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RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION	1000 COLLEGE STREET WILKESBORO, NC 28697

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E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		10/5/24

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

Electronically Signed | 10/04/2024

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to establish and maintain a comprehensive Emergency Preparedness (EP) Plan complete with policies and procedures which described the facility's comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation that met the federal requirements. The findings included: A review of the undated facility's Emergency Preparedness Plan revealed: a. The facility did not have a signed and updated revision to the EP Plan. b. The facility did not have a list of the names and contact information of staff, Nurse Practitioner and Medical Director. c. The facility did not have evidence that a table top or community-based exercise had been completed. d. The facility did not have a documented risk assessment and communication plan. e. The facility did not have a policy about provisions of subsistence and policy for alternate sources of emergency to maintain temperatures to protect resident health and safety and for the safe sanitary storage of provisions, emergency lighting fire detection/extinguishing/alarm systems and sewage and waste disposal. f. The facility did not have documentation of an	E 001	The EP plan has been signed by all parties and updated as revised on 9/22/24. The list of names and contact information of staff including but not limited to the Medical Director and Nurse Practitioner were updated on 9/22/24. The community-based drill/actual event was completed on started on 9/26/24 and completed on 9/27/24. The facility has a documented hazard vulnerability risk plan and communication plan completed by 9/22/24. The facility verified policies and procedures were part of the emergency plan on 9/22/24 regarding the provisions of subsistence for alternate sources of emergency. The facility verified that the EP policy has a shelter in place plan in the EP manual as of 9/22/24. The facility verified that they have a system in place for resident□s medical documentation in the EP manual on 9/22/24. The EP plan was verified to show a list of staff□s direct responsibilities on 9/22/24. The EP plan was verified on how information is shared with residents and families on 9/22/24. The EP plan was verified for the evidence of the annual completed yearly EP training on 9/22/24. The Regional Director of Operations provided in-service/education to the NHA on the Emergency preparedness manual	

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E 001	Continued From page 2 evacuation and shelter in place plan in place in case of an emergency. g. The facility did not have a system in place for the residents' medical documentation. h. The EP Plan failed to include a list of direct staff responsibilities. i. The EP Plan failed to address how information would be shared with residents' families. j. The EP Plan failed to contain evidence of staff completing the required yearly EP training. An interview was conducted with the Administrator on 09/06/24 at 2:41 PM. The Administrator explained that she was new to being a long-term care Administrator and stated she only had a brief inservice of the Emergency Preparedness Plan and was still learning the process.	E 001	and its requirements. This education was done on 10/2/24 and included but not limited to planning, preparation, services, staff responsibilities, annual education, evacuations, sheltering in place, community drills/tabletops, etc. The NHA will periodically throughout the week audit the EP manual for any updates/changes needed to be made to the EP manual and will make these changes. The audits will be performed for a total of (12) twelve weeks. This will be performed ensuring compliance. The Maintenance Supervisor will conduct (2) trainings annually for the EP manual review with staff ensuring training and understanding of emergency preparedness x1 year. Any new hires will be educated on the EP plan in orientation upon hire and/or annually ensuring compliance and education. The NHA will monitor this deficient practice via QAPI for the next three months reporting on Emergency preparedness manual. Any intervention/changes of the Emergency plan manual will be monitored through QAPI ensuring compliance with State and Federal regulations.	
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation were conducted from 09/03/24 through 09/06/24. Additional information was obtained offsite through 09/11/24. Therefore, the exit date was changed to 09/11/24. Event ID: 127B11. The following intakes were investigated: NC00208233, NC00208841, NC00210320,	F 000		

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F 000	Continued From page 3 NC00210448, NC00211247, NC00211288, NC00217315, NC00218309, NC00220051, NC00221503, NC00221562. 10 of the 25 complaint allegations resulted in deficiency.	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. 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	F 550		10/5/24

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F 550	Continued From page 4 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 record review and staff and resident interviews, the facility failed to treat a resident with respect and dignity when Nurse #3 told a resident (Resident #48) that he would not be sent out to the hospital after he yelled that he was uncomfortable and felt that no one was helping him. The facility also failed to treat a resident with respect and dignity when the facility failed to address unwanted facial hair on a resident (Resident #20) This was for 2 of 6 residents reviewed for treating residents with respect and dignity. The findings included: 1. Resident #48 was admitted to the facility on 03/15/23 with diagnoses that included anxiety disorder, paraplegia, and chronic pain syndrome. A review of Resident #48's quarterly Minimum Data Set assessment dated 07/05/24 revealed Resident #48 was cognitively intact with no delusions, behaviors, or rejection of care. During an interview with Resident #48 on 09/04/24 at 2:15 PM revealed he had been feeling bad on 08/21/24 with some pain in his	F 550	Resident #48 still resides in the facility and has reported no further issues. Nurse #3 is no longer employed by the facility. Resident #20 was shaved on 9/4/24. Residents residing in the facility have the potential to be affected by the deficient practice. The Activities Director and Assistant Social Worker completed an audit on 9/30/24 to assess for residents with facial hair and interviewed regarding being treated with dignity. There were no issues identified. Education was provided to staff regarding resident right to a dignified existence and self-determination. Education included offering a resident a facial shave when performing a bed bath, shower or as needed. Furthermore, staff were educated on treating residents with dignity and respect during interactions. Staff members that have not received the education by 10/4/24 will not be able to work until the education is completed. Newly hired staff will receive the education during orientation by the Director of	

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F 550	Continued From page 5 upper back. Resident #48 reported he was seen by the Physician Assistant (PA) #1 earlier in the day who prescribed him some medication that she thought would help. He stated the day progressed and in the early evening he started to have worsening discomfort not just in his back but also in his chest accompanied by some shortness of breath. He reported he rang his call light, and Nurse Aide (NA) #5 came in his room and checked on him. He stated he told NA #5 about his worsening chest pain and shortness of breath, and she told him she would immediately go tell his nurse (Nurse #3). Resident #48 called 911. Resident #48 reported once he hung up with 911, Nurse #3 came to the room. He reported he was scared and hurting and yelled stating his chest was tight and that he was not ok. Resident #48 admitted he was loud in his communication with Nurse #3 but insisted it was due to him being scared. Resident #48 reported Nurse #3 responded by telling him he was not going to speak to her like that and that she would not send him out and he could "just sit there". Resident #48 reported the interaction made him feel like he did not matter and was afraid that he would not get the help he felt he needed. Resident #48 reported after the interaction, Nurse #3 left his room, and he decided he would call 911 again. Resident #48 reported when he spoke with the 911 operator, he told them he was not ok and was having chest discomfort and shortness of breath. Resident #48 stated Emergency Medical Services (EMS) did arrive shortly after and took him to the hospital. An interview with NA #5 was conducted on 09/04/24 at 2:57 PM revealed she could not recall how she ended up in Resident #48's room on the evening of 08/21/24 but stated he reported to her	F 550	Nursing or Social Worker. The Activities Director or designee will audit 5 residents three times a week for 4 weeks, then 5 residents twice a week for 8 weeks for facial hair and the resident preference regarding facial hair. The Assistant Social Worker or designee will audit 5 residents a week for 12 weeks questioning if the staff have been treating them with dignity and respect. The Activities Director and Assistant Social Worker are responsible for forwarding the results of their audits the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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that he was hurting badly in his back and chest. NA #5 reported Resident #48 appeared red-faced during this interaction, and she immediately left his room and went and reported Resident #48's condition and his request to go to the hospital to Nurse #3. NA #5 reported Nurse #3 was at the nurse's station at that time and told her that she would go down to Resident #48's room. NA #5 also stated she remembered hearing some conversation between Resident #48 and Nurse #3 while she was in a room across the hall but stated she could not make out what they were talking about. NA #5 reported EMS did arrive at the facility after she took Resident #48's vital signs and transported him to the hospital.

An interview with Nurse #3 on 09/04/24 at 2:37 PM revealed she was the nurse assigned to Resident #48 on 08/21/24. She reported she was aware that Resident #48 had been seen by PA #1 earlier in the day for some pain in his back. She stated later in the day she was made aware by NA #5 that Resident #48 was complaining of pain. She stated she when she went down to the room to check on him, Resident #48 was agitated and was complaining of heaviness in his chest. She reported when she was trying to speak to Resident #48 about his complaints, he was very agitated and began beating on his chest and yelling "no one here will help me!" Nurse #3 reported at that point, she decided to remove herself from the room and asked NA #5 to get his vital signs. Nurse #3 insisted she never told Resident #48 that she would not send him out and that he was fine. She also indicated she felt her interactions with Resident #48 remained respectful throughout. Nurse #3 insisted that after she left Resident #48's room, she contacted the on-call provider and received an order to send

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Resident #48 to the hospital. She also reported she contacted EMS via telephone and requested them to come transfer Resident #48 to the hospital.

An interview with the DON on 09/06/24 at 12:23 PM revealed she was not in the facility at the time of the incident but stated she was aware that Resident #48 had called EMS for assistance on the evening of 08/21/24. She reported Resident #48 did not have a history of behaviors and was cognitively intact. The DON reported Resident #48 had been seen earlier in the day by PA #1 for some mild upper back pain. The DON stated it did not matter if a resident was agitated, combative, or rude, he should have been treated with respect and understanding and that Nurse #3 should have never told him he was fine and he was not going to be sent out if Resident #48 was in pain or was requesting to be transferred.

An interview with the Administrator on 09/06/24 at 2:55 PM revealed she was aware of the incident and that she was familiar with Resident #48. She reported Resident #48 did not have a history of behaviors and was cognitively intact. She reported she expected her staff to treat all residents with respect and dignity and she would have expected Nurse #3 to speak to Resident #48 in a respectful and dignified manner while trying to calm him down and reassure him that he would be taken care of.

2. Resident #20 was admitted to the facility on 05/02/23.

The quarterly Minimum Data Set (MDS) assessment dated 06/21/24 revealed Resident #20 was cognitively intact and required

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substantial to maximal assistance of one staff for personal hygiene which included shaving.

On 09/03/24 at 12:48 PM an observation and interview were made of Resident #20 who was lying in her bed. The Resident was noted to have black and gray hairs approximately one eighth of an inch long that covered her chin and neck. Resident #20 was asked about the hairs and the Resident stated she got a bed bath on Sunday 09/01/24, (her choice) and if she did not request to be shaved, then she would not be shaved by staff. She stated she did not know why she was not shaved on Sunday 09/01/24. Resident #20 voiced the last time she was shaved was her last bed bath on 08/25/24. When the Resident was asked about her facial hair, she hid her face with her right hand and explained her facial hair grew fast and it was embarrassing to her. She stated she always shaved her facial hair to prevent the growth of a beard and while shielding her face with her hand she explained that it made her feel "lesser of a woman."

An observation was made on 09/04/24 at 9:15 AM of Resident #20 lying in bed sleeping. The facial hair remained unchanged.

On 09/04/24 at 3:18 PM an interview was conducted with Nurse Aide (NA) #5 who explained that Resident #20 was alert and oriented and voiced her wants and needs. The NA continued to explain that he was assigned to Resident #20 on both Saturday 08/31/24 and Sunday 09/01/24 and received assistance of 2 other staff to provide the Resident's scheduled bed bath on Sunday. The NA stated that he first noticed the Resident's facial hair on Saturday (08/31/24), and he told Resident #20 on both

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F 550	Continued From page 9 Saturday and Sunday that he would shave her but there were no razors available to shave her with. The NA remarked that Resident #20 asked to be shaved on Sunday during her bed bath, but he knew there were no razors to shave her with. An interview was conducted with the Central Supply Clerk on 09/04/24 at 4:09 PM. The Central Supply Clerk explained that she was responsible for ordering medical supplies and she obtained the inventory and ordered the supplies once a week on Tuesday and the supplies arrived at the facility on Friday. She continued to explain that occasionally the delivery truck did not make the delivery on Friday and would usually come on the following Monday but the past Monday, 09/02/24 was a holiday and the delivery truck was delayed. The Central Supply Clerk confirmed there were no razors available to be used over the weekend and the Administrator obtained razors at a local store on Monday 09/02/24. An observation was made of Resident #20 on 09/05/24 at 11:00 AM. The Resident was noted to be clean shaven, and the Resident smiled and stated, "thank you." On 09/06/24 at 2:39 PM an interview was conducted with the Administrator who confirmed she obtained razors from a local store on Monday 09/02/24 when she was notified that there were no razors in the facility. She indicated not being able to shave a resident because of running out of razors was unacceptable and they would have to review the system on how supplies were ordered to prevent that from happening again.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		10/5/24

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§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide

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F 578	Continued From page 11 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and Nurse Practitioner (NP) interviews the facility failed to ensure a resident's code status election was accurate throughout the medical record (Resident #25) and failed to ensure an advanced directive form was signed by the Resident or Responsible Party (RP) (Resident #60) for 2 of 3 residents reviewed for advanced directives (Resident #25 and Resident #60). The findings included: 1) Resident #25 was admitted to the facility on 9/13/2023. A review of a physician's order dated 9/13/2023 revealed Resident #25 was a Do Not Resuscitate (DNR). A review of a Medical Orders for Scope of Treatment form (MOST) dated 1/17/2024 revealed Resident #25 wished to be a DNR with a limited scope of treatment. A review of a care plan dated 7/19/2024 revealed Resident #25 had an advanced directive and chose to be a DNR with an intervention that included to honor Resident #25's choice to be a full code. A review of a quarterly Minimum Data Set (MDS) assessment dated 8/25/2024 revealed Resident #25 was moderately cognitively impaired. An interview was conducted on 9/4/2024 at 11:57	F 578	Resident #25 care plan was updated on 9/4/24 to reflect that resident #25 is a Do Not Resuscitate (DNR). Resident # 60 MOST form was signed on 9/4/24. Residents residing in the facility have the potential to be affected by the deficient practice. On 9/30/24 Social Worker and Social Worker Assistant reviewed current resident MOST forms for signatures and code status care plans for accuracy. There were no issues identified. Education was provided to the nurses and nurse practitioner regarding ensuring that the resident or his/her responsible party sign the MOST form. Furthermore, education was completed regarding code status care plans and the need for care plan to accurately reflect the resident□s code status wishes. Staff members that have not received the education by 10/4/24 will not be able to work until the education is completed. Any new hired staff will receive the education during education by the Director of Nursing or Social Worker. The Social Services Director or designee will audit five residents a week for twelve weeks to ensure that their MOST form are signed and the care plan matches their desired wishes. The Social Services Director is	

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F 578	Continued From page 12 am with Nurse #1. Nurse #1 stated when a resident was admitted to the facility the hall nurse verified if the resident wanted to be a full code or a DNR and completed a MOST form. Nurse #1 stated that the MDS Nurse typically entered the code status and advanced directive information on the care plan. Nurse #1 stated the information on the MOST form, care plan, and physician orders should match. Nurse #1 stated she was unsure why Resident #25 was care planned as a full code and stated she should not have been. An interview was conducted on 9/5/2024 at 8:40 am with the Nurse Practitioner (NP). The NP stated when a resident was admitted to the facility she discussed code status with the resident. The NP stated she also discussed code status annually, as changes in condition occurred, or if a resident expressed a desire to change their code status. The NP stated she documented code status in her notes and there was an order for code status in the chart. The NP stated that the code status on the MOST form, care plan, and physician's order should match, and she was not sure why Resident #25 had a care plan for a full code. An interview was conducted on 9/6/2024 at 9:27 am with the MDS Nurse. The MDS Nurse stated the care plan was initially entered by the MDS Nurse and could be changed by the hall nurse if there was a change. The MDS Nurse stated that code status should be consistent throughout the record, and she was unsure why Resident #25 was care planned as a full code. An interview was conducted on 9/6/2024 at 1:10 pm with the Director of Nursing (DON). The DON stated that on admission the nurse reviewed code	F 578	responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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status with the resident or Responsible Party (RP) and completed the MOST form. The DON stated the resident, or RP signed the MOST form after the form was completed. The DON stated if the provider was not in the building, nursing staff called and obtained a verbal order until the MOST form was signed. The DON stated the physician's order, MOST form, and the care plan should all match. The DON stated she assumed the care plan entry had been an oversight when Resident #25 changed from full code to DNR status and stated the care plan should have been changed to reflect the resident's wishes.

2) Resident #60 was admitted to the facility on 3/15/2023.

A review of a MOST form dated 8/17/2023 revealed Resident #60 wished to be a Do Not Resuscitate (DNR) with limited additional interventions, to determine the use or limitations of antibiotics when infection occurred, and to have intravenous (IV) fluids long-term if indicated. The MOST form was signed by the former Medical Doctor (MD) and did not have a resident or Responsible Party (RP) signature.

A review of a quarterly MDS assessment dated 7/4/2024 revealed Resident #60 was moderately cognitively impaired.

A review of a care plan dated 7/17/2024 revealed Resident #60 wished to be a Do Not Resuscitate (DNR) with interventions which included not initiating cardiopulmonary resuscitation (CPR) and only performing limited interventions according to the MOST form.

An interview was conducted on 9/4/2024 at 11:57

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am with Nurse #1. Nurse #1 stated when a resident was admitted to the facility the hall nurse verified if the resident wanted to be a full code or a DNR and completed a MOST form. Nurse #1 stated the resident, or RP signed the MOST form after it was completed. Nurse #1 stated the nurse then had the provider sign the MOST form if they were in the building, or the nurse called the provider and obtained a verbal order for code status until the paper was signed. Nurse #1 stated the resident, or RP signed the MOST form after completion. Nurse #1 stated she was not aware that the resident or RP had not signed Resident #60's MOST form and stated they should have. Nurse #1 stated the MOST form was not valid without a signature from the resident or RP and Resident #60 was considered a full code until it was signed.

An interview was conducted on 9/5/2024 at 8:40 am with the NP. The NP stated when a resident was admitted to the facility she discussed code status with the resident. The NP stated she also discussed code status annually, as changes in condition occurred, or if a resident expressed a desire to change their code status. The NP stated she documented code status in her notes and there was an order for code status in the chart. The NP stated she was not aware Resident #60 or the RP had not signed the MOST form and stated the form was not valid without their signature and would be considered a full code. The NP stated she was not sure why it had not been signed.

An interview was conducted on 9/6/2024 at 1:10 pm with the DON. The DON stated that on admission the nurse reviewed code status with the resident or RP and completed the MOST

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F 578	Continued From page 15 form. The DON stated the resident, or RP signed the MOST form after the form was completed. The DON stated if the provider was not in the building, nursing staff called and obtained a verbal order until the MOST form was signed. The DON stated the MOST form should be signed by the resident or RP and was not aware that Resident #60's MOST form had not been signed and stated that it should have been.	F 578		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is	F 604		10/5/24

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F 604	Continued From page 16 indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to protect Resident #125 from being physically restrained by Nurse Aide #2 when Resident #125 had terminal agitation and was attempting to sit up in bed for 1 of 3 residents reviewed for employee to resident abuse. Nurse Aide #2 used her hand to push Resident #125's head back into the pillow in an attempt to keep him in the bed. The findings included: Resident #125 was admitted to the facility on 11/06/23 and expired on 11/28/23. Resident #125's diagnoses included malignant neoplasm of lung and skin, and anxiety. The admission Minimum Data Set (MDS) dated 11/16/23 revealed that Resident #125 was cognitively intact and required supervision with transfers. There was no behaviors or rejection of care noted during the assessment reference period. The MDS also revealed that Resident #125 had a prognosis of less than 6 months to live and received hospice care. Review of an initial allegation report dated 11/26/23 at 4:25 AM read, staff reported that Nurse Aide (NA) #2 handled Resident #125 roughly during the provision of care. The initial allegation report was completed by Former Administrator #1.	F 604	Resident #125 no longer resides in the facility. Nurse Aide #2 is no longer employed at the facility. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 9/30/24 the Social Services Assistant interviewed residents with a BIMS of 12 and higher questioning if they have experienced physical restraint. Residents with a BIMs of 11 or lower had skin assessments completed by the Director of Nursing to ensure there were no signs of physical restraint. There were no issues identified. Education was provided to the staff regarding the residents right to be free from abuse. This education included ensuring that the resident is free from physical and chemical restraints. Staff members that have not received the education by 10/4/24 will not be able to work until the education is completed. Newly hired staff will receive education during orientation by the Director of Nursing or Social Worker. The Social Services Assistant or designee will audit 5 residents a week for twelve weeks to ensure that they have not encountered physical restraint.	

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F 604	Continued From page 17 NA #2 was interviewed via phone on 09/04/24 at 11:40 AM. NA #2 confirmed that she was working the night shift on 11/26/23. She stated she was walking past Resident #125's room and found him lying flat on the floor with urine all around him. NA #2 stated she requested assistance from the nurse but could not recall who that was, but no one came to the room for a while. NA #2 stated that while she was in Resident #125's room waiting for other staff to assist she went ahead and got Resident #125 off the floor and back into bed and was in the process of getting him cleaned up when NA #3 and NA #4 came in to assist. NA #2 stated that while she and NA #3 and NA #4 were cleaning up Resident #125 the Resident kept trying to sit up and get out of bed. She stated, "I put my hand on his head and kinda of pushed him back and told him to stay in the bed." NA #2 added that after they had finished cleaning up Resident #125, she returned to his room a few times after that and each time Resident #125 was trying to sit up or get out of bed and she again stated, "I put my hand on top of his head/forehead and pushed his head back to the pillow" to keep him from getting up. NA #2 stated "I had no intentions of hurting him" and did not think her actions could have been perceived as rough. NA #2 also stated she tried rubbing Resident #125's head to help him settle down but it was not effective. NA #2 further stated that shortly after the incident Nurse #2 told her that she needed to leave the facility due to an allegation of abuse and not to return to the facility. NA #3 was interviewed via phone on 09/04/24 at 2:43 PM. NA #3 confirmed that she was working the night shift on 11/26/23 along with NA #2 and NA #4. NA #3 stated she recalled that she, NA #2	F 604	The Assistant Social Worker is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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and NA #4 were in Resident #125's room and NA #2 had assisted Resident #125 from the floor to the bed after NA #3 and NA #4 had changed the sheets on the bed. NA #3 stated once Resident #125 was back in bed he continued to try and sit up and NA #2 kept putting her fingertips on Resident #125's forehead and pushing his head back onto the pillow. After a few times of that NA #3 stated that NA #2's actions "seemed harsh and I left the room" to get Nurse #2 because NA #2 was being too rough." NA #3 stated when she left the room to get Nurse #2, she was on the phone, so she went and alerted Nurse #3 of what had occurred. She added that after she reported the incident, she did not recall going back to Resident #125's room and stated NA #2 and NA #4 finished getting the room cleaned up before leaving. Very soon after she reported the incident NA #2 was asked to leave the facility and did not finish her shift.

Attempts to speak to NA #4 were made on 09/04/024 and 09/05/24 and were unsuccessful.

A handwritten statement from NA #4 dated 11/26/23 read in part, "once the resident {Resident #125} was on the bed NA #3 began putting the clean linen on while I got a brief out of the closet. At this time the resident {Resident #125} tried to sit up and NA #2 held him down preventing him from raising up. We finished placing the brief on the resident and got him comfortable and I stayed with resident while {NA #2} went and got our nurse. We reported what we had witnessed." The statement was signed by NA #4.

Nurse #2 was interviewed via phone on 09/04/24 at 12:10 PM who confirmed that she was working

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the night shift on 11/26/23. She stated she was on the phone with hospice trying to get something for Resident #125 when NA #2 approached her about something. Because she was on the phone NA #2 went and got Nurse #3 but after the phone call was over Nurse #2 stated she went and got the rundown of what had occurred. It was reported that Resident #125 had fallen, and they got him back to the bed and NA #2 had "grabbed him by his face and forcefully pushed his head back down repeatedly." Nurse #2 stated when she heard what had happened, she immediately reported the incident to Former Administrator #1 who instructed her to send NA #2 home. Nurse #2 stated that NA #3 reported the force that NA #2 used to push Resident #125's head back "made her sick to her stomach and caught her off guard." Nurse #2 stated she sent NA #2 home and then she went to check on Resident #125. She stated she was concerned about a head injury due to the report, but his neurological assessment was negative, and she could not identify any other injuries.

Nurse #3 was interviewed via phone on 09/04/24 at 3:17 PM who confirmed that she was working the night shift on 11/26/23. Nurse #3 stated that one of the NA's, but she could not recall which one reported that NA #2 had pushed Resident #125's head down into the bed and was being very rough with him. Nurse #3 stated that she and Nurse #2 went to Resident #125's room and Nurse #2 assessed Resident #125 and she escorted NA #2 out of the building. Nurse #3 stated she had the staff members write statements and gave them to Former Administrator #1.

Former Administrator #1 was interviewed via

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phone on 09/04/24 at 3:04 PM who stated he could not recall the events of the incident. He stated that he was relieved of his duties during this investigation and Former Administrator #2 took over for him and maybe could recall the incident better than he could.

Former Administrator #2 was interviewed via phone on 09/05/24 at 3:17 PM who stated that she was notified of the incident by Former Administrator #1 on 11/26/23. She stated that when she arrived at the facility on 11/27/23 she realized that Administrator #1 was not taking the incident seriously and she relieved him of his duties and then took over the investigation. Former Administrator #2 stated that she began interviewing the involved staff members and through the investigation no one truly felt that anything was done wrong, it was more vindictive between the employees. She stated she honestly could not recall the whole situation but recalled one of the NAs put her fingertips on the top of Resident #125's head never with any pressure but she was trying to calm him down. During the investigation it was never brought to light that the NA who she could not recall forced Resident #125's head down and she unsubstantiated the incident. Administrator #2 stated that she did not feel like the NA was restraining Resident #125 and felt like one employee was out to get the other employee.

The Director of Nursing (DON) was interviewed on 09/06/24 at 11:56 AM who stated she did not find out about the incident until 11/27/23 and she was very upset that Former Administrator #1 had not called her. The DON stated that Former Administrator #2 conducted all the interviews with the staff and felt that NA #2 had put Resident

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F 604	Continued From page 21 #125 in bed, and she had slipped in the urine that was on the floor which made the transfer appear rough and then she had her fingers on his head to hold him down because he was agitated and trying to get up that night. The DON stated Administrator #2 made it seem like NA #2 was trying to do the best thing for the resident "but you can not hold them down." She stated she did not understand the thought process because when you step back and look at the interviews and statements NA #2 should not have held or pushed Resident #125's head back to the pillow. The DON stated she shared her thoughts with Administrator #2, but she continue to insist NA #2 was doing what was in the best interest of the resident.	F 604		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		10/5/24

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F 656	Continued From page 22 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and Nurse Practitioner (NP) interviews, the facility failed to develop and implement a person-centered care plan for a resident on one-on-one supervision for 1 of 4 residents reviewed for development and implementation of a comprehensive care plan (Resident # 51). The findings included: Resident #51 was admitted to the facility on 7/22/2024 with diagnoses which included	F 656	Resident #51 is no longer on a 1:1 for supervision. Residents that reside in the facility that require 1:1 supervision have the potential to be affected by the deficient practice. The Administrator conducted an audit on residents currently requiring 1:1 supervision to ensure the care plan is in place. There are currently no residents in the facility that require 1:1 supervision.	

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F 656	Continued From page 23 dementia, disorientation (a state of confusion), and hallucinations (seeing/hearing something that is not there). A review of an admission Minimum Data Set (MDS) dated 7/29/2024 revealed Resident #51 was severely cognitively impaired, had no behaviors, and no rejections of care. A review of the care plan dated 7/31/2024 revealed Resident #51 was at risk for elopement and wandering related to impaired safety awareness with interventions which included application of a wander guard and to address wandering behaviors. There was no care plan intervention related to one-on-one supervision. An observation was conducted on 9/3/2024 at 11:28 am of Resident #51. Resident #51 was sitting in a reclining chair beside of her bed holding a baby doll. There was a sitter at the resident's bedside. An interview was conducted on 9/4/2024 at 8:52 am with the NP. The NP stated Resident #51 had advanced dementia and behaviors. The NP stated the Regional Consultant instructed staff to place Resident #51 on one-on-one supervision. An interview was conducted on 9/4/2024 at 9:08 am with Nurse Aide (NA) #1. NA #1 stated she worked first shift (7:00 am to 7:00 pm) and was assigned to Resident #51. NA #1 stated Resident #51 had dementia and wandered around the facility. NA #1 stated Resident #51 was placed on one-on-one supervision because of behaviors. An interview was conducted on 9/4/2024 at 9:35 am with the Director of Nursing (DON). The DON	F 656	Education was provided to the staff regarding the implementation of a person-centered care plan for residents on one-to-one supervision. Staff members that have not received the education by 10/4/24 will not be able to work until the education is completed. Newly hired staff will receive the education during orientation by the Director of Nursing. The Administrator will audit 5 residents a week for 12 weeks that require 1:1 supervision to ensure an appropriate care plan is in place. The Administrator is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 656	Continued From page 24	F 656		

stated Resident #51 was on hospice services and had behavioral issues. The DON stated Resident #51 was placed on one-on-one supervision to protect her dignity.

An interview was conducted on 9/4/2024 at 9:56 am with the Regional Consultant. The Regional Consultant stated Resident #51 wandered the facility, however, was not exit seeking. The Regional Consultant stated she was initially placed on one-on-ones because she was giving her baby doll to other residents, then trying to take it back afterwards, and she was fearful another resident would take it the wrong way and try to hit Resident #51. The Regional Consultant stated after Resident #51 was initially placed on one-on-one supervision, she was treated for a urinary tract infection (UTI) and her behaviors subsided, and she was taken off one-on-one supervision. The Regional Consultant stated Resident #51 was placed back on one-on-one supervision after an incident to protect her dignity. The Regional Consultant stated Resident #51 was not care planned for one-on-one supervision because she was placed on it for dignity, not behaviors.

An interview was conducted on 9/6/2024 at 9:27 am with the Minimum Data Set (MDS) Nurse. The MDS Nurse stated if a resident was on one-on-one supervision for an extended period that it should be care planned and stated if it needed to be care planned it should be documented under the interventions. The MDS Nurse was not sure why Resident #51 was not care planned for one-on-one supervision. The MDS Nurse stated the hall nurse should have updated the care plan to include one-on-one supervision after it was ordered.

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F 656	Continued From page 25 An interview was conducted on 9/6/2024 at 10:32 am with Nurse #1. Nurse #1 stated the care plan was placed and updated by the MDS Nurse. Nurse #1 stated if a resident was on one-on-one supervision, it should be care planned. Nurse #1 was unsure why Resident #51 was not care planned for one-on-one supervision and stated she should have been. An interview was conducted on 9/6/2024 at 1:04 pm with the DON. The DON stated the care plans were initiated and updated by the MDS Nurse. The DON stated one-on-one supervision should have been care planned for Resident #51 and stated she was not sure why the care plan had not been updated.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility failed to trim a dependent female resident's facial hair for 1 of 6 residents (Resident #20) reviewed for activities of daily living (ADL). The finding included: Resident #20 was admitted to the facility on 05/02/23 with diagnoses that included heart failure, diabetes mellitus, chronic obstructive pulmonary disease and respiratory failure.	F 677	Resident #20 was shaved on 9/4/24. Female residents that reside in the facility have the potential to be affected by the deficient practice. Social Services Assistant conducted an audit of current female residents to ensure that facial hair was addressed. Education was provided to the staff regarding the need carry out activities of daily living for residents who are unable to	10/5/24

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F 677	Continued From page 26 A review of Resident #20's care plan revised 06/19/23 revealed the Resident had a self-care ADL deficit related to decreased mobility and disease process. The goal to maintain her current level of function would be attained by utilizing interventions which included providing extensive assistance of one staff with personal hygiene (shaving). The quarterly Minimum Data Set (MDS) assessment dated 06/21/24 revealed Resident #20 was cognitively intact and required substantial to maximal assistance of one staff for personal hygiene which included shaving. There was no documentation on the MDS that indicated Resident #20 rejected care. On 09/03/24 at 12:48 PM an observation and interview were made of Resident #20 who was lying in her bed. The Resident was noted to have facial hair that covered her chin and neck. Resident #20 explained that she received a bed bath on Sunday (09/01/24) and did not get a shaved even after she requested to be shaved. The Resident indicated she had to request to be shaved when she was given a bed bath otherwise, she would not be given a shave. Resident #20 stated she did not know why she did not get a shave on Sunday. An observation was made on 09/04/24 at 9:15 AM of Resident #20 lying in bed sleeping. The facial hair remained unchanged. An interview and observation were made with Resident #20 on 09/04/24 at 3:11 PM. The Resident explained that she received a bed bath once a week on Sunday and usually got a shave	F 677	do themselves. This education included the need to maintain good nutrition, grooming, and personal and oral hygiene. Staff members that have not received the education by 10/4/24 will not be able to work until the education is completed. Newly hired staff will receive education during orientation by the Social Worker or Director of Nursing. Social Services Assistant or designee will audit 5 female residents three times a week for 4 weeks, then 5 residents twice a week for 8 weeks for facial hair. The Assistant Social Worker is responsible for forwarding the results of audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 677	Continued From page 27	F 677		

on the same day. Resident #20 still had a facial hair during the interview.

On 09/04/24 at 3:18 PM an interview was conducted with Nurse Aide (NA) #5 who explained that Resident #20 was alert and oriented and voiced her wants and needs. The NA continued to explain that he was assigned to Resident #20 on both Saturday 08/31/24 and Sunday 09/01/24 and received assistance of 2 other staff to provide the Resident's scheduled bed bath on Sunday 09/01/24. The NA stated that he noticed the Resident's facial hair on Saturday 08/31/24, and he told Resident #20 on both Saturday and Sunday that he would shave her but there were no razors available to shave her with. He indicated he looked in the shower room and the central supply room on both days and there were no razors available to use. NA #5 stated Resident #20 does not refuse her bed baths or her shaves.

At 09/04/24 at 4:00 PM NA #5 was accompanied to the central supply room to locate razors and there were several packages of razors in a bag labeled with a local store brand. The NA explained that the bag of razors was not in the central supply room on Saturday or Sunday.

An interview was conducted with the Central Supply Clerk on 09/04/24 at 4:09 PM. The Clerk explained that she was responsible for ordering medical supplies and she obtained the inventory and ordered the supplies once a week on Tuesday and the supplies arrived at the facility on Friday. She continued to explain that occasionally the delivery truck did not make the delivery on Friday and would usually come on the following Monday but the past Monday 09/02/24 was a

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F 677	Continued From page 28 holiday therefore, the delivery truck was delayed. The Clerk confirmed there were no razors available to be used over the weekend and stated she learned that they ran out of razors on Monday when the Administrator obtained razors at a local store. The Clerk indicated she should have thought to get razors when the delivery truck did not come Friday but she did not think of it. On 09/06/24 at 2:39 PM an interview was conducted with the Administrator who confirmed she obtained razors from a local store on Monday 09/02/24 when she was notified that there were no razors in the facility. She indicated it was unacceptable to run out of razors.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Nurse Practitioner interviews the facility failed to assess Resident #125 before transferring him back to bed after he was found on the floor for 1 of 2 residents reviewed for falls. The findings included: Resident #125 was admitted to the facility on	F 684	Resident #125 no longer resides in the facility. Residents residing in the facility that encounter a fall have the potential to be affected by the deficient practice. The Director of Nursing reviewed 30 days of falls to ensure that an assessment was completed post fall prior to moving the	10/5/24

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F 684	Continued From page 29 11/06/23 and expired on 11/28/23. Resident #125's diagnoses included malignant neoplasm of lung and skin, and anxiety. The admission Minimum Data Set (MDS) dated 11/16/23 revealed that Resident #125 was cognitively intact and required supervision with transfers. There was no behaviors or rejection of care noted during the assessment reference period. There was also no history of falls in the 6 months prior to admission or since admission to the facility. The MDS also revealed that Resident #125 had a prognosis of less than 6 months to live and received hospice care. Review of an initial allegation report dated 11/26/23 at 4:25 AM read, staff reported that Nurse Aide (NA) #2 handled Resident #125 roughly during the provision of care. The initial allegation report was completed by Former Administrator #1. NA #2 was interviewed via phone on 09/04/24 at 11:40 AM. NA #2 confirmed that she was working the night shift on 11/26/23. She stated she was walking past Resident #125's room and found him lying flat on the floor with urine all around him. NA #2 stated she requested assistance from the nurse but could not recall who that was, but no one came to the room for a while. NA #2 stated that while she was in Resident #125's room waiting for other staff to assist she went ahead and got Resident #125 off the floor and back into bed and was in the process of getting him cleaned up when NA #3 and NA #4 came in to assist. NA #2 stated that she alerted the nurse and when she did not show up in the room, she assumed it was okay to get Resident #125 back	F 684	resident. Education was completed with staff regarding the need for an assessment to be completed prior to moving a resident that has fallen. Staff members that have not received the education by 10/4/24 will not be able to work until the education is completed. Newly hired staff will receive the education during orientation by the Director of Nursing. The Director of Nursing or designee will audit five residents a week for twelve weeks that have encountered a fall to ensure an assessment was completed prior to moving the resident. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 684	Continued From page 30	F 684		

into the bed because the nurse was aware that he was on the floor. Again NA #2 could not recall which nurse she reported to.

NA #3 was interviewed via phone on 09/04/24 at 2:43 PM. NA #3 confirmed that she was working the night shift on 11/26/23 along with NA #2 and NA #4. NA #3 stated she recalled that she, NA #2 and NA #4 were in Resident #125's room and NA #2 had assisted Resident #125 from the floor to the bed after NA #3 and NA #4 had changed the sheets on the bed. NA #2 had reported to NA #3 and #4 that Nurse #3 was aware that Resident #125 was on the floor. NA #3 stated she did not recall Nurse #3 being in the room before NA #2 transferred him from the floor back to bed but stated "but they were aware we moved him."

Attempts to speak to NA #4 were made on 09/04/024 and 09/05/24 and were unsuccessful.

A handwritten statement from NA #4 dated 11/26/23 read in part, "I answered the call bell for {Resident #125} and when I entered the room, I noticed that he was half on and half off the bed in a praying stance. He was very confused and disoriented. I called for help and {NA #2 and NA #3} entered the room. {NA #2} began to try to assist the resident up out of the floor. In his given condition, he was unable to do so. {NA #2} ended up transferring the resident by herself without waiting for {NA #3} or myself to help. Once the resident was on the bed, I stayed with the resident while {NA #3} went and got our nurse." The statement was signed by NA #4.

Nurse #2 was interviewed via phone on 09/04/24 at 12:10 PM who confirmed that she was working the night shift on 11/26/23. She stated she was on

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the phone with hospice trying to get something for Resident #125 when NA #2 approached her about something. Because she was on the phone NA #2 went and got Nurse #3 but after the phone call was over Nurse #2 stated she went and got the rundown of what had occurred. It was reported that Resident #125 had fallen, and they got him back to the bed without being assessed. Nurse #2 stated that it was not reported to her that Resident #125 had fallen until after NA #2 had transferred him back to bed. She stated when she found out she did go and assess Resident #125 for injuries and range of motion but could not identify any injuries sustained from the fall.

Nurse #3 was interviewed via phone on 09/04/24 at 3:17 PM who confirmed that she was working the night shift on 11/26/23. Nurse #3 stated that she was unaware that Resident #125 had fallen, or that NA #2 had transferred him back to bed until after Resident #125 was back in the bed. Nurse #3 stated that she and Nurse #2 went to Resident #125's room and Nurse #2 assessed him to have no injuries from the fall.

The Nurse Practitioner was interviewed on 09/05/24 at 8:35 AM who stated that any resident that had a fall should be assessed by a nurse for injury before being moved.

The Director of Nursing was interviewed on 09/06/24 at 11:56 AM. The DON stated that she was unaware that Resident #125 had fall on the night of 11/26/23. She stated when a resident had a fall they have to be assessed by a nurse before being moved. The NAs should never get anyone up including Resident #125 without an assessment from the nurse. Once the nurse

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F 684	Continued From page 32 assessed the resident and deemed it safe to move the resident then the resident can be assisted back to bed or chair.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, Registered Dietitian (RD), Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to meet the recommended fluid needs for 1 of 2 residents (Resident #42) reviewed for nutrition. The findings included:	F 692	Resident #42 water flush rate was changed to 30 cc/hr on 9/5/24 per registered dietician recommendations. Residents residing in the facility that have recommendations from the registered dietician (RD) regarding fluid needs have the potential to be affected by the deficient practice. The RD recommendations for	10/5/24

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F 692	Continued From page 33 Resident #42 was admitted to the facility on 4/19/2021 with diagnoses which included dysphagia (difficulty swallowing), required the use of a gastrostomy tube (artificial opening in the stomach used for tube feeding) and tracheostomy. A physician order dated 07/21/24 read; flush tube with 30-60 milliliters (ml) of water before/after meds twice a day (120-240 ml). Review of the Registered Dietician (RD) nutritional assessment dated 07/25/24 revealed that Resident #42 required 1982-2379 ml of fluid per day. A review of the RD recommendations dated 7/25/2024 revealed Resident #42 was recommended to have free water at 30 ml per hour which totaled 720 ml (additionally 1094 ml of water were noted from the tube feeding formula). A review of the physician's orders dated 7/25/2024 revealed Resident #42 was to receive 30 ml every 4 hours of free water (180 ml of per day). A review of a care plan dated 7/30/2024 revealed Resident #42 had dehydration and potential fluid deficit related to tube feeding with interventions which included monitoring for signs and symptoms of dehydration which included decreased/no urinary output, concentrated urine and/or strong odor, tenting skin, cracked lips, furrowed tongue, new onset of confusion, dizziness on sitting/standing, increased heart rate, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, and/or dry/sunken eyes.	F 692	the last 30 days were reviewed for follow through by the Regional Nurse Consultant and Director of Nursing. Education was provided to the Director of Nursing by the Regional Nurse Consultant in regard to reviewing the RD recommendations and addressing them timely to ensure the residents fluid needs are met. Staff members that have not received the education by 10/4/24 will not be able to work until the education is completed. Newly hired staff members will be educated during orientation by the Director of Nursing. The Director of Nursing will audit 5 residents with RD recommendations weekly for 12 weeks to ensure recommendations for fluids was put in to place. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into and to determine the need for further and/or frequency of monitoring.	

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	345133	A. BUILDING _____ B. WING _____	C 09/11/2024

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A review of the labratory results revealed a blood urea nitrogen (BUN, helps diagnose kidney issues) was not obtained in July or August of 2024.

A review of a quarterly Minimum Data Set (MDS) assessment dated 8/13/2024 revealed Resident #42 was moderately cognitively impaired, had no weight loss or weight gain, and received 501 mls or greater fluid per day via tube feeding.

A review of the September 2024 Medication Administration Record (MAR) revealed Residnet #42 was documented as having received 30 ml water flushes every 4 hours as ordered.

An observation was conducted on 9/3/2024 at 11:15 am of Resident #42. Resident #42's lips were dry, cracked, and had dried tan crust-like substance on his upper and lower lip. Resident #42's free water flushes were infusing at 30 ml every 4 hours (180 ml per day).

An observation was conducted on 9/3/2024 at 5:10 pm of Resident #42. Resident #42's lips were dry, cracked, and had dried tan crust-like substance on his upper and lower lip. Resident #42's free water flushes were infusing at 30 ml every 4 hours (180 ml per day).

An interview was conducted on 9/5/2024 at 8:53 am with the Nurse Practitioner (NP). The NP stated Resident #42 received tube feeding and had a history of having high residuals and at one time was not tolerating his tube feedings or flushes. The NP stated Resident #42's urine output was measured by counting briefs and that he always had dry lips, mouth, and tongue

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regardless of how many times his mouth was cleaned per day. The NP stated dry mouth could be a sign of dehydration, but stated his lips and mouth were dry because he was a "mouth-breather" (breathed through his mouth). The NP stated she had lowered the rate of his free water flushes when he had high residuals and was experiencing an intolerance to the feedings and flushes.

An interview was conducted on 9/5/2024 at 10:49 am with the RD. The RD stated she reviewed Resident #42's weights and tube feeding/free water every month, anytime there was a concern, or whenever a resident returned from the hospital. The RD stated he was placed on an elemental feeding (feeding that is broken down to simplest form for easier digestion) around July 2024 due to an intolerance. The RD stated Resident #42 received 1774 ml of free water from flushes, tube feeding, and medication administration and had a requirement of 1982 ml/day and could not explain the deficit of free water. The RD stated she was not aware that Resident #42's free water flushes were running at 30 ml every 4 hours instead of 30 ml every hour and stated she must have overlooked that and reported he should have been on 30 ml every hour of free water. The RD stated dry, cracked lips/mouth could be an indicator of dehydration and stated she was not aware Resident #42 had dry/cracked lips.

An interview was conducted on 9/6/2024 at 10:36 am with Nurse #1. Nurse #1 stated Resident #42 was incontinent or urine and wore a brief. Nurse #1 stated Nurse Aides (NAs) reported brief counts and there had been no concerns with Resident #42's urinary output and no foul odors.

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An interview was conducted on 9/6/2024 at 10:55 am with the Medical Director (MD). The MD stated she was not familiar with Resident #42 and had only been employed at the facility for approximately one month. The MD stated she ideally checked tube feeding residents' lab every 2 weeks or month to assess their hydration status and monitored their intake and output via brief count. The MD stated an elevated BUN creatinine ratio and dry/cracked lips could be an indicator of dehydration and reported she was going to order laboratory testing to assess Resident #42's hydration status.

An interview was conducted on 9/6/2024 at 1:07 pm with the Director of Nursing (DON). The DON stated when a resident was on tube feeding and free water flushes, the provider would look at laboratory results and RD recommendations to adjust the feeds and water intake as needed. The DON stated Resident #42 had not tolerated his tube feeding at one time and his orders were changed. The DON stated the most up to date recommendation had not been followed for Resident #42 and could not explain why Resident #42 was not getting the required amount of free water he needed.

A review of laboratory results dated 9/9/2024 revealed resident #42 had an elevated blood urea nitrogen (BUN) to creatinine ratio of 31.3 mg/dl normal levels were 10-20 (high levels can be indicative of dehydration).

A follow-up telephone interview was conducted on 9/11/2024 at 1:18 pm with the NP. The NP stated that she initially lowered the amount of free water flushes at the end of May/beginning of June 2024

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F 692	Continued From page 37 due to Resident #42 having high residuals and intolerance. The NP stated that she was not at the facility for a majority of June, all of July, and returned 8/5/2024 due to a change in physicians. The NP stated that her plan before she left was to slowly increase the free water flushes and stated she was unsure why the fill-in provider had not done so. The NP stated she increased Resident #42's free water flushes to 30 ml per hour on 9/5/2024 and reported Resident #42 had tolerated them well with no high residuals.	F 692		
F 697 SS=D	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, Resident, and staff interviews, the facility failed to assess a resident for pain on admission and when there was a change in condition for 1 of 3 residents reviewed for pain management (Resident # 88). The findings included: Resident #88 was admitted to the facility on 6/14/2024 with diagnoses which included a left femur (long bone in the upper leg) fracture (break), sternal body (breastbone) fracture, liver laceration (trauma to the liver that causes bleeding), L1 vertebral body (spinal bone in the lower portion of the back) fracture, right forehead laceration (tear), and metacarpal (hand bone)	F 697	Resident #88 no longer resides in the facility. Residents newly admitted to the facility that experience a change in condition have the potential to be affected by the deficient practice. New admissions for the last 14 days were reviewed by the Regional Nurse Consultant for a change in condition and to ensure pain was assessed. There were no issues identified. Education was provided by the Director of Nursing and Regional Nurse Consultant regarding assessing newly admitted	10/5/24

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F 697	Continued From page 38 fractures. A review of an admission nurse's note, authored by Nurse # 3, dated 6/14/2024 revealed Resident #88 had arrived at the facility via Emergency Medical Services (EMS), was pleasant, and alert and oriented. Resident #88 had extensive bruising and staples in his left leg and had a femur fracture. Resident #88 had staples on his right forehead and had a cast on his right arm. Resident #88 reported he had been in a motorcycle crash and sustained injuries. Resident #88 was wearing a two piece back brace. An interview was conducted on 9/4/2024 at 3:11 pm with Nurse #3. Nurse #3 stated she admitted Resident #88 to the facility on 6/14/2024. Nurse #3 stated Resident #88 was pleasant when he arrived at the facility and was placed in a room on one side of the building, but had requested a room change shortly after he arrived. Nurse #3 stated she moved Resident #88 to his new room and was unsure if she assessed his pain on admission. A review of Resident #88's Electronic Health Record (EHR) revealed there was no pain assessments documented on 6/14/2024. A review of the physician's orders dated 6/14/2024 revealed orders for Resident #88 to receive Hydrocodone-Acetaminophen (pain medication) 5-325 milligrams (mg) by mouth every 6 hours as needed for moderate (4-6 out of 10 on the numerical pain scale) pain or severe (7-10 out of 10 on the numerical pain scale) pain for 7 days, Tramadol (pain medication) 50 mg by mouth every 6 hours as needed for back pain for	F 697	residents for changes in condition and pain secondary to the change. Staff members that have not received the education by 10/4/24 will not be able to work until the education is completed. Newly hired staff will be educated during orientation by the Director of Nursing. The Director of Nursing or designee will audit 5 newly admitted residents a week for 4 weeks, then 10 newly admitted residents a month for two months for a change in condition and pain secondary to the change. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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5 days, and Acetaminophen 325 mg by mouth every 6 hours as needed for mild (1-3 out of 10 on the numerical pain scale) pain for 10 days.

A review of Resident #88's Medication Administration revealed Resident #88 had not received any medications on 6/14/2024.

A review of the medication count from the medication dispensing machine dated 6/14/2024 revealed the facility had a total of 6 tablets of Tramadol 50 mg tablets on hand.

An interview was conducted on 9/6/2024 with Nurse Aide (NA) #6. NA #6 stated she worked first shift (7:00 am to 7:00 pm) and stated she was assigned Resident #88 on 6/14/2024. NA #6 stated Resident #88 was initially placed in a room on another hall and transferred to her hall soon after his arrival due to an issue with the air conditioning. NA #6 stated he was frustrated and upset because he was in pain and requested pain medication. NA #6 stated she told Nurse #5 that Resident #88 was in pain wanted pain medication. NA #6 stated Nurse #5 told her Resident #88's pain medication had not arrived. NA #6 stated he was upset the remainder of her shift and had not received any pain medication.

An interview was conducted on 9/6/2024 at 11:53 am with Nurse #5. Nurse #5 stated she worked first shift (7:00 am to 7:00 pm) and was assigned Resident #88 on 6/14/2024. Nurse #5 stated Resident #88 was originally placed in a room on another hall and then transferred to her hall. Nurse #5 stated Nurse #3 told her Resident #88's admission had been completed. Nurse #5 stated she did not assess Resident #88 for pain because she was under the impression given by

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Nurse #3 that there were no needs/issues. Nurse #5 stated she did not recall NA #6 reporting Resident #88 being in pain to her during her shift.

A review of a late entry nursing progress note dated 6/15/2024, authored by Nurse #4, revealed Resident #88 approached Nurse #4 in the hallway and requested to be sent to the hospital at which time he stated, "I'm having chest pains." Resident #88's blood pressure was 206/135, heart rate was 87 beats per minute, respiration rate was 18 breaths per minute, and oxygen saturation level was 94% on room air (not on oxygen). Nurse #4 contacted the on-call provider and Director of Nursing (DON) and Resident #88 was sent to the Emergency Department.

A review of the Emergency Medical Services (EMS) report dated 6/14/2024 revealed EMS was dispatched to the facility at 9:42 pm in reference to chest pain (non-cardiac) and hypertension. Upon arrival Resident #88 was found in bed, alert and oriented. Resident #88 had an initial blood pressure of 186/111, a heart rate of 82 beats per minute (normal is 60-100 beats per minute), a respiration rate of 18 breaths per minute (normal is 12-20 breaths per minute), and an oxygen saturation level of 97% (normal is greater than 92%) on room air. Resident #88 rated his pain as a 2 out of 10 (mild) on the numerical pain scale and did not receive any medications from EMS. Resident #88 was transported to the hospital and remained pleasant and talkative throughout the transport.

A review of the Emergency Department documentation dated 6/14/2024 revealed Resident #88 arrived in the Emergency Department with chest pain and reported the

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facility wanted him to stay in bed all day until he was evaluated and not given him any pain medication since he had arrived at the facility. Resident #88 reported he did not want to return to the facility. Resident #88 received Morphine (pain medication) 4 milligrams (mg) intravenously and was admitted to the hospital for malignant hypertension (an elevated blood pressure accompanied by multiple complications). Resident #88 was discharged home from the hospital on 6/19/2024.

A telephone interview was conducted on 9/6/2024 at 11:22 am with Resident #88. Resident #88 stated he arrived at the facility on a Friday afternoon after he was discharged from the hospital following a motorcycle accident. Resident #88 stated he was in pain when he arrived at the facility, and reported his pain was a 9-10 out of 10 on the numerical pain scale. Resident #88 stated he had back and leg pain. Resident #88 stated he had told a NA (unable to remember who), that he was in pain and requested pain medication. Resident #88 stated he was told the facility did not have his medication. Resident #88 stated the pain continued into the night, at which point he started to develop chest pains. Resident #88 stated he told the nurse he was having chest pain and wanted his vital signs checked. Resident #88 stated after he saw how high his blood pressure was, he demanded to go to the hospital. Resident #88 stated when he arrived at the hospital, he was given pain medication and later admitted.

An interview was conducted on 9/6/2024 at 11:36 am with the Medical Director (MD). The MD stated she was not employed by the facility on

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F 697	Continued From page 42 6/14/2024. The MD stated when a resident was admitted to the facility, the staff should assess for pain at that time and whenever the resident expressed that they were experiencing pain. An interview was conducted on 9/6/2024 at 1:16 pm with the DON. The DON stated she was on leave at the time Resident #88 was admitted to the facility. The DON stated a pain assessment should have been performed on admission. An interview was conducted with the former Interim DON. The former Interim DON stated she was present at the facility on 6/14/2024 when Resident #88 arrived. The former Interim DON stated he was initially on one hall and had to be moved to another hall. The former Interim DON stated when Resident #88 arrived at the facility he was smiling and conversating with other residents. The former Interim DON stated after he switched rooms, his mood changed, and he became aggravated and wanted to leave. The former Interim DON stated Resident #88 never mentioned being in pain and did not appear to be in pain while she was at the facility. The former Interim DON stated a pain assessment should be performed on admission and when changes occurred and was not sure why there was no pain assessment documented for Resident #88.	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		10/5/24

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(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or

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F 758	Continued From page 44 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff, Nurse Practitioner and Pharmacist interviews, the facility failed to identify the lack of documentation of monitoring for side effects (Resident #35) for psychotropic medications for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #35 was admitted to the facility on 10/12/22 with diagnoses that included Parkinson Disease, unspecific dementia without behavioral disturbance, psychosis, mood disorder and neurogenic disturbance with Lewy body dementia. A review of Resident #35's physician orders revealed orders for: Seroquel (an antipsychotic) 25 milligrams (mg) by mouth once a day for dementia dated 07/12/24, Nuplazid (an antipsychotic) 34 mg by mouth once a day for psychosis related to Parkinson Disease dated 07/13/24, and Seroquel 12.5 mg by mouth once a day for dementia dated 07/13/24. A review of Resident #35's Medication Administration Record (MAR) for 07/2024, 08/2024 and 09/2024 revealed the antipsychotic medications were intialed as administered as ordered. A review of Resident #35's MAR for 07/2024 revealed there were no side effect monitoring for the antipsychotic medications after 07/11/24, 08/2024 and 09/2024.	F 758	Resident #35 still resides in the facility. Resident #35 MAR was updated to include monitoring for side effects for psychotropic medications on 10/2/24. Residents residing in the facility that have psychotropic medications ordered have the potential to be affected by the deficient practice. Regional Nurse Consultant reviewed residents residing in the facility that have orders for psychotropic medications to ensure that monitoring for side effects was in place. Education was completed with staff regarding the need for side effect monitoring on psychotropic medications. The monitoring is to be placed on the eMAR for the nurse to sign off on once assessment for side effects has been completed. Staff members that have not received the education by 10/4/24 will not be able to work until the education is completed. Newly hired nurses will receive the education during orientation by the Director of Nursing. The Director of Nursing or designee will audit 5 residents receiving psychotropic medications a week for 12 weeks to ensure that side effect monitoring is in place. The Director of Nursing is responsible for forwarding the results of the audits to the	

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F 758	Continued From page 45 During an interview with Nurse Aide (NA) #5 on 09/04/24 at 3:48 PM the NA stated he was often assigned to care for Resident #35 and explained that the Resident was alert, but his cognition was "jaded" like he talked about working on old cars. The NA stated the Resident could be physically aggressive and instantly angered but he had not displayed those behaviors with him. An interview was conducted with Nurse Aide (NA) #7 on 09/05/24 at 11:33 AM. The NA stated she was often assigned to care for Resident #35 and explained that the Resident had periods of physical aggression toward the staff and his behaviors had become more frequent. The NA continued to explain that Resident #35 had behaviors of hollering and had visual hallucinations of "old cars" coming after him. On 09/06/24 at 10:34 AM an interview was conducted with Nurse #1 who stated that Resident #35 was physical with the staff and had periods of continuous hollering especially during the night. She stated the Resident was not as bad as he used to be and that his medications seemed to control the behaviors better. The Nurse explained that the nurses documented the side effects of the psychoactive medications on the MARs along with the medications every shift. The Nurse looked at Resident #35's 09/2024 MAR and acknowledged there was no side effect monitoring on the MAR and stated it should be on there to watch for side effects. During an interview with the Director of Nursing (DON) on 09/06/24 at 11:14 AM the DON explained that it was an oversight that the side effects monitoring was left off the MARs when	F 758	QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 758	Continued From page 46 Resident #35 came back from the hospital. She stated the Unit Manager, or the Assistant Director of Nursing were responsible for reviewing the medical records after admissions to ensure accuracy but currently the facility did not have an active Unit Manager or Assistant Director of Nursing.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		10/5/24

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F 880	Continued From page 47 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility staff	F 880	The deficient practice has the potential to affect residents residing in the facility.	

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F 880	Continued From page 48 failed to don appropriate Personal Protective Equipment (PPE) before entering residents' room under transmission-based precautions. The facility also failed to utilize hand hygiene after removing gloves for 2 of 4 residents reviewed for infection control (Resident #40 and Resident #74). The findings included: 1. Review of the facility's policy for Enhanced Barrier Precautions (EBP) dated 12/2023 revealed the EBP will be implemented for the prevention of transmission of multidrug-resistant organisms. EBP employs gown and glove use during high resident care activities such as: Dressing Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting wit toileting, Device Care or use: central line, urinary catheter, feeding tube and tracheostomy, Wound Care: any skin opening requiring a dressing. Review of the facility's Hand Hygiene policy dated 12/2023 revealed staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility. #6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your talk requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. On 09/05/24 at 4:00 PM an observation was made of Nurse Aide (NA) #5 and NA #7 transferring Resident #40 from the bed to the chair using a total lift. Resident #40 was under EBP for multiple stage 3 and 4 pressure ulcers	F 880	Education was provided to staff regarding properly donning personal protective equipment (PPE) before entering residents□ rooms that are under transmission-based precautions. Demonstration of donning PPE was provided. In addition, education was provided on hand hygiene after removing gloves. Staff performed hand hygiene in return to show understanding. Staff members that have not received the education by 10/4/24 will not be able to work until the education is completed. Newly hired staff will receive the education during orientation by the Director of Nursing. The Director of Nursing or designee will conduct five observations a week for five weeks to ensure staff are donning PPE prior to entering residents with transmission-based precautions. Five observations will also be completed for proper hand hygiene after removing gloves. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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and a suprapubic urinary catheter and the signage for EBP was posted on the Resident's door. The two NAs sanitized their hands and applied gloves then proceeded to enter Resident #40's room and announced why they were there. NA #5 emptied the Resident's colostomy and handed the container to NA #7 to empty in the restroom. NA #7 then removed her gloves and went to the hallway to obtain pack of briefs and brought the briefs back into the room then donned new gloves without sanitizing her hands. NA #5 removed his gloves then washed his hands before he donned new gloves. Both NAs changed the Resident's brief then NA #7 removed her gloves and donned new gloves without sanitizing her hands. NA #5 removed his gloves and washed his hands before he donned new gloves. NA #7 obtained the Resident's urinal and handed it to NA #5 to empty the catheter bag. NA #5 took the urinal to the restroom to empty then removed his gloves and washed his hands before he donned new gloves. NA #7 then removed her gloves and proceeded to change the Resident's bed linens without wearing gloves. NA #5 assisted with the linen change while wearing gloves. NA #7 then brushed and braided Resident #40's hair without wearing gloves.

An interview was conducted with both NA #5 and NA #7 simultaneously on 09/05/24 at 4:49 PM. The NAs were asked if Resident #40 was under any kind of precautions and both replied yes, Enhanced Barrier Precautions which meant they needed to don gloves and gown before entering the Resident's room. NA #5 explained he only wore the gloves because he did not intend on letting his uniform get against the Resident or his bed. NA #7 stated she always wore gloves and gown when working with Resident #40 and she

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knew to wash or sanitize her hands between glove changes but today she was nervous and forgot the procedure.

On 09/06/24 at 11:46 AM during an interview with the Director of Nursing (DON) the DON explained that her former Assistant Director of Nursing oversaw infection control infection control education, but she left employment about 2-3 weeks prior. The DON stated regardless all the staff knew to abide by the different types of precautions posted on the residents' door and to follow the assigned PPE.

2. Review of a facility policy revised on 12/2023 read in part, Personal Protective Equipment Considerations: Health Care Personnel should follow standard precautions if SARS-CoV-2 infection is not suspected in a resident presenting for care or transmission-based precautions if required based on suspected diagnosis. The facility may consider implementing broader use of respirators and eye protection by Heath Care Personnel during care encounters if SARS-CoV-2 transmission in the community increases as follows: eye protection (i.e. goggles or a face shield that covers the front and sides of the face) worn during all resident care encounters.

Resident #74 was admitted to the facility on 08/30/24 with diagnosis of COVID-19.

A Brief Interview for Mental Status was completed on 09/04/24 and revealed that Resident #74 was cognitively intact.

An observation and interview were conducted with Resident #74 on 09/03/24 at 11:52 AM. There was a sign on the door of Resident #74's

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room that stated, "Special Droplet Contact Precautions" and instructed all healthcare personnel to clean hands before entering and when leaving room, wear a gown when entering room and remove before leaving, wear N95 or higher-level respirator before entering the room and remove after exiting, protective eyewear (face shield or googles), wear gloves when entering room and remove before leaving, and place in private room. Keep door closed.
Resident #74 was up and dressed appropriately watching television sitting in a straight back chair in his room. He stated he was feeling much better and did not think he would have to stay at the facility for an extended period of time. Resident #74 explained that he was a retired respiratory therapist and was well aware of the COVID-19 precautions in place, when asked if all the staff that came in to assist him dressed appropriately in the recommend personal protective equipment he replied "not as much as you have on" indicating that the staff always had on gown, gloves, and mask but he did not see them wear a face shield or eye protection like the surveyor had on.

An observation and interview were conducted on 09/03/24 at 1:09 PM of Nurse Aide (NA) #9. NA #9 was observed entering Resident #74's room to deliver his meal tray and was noted to be dressed in a gown, gloves, and N95 respirator but had no eye protection on. NA #9 knocked on the door and entered the room and sat the lunch tray down on Resident #74's table and proceeded to ensure the tray was set up for the resident to eat and make sure he had all needed items. Before exiting Resident #74's room NA #9 removed his N95 respirator, gown, and gloves and used hand sanitizer. NA #9 was asked about Resident #74,

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and he stated that the resident had COVID-19 and that when he went into his room, he applied personal protective equipment that included N95 respirator, gown and gloves. When asked if he wore eye protection, NA #9 stated "no" and when asked if he should wear eye protection NA #9 stated "yes." NA #9 was then asked why he did not wear eye protection when he entered Resident #74's room and he stated that there was none in the personal protective equipment cart outside the room. The surveyor opened the second drawer of the personal protective equipment cart and there were two face shields in the drawer and NA #9 stated "oh I guess I should have looked."

The Director of Nursing (DON) was interviewed on 09/06/24 at 11:45 AM who explained that Resident #74 had recently admitted to the facility from the hospital on 08/30/24 with COVID-19 and was placed on special droplet contact precautions that required all staff who entered his room to clean their hands, apply gown, gloves, N95 respirator, and eye protection. The DON stated that NA #9 should have applied eye protection as the sign on the door indicated and if there was none in the personal protective equipment cart outside of the room there were plenty of extra supplies in the break room.