, resident, family and staff interviews, the facility failed to provide incontinence care prior to a resident (Resident #17) wetting through her brief onto her draw sheet, failed to provide incontinence care to a resident (Resident #2) who had a bowel movement, failed to provide showers as scheduled for 1 resident (Resident #3), and failed to provide nail care for 2 residents (Resident #18 and Resident #2) for 4 of 4 residents reviewed for activities of daily living for dependent residents. Interview on 10/11/21 at 4:50 PM with the Treatment Nurse revealed last week she had been assigned to work on a medication cart every	F 725	recruiting and retention efforts in QAPI on 11/8/21 that are in place and reviewed for changes for future recruiting and retention efforts. The Administrator, DON, and scheduling coordinator meet five times weekly to discuss current staffing ratios and changes that could be put in place to ensure that quality care is provided based on the acuity of resident population. 4. The Director of Nursing, Administrator, and scheduling coordinator will review nursing department schedules four (4) times a week for 4 weeks then weekly for 3 months to ensure adequate staffing for all shifts. Staffing agencies will be utilized as needed ongoing until in-house staffing can sufficiently cover all nursing positions. Staffing coordinator will notify Director of Nursing of open positions that they are unable to fill for further direction in filling the positions. Staff call outs will be reviewed for trends during IDT meetings. Compliance date of 11/15/2021	

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day. She further revealed she had worked all shifts as needed to cover the schedule instead of her normal job of wound care. The Treatment Nurse stated when she was assigned to work on a cart each nurse was responsible for the wound care of their assigned residents.

Interview on 10/12/21 at 9:15 AM with Nurse Aide (NA) #13 revealed she was assigned 22 residents to care for the morning of 10/12/21. She stated she usually had that many residents for a portion of the day if not all day. NA #13 stated she was not able to get all her tasks done for 22 residents. She indicated the NAs did their best to keep the residents dried, turned, and fed and if no one was assigned to showers they did their best to wash their "face, armpits, privates, and butt." NA #13 indicated the NAs didn't have time to wash the residents' hair and said they hadn't had shampoo caps in a long time. According to NA #13, on days they had 22 residents they were only able to do 2 rounds for incontinence care and maybe were able to get 1 shower per shift done. NA #13 explained she was frequently asked to stay late or come in early to cover schedules. She further explained that residents were frequently found "in a mess" when she came in for her shift. NA #13 said residents were probably found that way because the staff on the previous shift didn't have time to keep residents dry due to the workload.

Interview on 10/12/21 at 11:13 AM with Nurse #2 revealed residents frequently complained about not getting showers and not receiving incontinence care. Nurse #2 further revealed the NAs were only able to complete 2 rounds of incontinence care per shift and with their workload it was impossible for them to do rounds every 2 hours. She stated they were not able to

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F 725	Continued From page 51 get showers done as scheduled and were lucky if they had time to do one shower per shift. Nurse #2 further stated the nurses did not have time during their shift to assist the NAs with resident care. Interview on 10/12/21 at 4:45 PM with the Director of Nursing (DON) revealed there were staffing challenges at the facility. The DON further revealed she only had 2 full time nurses working at the facility and the other nurses were either as needed (prn) or agency nurses. She stated corporate had recently increased the base salary for NAs and nurses to be more competitive with hiring but still had several positions open on all shifts. The DON stated she was not sure how many positions were still open, that would be a question for the Regional Director of Operations. Interview on 10/12/21 at 5:30 PM with the Regional Director of Operations (RDO)revealed there were 3 Licensed Practical Nurse (LPN) open positions, 5 Registered Nurse (RN) open positions, 2 NA open positions, and 3 Certified Medication Aide (CMA) open positions. She further revealed over the past 5 weeks they had hired 8 NAs, 2 CMAs and 1 RN. The RDO stated they had increased wages to allow for better recruitment of their open positions and were orienting staff as they were hired. She further stated they had not and were not planning to stop taking admissions to the facility.	F 725		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		11/15/21

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F 760	Continued From page 52 This REQUIREMENT is not met as evidenced by: Based on record review, staff, hospice, and physician interviews, the facility failed to prevent significant medication errors by not accurately transcribing and administering medication as ordered from the hospital discharge summary prescribed to treat chronic pain, shortness of breath, and anxiety for a hospice resident for 1 of 1 resident reviewed for medication errors (Resident #15). As a result, Resident #15 reported her pain level was 7 to 9 on a scale of 1 to 10 across all three shifts during her 4 days as resident in the facility. Findings included: A review of the hospital records dated 08/25/21-08/27/21 indicated in part Resident #15 was restarted on narcotic pain medications following withdrawal symptoms. Resident #15's discharge summary revealed she had been discharged to the facility with the following orders with fill dates of 08/27/21: - Morphine Sulfate Immediate Release 15 milligram (mg) tabs give 3 to equal 45mg every 4 hours for 15 days for pain or shortness of breath. - Lorazepam 1mg tabs every 4 hours for anxiety. A copy of the original hard script for controlled substances provided by the hospital written by the discharging physician's assistant indicated: - Morphine Sulfate Immediate Release 15 milligram (mg) tabs give 3 to equal 45mg every 4 hours for 15 days start 08/27/21. Dispense 270 tablets.	F 760	F760-Residents are Free of Significant Med Errors 1. Resident #15 discharged from the facility on 8/30/21. 2. The Director of Nursing completed an audit on November 10th of residents admitted to the facility from 10/16/21-10/31/21 for accurate transcription and administration of medications as ordered from the hospital discharge summary. No resident harm was identified. 3. Education completed 10/18/21 – 11/12/21. The Director of Nursing provided education to current facility licensed nurses and agency staff on the proper transcription and administration of medication orders upon admission. Education includes the process and procedure for verifying, transcribing, and administering medications per facility Medication Management policy to ensure residents are free from significant medication errors. Newly hired licensed nurses and agency staff will receive education upon hire. 4. The Director of Nursing and/or nurse designee will complete an audit to ensure new admission orders are entered per the Medication Management policy. Monitoring will be completed for five (5) random newly admitted residents at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team	

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F 760	Continued From page 53 - Lorazepam 1mg tabs every 4 hours for 15 days start 08/27/21. Dispense 90 tablets. Resident #15 was admitted to the facility on 08/27/21 under hospice services following a hospitalization for narcotic medication withdrawal and chronic obstructive pulmonary disease (COPD) and she had a history of a motor vehicle accident (MVA) that resulted in a left above the knee amputation and long-term opiate dependance. She was subsequently discharged home on continued hospice services on 08/30/21. A review of the control substance sheets provided by pharmacy with the narcotic medications indicated in part controlled substances were dispensed as follows: - Morphine Sulfate 15mg tablets (MSIR) three tablets by mouth every 4 hours for 15 days and was filled for 252 tablets with a quantity of 18 remaining to be dispensed later by Polaris pharmacy and indicated 9 doses had been administered. - Lorazepam 1mg tablets one tablet by mouth every 4 hours for 15 days and was filled for 88 tablets with 7 doses administered. Resident 15's Medication Administration Record (MAR) dated August 2021 revealed the above orders were transcribed as: - Morphine Sulfate Immediate Release (MSIR) 15 milligram (mg) tabs give 3 to equal 45mg every 4 hours as needed for 15 days - Lorazepam 1mg tabs every 4 hours as needed	F 760	(IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain ADL care for dependent residents. Compliance date of 11/15/2021	

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for anxiety.

A review of the MAR dated August 2021 also revealed Resident #15 was administered: MSIR on 7 occasions:

- Resident #15 received no MSIR on 08/27/21 while in the facility.

Resident #15 was administered MSIR on 8/28/21 at the following time: 8:40 AM when her pain was documented to be a #9 and again at 10:15 PM with pain levels documented at an #8. Based on the original order prescribed Resident #15 missed 4 doses which is over half of her doses ordered for 08/28/21.

Resident #15 was administered MSIR on 08/29/21 at the following times: 4:58 AM when her pain was documented to be a #7, 10:57 AM with an unidentified pain level- NA was listed, and again at 11:48 PM with pain level documented to be a #8. Resident #15 missed 3 doses on 08/29/21.

Resident #15 was administered MSIR on 8/30/21 at the following times: 4:23 AM when pain was documented to be a #7 and 8:58 AM with pain levels documented at a #3.

Resident #15 missed an undetermined number of doses of pain medication on 08/30/21 secondary to the facility being unable to determine the exact time of discharge from the facility.

It further revealed Lorazepam was administered on 6 occasions:

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Resident #15 was not administered any Lorazepam on 08/27/21 following her admission time of 5:20 PM.

Once on 8/28 at 3:52 PM. Based on the original ordered prescribed Resident #15 missed 5 doses of Lorazepam on 08/28/21.

Three times on 8/29 at 4:57 AM, 10:57 AM, and 11:47 PM; Missed 3 doses of Lorazepam on 08/29/21.

Twice on 8/30 at 4:23 AM and 8:56 AM.

The discharge Minimum Data Set (MDS) dated 08/30/21 assessed Resident #15 with intact cognition and noted she received opiates and antianxiety medications on 3 of 7 days during the MDS assessment period. The MDS further indicated Resident #15 had experienced pain on resulting in a level 9 of 10 on the pain scale over the last 5 days.

A review of a hospice note dated 08/30/21 written by Hospice Nurse #1 indicated Resident #15 had expressed being very displeased with her stay at the facility due to not receiving medications as prescribed and having to wait 1-2 hours after she requested them before they were administered.

An interview with Med Aide #1 (MA #1) on 10/13/21 at 3:20 PM revealed she was familiar with Resident #15 and had been responsible for administering her medications on 08/29/21 during the evening shift. MA #1 stated she recalled medicating Resident #15 with controlled substances to include an opiate and antianxiety medication. MA #1 explained Resident #15 had approached her on one occasion although she

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was unable to recall the time inquiring why her medications were not being administered routinely and why she had to ask and wait to receive them every time she wanted them. MA #1 elaborated that she told Resident #15 the medications were ordered as needed and she would have to ask for them to receive them.

An interview with Med Aide #2 on 10/13/21 at 4:11 PM revealed she was the familiar with Resident #15 and had been responsible for medicating Resident #15 on the date of her discharge of 08/30/21. MA #2 stated she recalled administering controlled substances for pain and anxiety to include MSIR and Lorazepam. MA #2 explained she had not thought to ensure the order in the electronic medical record matched the control substance log and card in which the medication was being dispensed, she only checked to ensure the dosage was equal to the ordered dosage.

An interview with Hospice Nurse #1 on 10/14/21 at 11:13 AM revealed she was familiar with Resident #15 and had overseen her hospice care for the last year prior to admission to the facility. Hospice Nurse #1 indicated her records indicated Resident #15 was routinely ordered Fentanyl 75mcg/hr. patches, MSIR 45mg every 4 hours, and Lorazepam 1mg every 4 hours. Hospice Nurse #1 stated she had been present at the hospital with Resident #15 on the day she was discharged to the facility and saw her in the facility shortly after her time of admission to the facility on 08/27/21. Hospice Nurse #1 also revealed she visited her on the date Resident #15 was discharged home under hospice services on 08/30/21 but despite Resident #15 expressing to her that she did not believe her medications had

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been administered as ordered, Hospice Nurse #1 did not have access to the physician's orders to verify if the medications were administered correctly. Hospice Nurse #1 recalled Resident #15 having increase heart rate, decrease oxygen saturations, anxiety, and pain on the date of discharge and felt her to be experiencing some withdrawal from her medications.

An interview with Nurse #3 on 10/14/21 at 2:18 PM revealed she vaguely recalled Resident #15 being in the facility although verified that when any controlled substance is ordered the medication should be checked to verify the ordered medication and the card the medication is stored match both in name, strength, route, and frequency before administering the medication and she forgot to verify the match when administering the medications to Resident #15.

An interview with the Interim Director of Nursing (DON) on 10/12/21 at 10:45 AM revealed she was the nurse who transcribed the medication orders from the discharge summary for Resident #15 on the date of admission and felt the medications should have been as needed (PRN) based on the dosage and therefore transcribed the MSIR and Lorazepam as PRN medications instead of scheduled medications. The DON indicated the morning following a resident's admission, orders are verified in a clinical meeting, but she acknowledged these medications were transcribed incorrectly and were not verified the following morning although she could not provide an explanation as to what happen.

An interview with the Medical Director (MD) on

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F 760	Continued From page 58 10/12/21 at 3:39 PM revealed he was not aware Resident #15's medications were transcribed incorrectly as her stay was limited in days and he did not see her while in the facility. The MD indicated if Resident #15 was a patient who was on long term use of opiates and antianxiety medication there was a possibility for her to begin to experience withdrawal symptoms if her medications were not given as prescribed. The MD stated he expected all orders to be transcribed, verified, and clarified as quickly as possible following admission to the facility and classified these errors to be significant.	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		11/15/21

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F 880	Continued From page 59 §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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 60 §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 record reviews, observations, staff interviews and the high level of transmission for COVID-19 in the county, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 2 of 3 staff members (Nurse #1 and Nurse Aide #1) failed to wear eye protection while providing care to 1 of 1 resident (Resident #24) who was on enhanced droplet contact precautions and when 5 of 8 staff members (Medication Aide #3, Nurse Aide #11, Medication Aide #2, Nurse Aide #18 and Nurse #7) failed to wear eye protection while providing care to 7 of 7 residents (Resident #19, Resident #20, Resident #7, Resident #22, Resident #21, Resident #6 and Resident #3) in the general halls. These practices affected 8 of 8 residents reviewed for infection control. These failures occurred during a COVID-19 pandemic. The findings included: A review of the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker on 10/11/21 indicated that the county where the facility was located had a high level of community transmission for COVID-19. The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 9/10/21 indicated the following information	F 880	F880 Infection Prevention and Control 1. Residents #3, #7, #19, #20, #21, #22, and #24 are receiving care and services that are adequate and appropriate as related to infection control practices during COVID-19 pandemic. Residents #6 is no longer a resident at the facility. 2. On November 8th, the Director of Nursing and nurse designee performed infection control facility rounds to ensure standard and transmission-based precautions were being followed by all facility staff. Daily rounds are being completed to ensure compliance by nurse designee, Director of Nursing, department heads, and/or Administrator. 3. Education completed 10/18/21 – 11/12/21. The Director of Nursing provided education to all facility staff to ensure infection prevention and control program practices were in compliance with updated CDC and state guidelines. 4. The Director of Nursing and/or nurse designee will complete an audit to ensure the facility is maintaining 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 during a COVID-19 pandemic. Monitoring will be completed for five (5) random staff at a frequency of five (5) times weekly for four (4) weeks,	

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F 880	Continued From page 61 under the section "Implement Universal Use of Personal Protective Equipment for HCP (Healthcare Personnel): *If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. A review of the facility policy entitled, "Novel Coronavirus Prevention and Response," revised on 9/15/21 indicated: f. Implement standard, contact, and droplet precautions. Wear gloves, gowns, goggles/face shields, and a NIOSH-approved N95 or equivalent or higher-level respirator upon entering room and when caring for the resident. A continuous observation was conducted on 10/11/21 from 10:05 AM to 10:30 AM of the quarantine hallway for newly admitted unvaccinated residents and residents admitted for rehab services. 1. a. At 10:12 AM Nurse #1 was observed going into Resident #24's room with her morning medications. Resident #24 was unvaccinated and admitted to the facility on 10/04/19 and readmitted on 10/06/21. Nurse #1 donned an N95 respirator, isolation gown, clean gloves and proceeded into Resident #24's room who was on enhanced droplet contact isolation with no goggles or face shield on and provided a medication pass to the resident within 6 feet of	F 880	then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with residents right to self-determination with bathing. Compliance date of 11/15/2021	

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the resident.

Interview on 10/11/21 at 10:14 AM with Nurse #1 revealed she was an agency nurse working at the facility. Nurse #1 stated she should have worn eye protection into Resident #24's room since she was on enhanced droplet contact precautions. She stated she knew better but forgot to put her goggles on because it was difficult to see with them on due to them fogging up over her glasses. Nurse #1 further stated she had to wear her glasses to be able to see and the goggles made it difficult.

b. At 10:25 AM NA #1 was observed going into Resident #24's room to provide care. Resident #24 was unvaccinated and admitted to the facility on 10/04/19 and readmitted on 10/06/21. NA #1 donned an N95 mask, isolation gown and gloves prior to entering the room. NA #1 had her goggles on top of her head but never placed them on her face prior to going into Resident #24's room. NA #1 doffed her gown and gloves, changed her mask prior to coming out of Resident #24's room and her goggles were still on the top of her head.

Interview on 10/11/21 at 10:35 AM with NA #1 revealed she knew she was supposed to wear eye protection while providing care to residents on enhanced droplet contact precautions. NA #1 stated she was in a hurry to get in the room to help the resident and simply forgot to pull her goggles down on her face prior to going into the resident's room. NA #1 further stated she knew better and should have placed the goggles on her face prior to going into the room.

Interview on 10/12/21 at 5:47 PM with the Regional Director of Clinical Services (RDCS)

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revealed the facility's policy for PPE use included using eye protection when coming within six feet of a resident or when providing care to a resident. The RDCS stated this policy applied to all residents in the facility and especially residents on enhanced droplet contact precautions whose COVID status was unknown. The RDCS further stated she was not sure whether this new guideline from CDC had been presented to all the staff members in the facility but expected all staff on the quarantine hall to wear the appropriate PPE and to wear PPE as indicated.
2. a. During an observation of medication administration on Resident #19 on 10/11/21 at 9:50 AM, Medication Aide (MA) #3 was observed wearing a surgical mask and prescription eyeglasses which she pulled over the top of her head while she administered Resident #19's medications. MA #3 did not have eye protective gear on. MA #3 used hand sanitizer to both hands prior to leaving Resident #19's room.

On 10/11/21 at 9:55 AM, MA #3 was further observed walking back to the medication cart in the hallway and preparing Resident #20's medications. On 10/11/21 at 10:05 AM, MA #3 entered Resident #20's room and administered medications to her while wearing a surgical mask and no eye protective gear on.

An interview with MA #3 on 10/11/21 at 3:50 PM revealed she had placed her goggles in her pocket and forgot to pull them out and use them while she was administering medications to Resident #19 and Resident #20. MA #3 stated she had difficulty seeing clearly without her prescription eyeglasses on which she had to remove to put her goggles on. MA #3 stated she was unable to wear goggles over her prescription

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eyeglasses but did not think about wearing a face shield instead of goggles as protective eye gear.

b. An observation was made on 10/11/21 at 10:10 AM of Nurse Aide (NA) #11 talking to Resident #7 inside her room. NA #11 was wearing a surgical mask with no eye protective gear on while talking to Resident #7 within six-feet distance.

An interview with NA #11 on 10/11/21 at 3:01 PM revealed she had not been instructed to wear eye protective gear on whenever she was going to be within six feet of any resident. NA #11 stated she later obtained a face shield after she was told by one of the housekeepers that all staff members were supposed to wear eye protection whenever they entered each resident room.

c. An observation on 10/11/21 at 10:55 AM was made of Medication Aide (MA) #2 while she was preparing medications on top of the medication cart in the hallway. MA #2 was wearing a surgical mask with no eye protective gear on. On 10/11/21 at 11:05 AM, MA #2 was further observed entering Resident #22's room carrying her medications. MA #2 was wearing a surgical mask with no eye protective gear on.

An interview with MA #2 on 10/11/21 at 10:55 AM revealed she did not have her face shield when she started her shift because she had kept it in her vehicle and forgot to bring it into the facility. MA #2 stated she retrieved her face shield when she realized that she was not wearing eye protection about halfway through her medication administration. MA #2 further stated they had been used to wearing just a surgical mask

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whenever there were no COVID-19 cases in the facility, but she was aware that the CDC had changed their guidelines regarding eye protection which should be worn all the time especially when they were going to be within six feet of the residents.

d. An observation was made on 10/11/21 at 10:55 AM of Nurse Aide (NA) #18 coming out of Resident #21's room while carrying a bag of trash and a bag of dirty linens. NA #18 was wearing a surgical mask with no eye protective gear on. NA #18 placed the bag of trash into the trash bin and placed the bag of dirty linens inside the soiled linen room. NA #18 exited the soiled linen room and used hand sanitizer to both hands.

Further observation of NA #18 on 10/11/21 at 11:00 AM revealed her entering Resident #6's room and answering his call light. NA #18 continued to have the same surgical mask on with no eye protection.

An interview with NA #18 on 10/11/21 at 12:40 PM revealed she could not find a face shield earlier when her shift started, so she proceeded to provide care to residents in their rooms without eye protection.

e. During an observation of incontinence care on Resident #3 on 10/11/21 at 4:05 PM, Nurse #7 assisted NA #19 with the procedure. Nurse #7 was wearing a surgical mask with no eye protective gear on.

An interview with Nurse #7 on 10/11/21 at 4:10 PM revealed she only wore eye protection whenever she worked on the quarantine hall for residents on enhanced droplet precautions.

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F 880	Continued From page 66 Nurse #7 stated she had been told that she did not have to wear a face shield or goggles when working with residents who were not on enhanced droplet precautions. An interview with the Regional Director of Clinical Services (RDCS) on 10/12/21 at 5:47 PM revealed the facility's policy for PPE use included using eye protection when coming within six feet of a resident or when providing care to a resident. The RDCS stated this policy applied to all residents in the facility and did not matter whether the resident was on precautions or not. The RDCS further stated she was not sure whether this new guideline from CDC had been presented to all the staff members in the facility.	F 880		