STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MONROE	204 OLD HIGHWAY 74 EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 02/10-20 through 02/13/20. The facilty was found in compliance with the requirements CFR 483.78, Emergency Preparedness. Event ID#NLMH11	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted 2/10/20 through 2/13/20. Immediate Jeopardy was identified at CFR 483.25 at tag F689 at a scope and severity (J) The tags F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 1/30/2020 and was removed on 2/7/2020. An extended survey was conducted. 41 Allegations were investigated, 15 allegations were substantiated.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health	F 561		3/11/20

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

Electronically Signed | 03/09/2020

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F 561	Continued From page 1 care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to provide showers as scheduled for 1 of 2 resident reviewed for choices (Resident #11). Findings included: Resident #11 was admitted to the facility on 8/26/19 with diagnoses of heart disease and osteoarthritis. A Quarterly Minimum Data Set (MDS) assessment dated 12/31/2019 revealed Resident #11 was cognitively intact and required limited assistance of staff for bathing. During an interview with Resident #11 on 2/13/2020 at 3:06 pm she stated it was difficult to get anyone to take her to the shower. Resident	F 561	1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident # 11 was interviewed by Director of Nursing Service on her recommendation for preferred shower day. Resident #11 received showers according to her schedule but the indication for whether a bed bathe or shower happened to Resident #11 could not be found in patient chart. Resident #11 did receive showers on her assigned days according to staff. 2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken; All patients on assigned shower schedules were interviewed by the	

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F 561	Continued From page 2 #11 stated the Nurse Aides would bring her a washcloth and towel to clean herself up but did not take her to the shower on her scheduled shower days. Resident #11 stated she had not had her showers for two weeks. Resident #11 stated she preferred to go to the shower on her shower days. A review of the facility's Resident Shower List which was updated 2/9/2020 revealed Resident #11's showers were scheduled every Wednesday and Saturday. A review of Resident #11's Point of Care Audit Report from 1/1/2020 to 2/13/2020 revealed she did not have a shower recorded during 1/2020 or 2/2020. On 2/13/2020 at 8:21 am Nurse Aide #3 stated Resident #11's showers were scheduled for Wednesdays and Saturdays. Nurse Aide #3 stated Resident #11 could bath herself with set up on the days she did not go to the shower and never refused a bath or shower. Nurse Aide #3 stated Resident #11 had not told her she was not getting her showers. During an interview with the Director of Nursing on 2/13/2020 at 2:52 pm she stated Resident #11 had a shower on 2/12/2020 but the electronic medical record showed the resident had a bath. The Director of Nursing stated she was not sure why the system did not show the resident had a shower on 2/12/2020. The Director of Nursing stated Resident #11 was scheduled for a shower twice a week, but the electronic medical record system did not show them. The Director of Nursing stated she discussed the issue with the Corporate Liaison and was trying to get the	F 561	Director of Nursing Service on 03/09/2020 for their acceptance of their assigned scheduled days. Patients who chose to change their shower days were changed. 3. Measure/ Systemic changes put in place to ensure the deficient practice will not reoccur; The Director of Nursing Services contacted Help Desk PCC on 02/17/2020 to create an option for staff to log bathing options i.e. bed bathe or shower into PCC. Options are available for CNA staff to select. On 03/9/2020 All CNA staff will be educated on the new change to point of care charting for appropriate compliance of deficient practice. On 03/9/2020 the Director of Nursing Service developed a shower spreadsheet for staff to sign on refusals or acceptances to bathe options. Spreadsheet can be found with nursing assignment sheet at nursing station. On 03/09/2020 All CNA staff will be educated by the Director of Nursing Service on new signing tool for patient refusals or acceptances to showers or bed bathe. New staff will be educated upon hire. 4. Monitoring of the corrected action to ensure deficient practice will not reoccur; Director of Nursing Service will collect shower spreadsheets weekly for 8 weeks to ensure staff compliance with logging information. Director of Nursing Service will then collect a spreadsheet monthly for 3 months. Director of Nursing Service will review information monthly to Quality Assurance Performance committee. Administrator will ensure staff compliance	

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F 561	Continued From page 3 problem corrected. An interview was conducted 2/13/2020 at 3:27pm with the Administrator and he stated residents should be assisted with a shower whenever they requested one and the documentation should reflect whether she was assisted with a bath or a shower.	F 561	with POC monthly in QA meeting.	
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense.	F 576		3/11/20

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F 576	Continued From page 4 §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide residents with access to a telephone and area where calls could be made without the conversation being overheard for 1 of 1 resident reviewed for privacy (Resident #12). The findings included: Resident #12 was readmitted to the facility on 3/18/19. The resident ' s cumulative diagnoses included: Schizophrenia, anxiety, and depression. Resident #12 ' s most recent Minimum Data Set assessments revealed a quarterly assessment with an Assessment Reference Date of 1/3/20. Review of the assessment revealed the resident was coded as having no cognitive loss and was coded as having no behaviors during the assessment period. During an interview conducted on 2/10/20 at 12:30 PM, with Resident #12, she that she was unable to have a private phone conversation. She clarified she had used the resident phone at the nurses ' station or the Social Worker (SW)	F 576	1. Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #12 was educated on 03/03/2020 by the Administrator on the places in the nursing home where she can have calls without being overheard. 2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken: Administrator changed the telephone at the nursing station from a wireless phone to a cordless phone to benefit residents need for privacy. On 03/09/2020 each resident will be required to sign out the telephone during each use. On 03/09/2020 all residents were educated by the Activity Director on areas of the nursing home where they can have calls without being overheard. 3. Measure / systemic changes put in place to ensure the deficient practice will not reoccur; On 03/09/2020 all residents will be educated on the location of cordless phone and the facility expectation for the cordless phone by the	

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F 576	Continued From page 5 would take her to use the phone in his office, but she was unable to have a private phone conversation without being overheard by SW and or the Business Office Manager because they would be in the office or near the office during her phone conversations. Resident #12 stated she could use the facility phone at the nurses ' station but if she wanted to have more of a private phone conversation, she had to ask the Social Worker to use the phone in his office. An interview was conducted on 2/12/20 at 2:42 PM with the SW. The SW stated one of the resident ' s family members had recently moved and the resident had phone conversations with the family member using the phone in his office. The SW stated the resident did not have her own phone or a facility supplied in room phone. The SW stated whenever the resident wanted to use the phone she would come to his office for more privacy. The SW stated there was a designated resident ' s phone at the nurses ' station which was on a different line and residents could use that phone at any time. The SW stated the resident ' s phone at the nurses ' station was a corded phone and could not be carried away from the nurses ' station for a resident to have a private conversation. An observation of the resident phone at the nurse ' s station was conducted in conjunction with an interview on 2/12/20 at 2:54 PM. The observation revealed a corded phone behind the elevated counter surface of the nurses ' station on the nurses ' station desk. The nurses ' station was located at the junction of an access hall, 100 Hall, 200 Hall, and 300 Hall, and was the only nurses ' station in the facility. The SW stated on the weekends if a resident wanted to make a phone	F 576	facility Social Worker/designee. All staff will be educated on the new system on 03/10/2020 by the facility Administrator. 4. Monitoring of the corrected action to ensure deficient practice will not reoccur; The facility Social Worker will interview 5 alert residents regarding their privacy during phone use 5 times/week for 4 weeks then 3 times/week for 2 months. The Administrator will report findings at each monthly Quality Assurance Performance Improvement Committee meeting.	

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F 576	Continued From page 6	F 576		

call, the resident could use either the phone at the nurses ' station or the phone in the nurses ' office. The SW stated the nurses ' station would not be a good place for a resident to have a private phone conversation. The SW said during the weekends or after hours the nurse supervisor had a key and could open the nurses ' office to allow a resident to have a private phone conversation. The SW added he felt it was important for the residents to have a private area to have a phone conversation.

An interview was conducted on 2/12/20 with Nurse #5 at 3:00 PM. The nurse stated sometimes Resident #12 would use the phone in the conference room to talk to her family member. The nurse stated there was a staff member who also utilized the conference room as an office.

During an interview conducted with the Director of Nursing (DON) on 2/13/20 at 3:35 PM she stated she did not feel like the nurses ' station, where the resident phone was located, was an area where residents could have a private phone conversation. The DON added sometimes residents used the facility phone in the nurses ' office or the conference room. The DON stated there was a staff member who utilized the conference room as her office, and she could leave while the resident was having a phone conversation. The DON explained the nurses had a key to access the conference room if a resident wanted to make a call during the weekend or non-business hours. The DON said if it were the weekend or non-business hours, a resident would have to ask a nurse to have access to a phone to have a private conversation. The DON concluded she felt residents should be

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F 576	Continued From page 7 able to have a private phone conversation without having to ask a staff member to gain access to a private area. An interview conducted on 2/13/20 at 3:48 PM with the facility ' s Administrator. He stated there was a resident phone available at the nurses ' station, some of the resident rooms had phones for the residents, and the nurses ' office and/or the conference room were available if a resident wanted to have a private phone conversation.	F 576		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		3/11/20

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F 580	Continued From page 8 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff and family member interviews and record review, the facility failed to notify a resident's responsible party of a resident's fall which resulted in a skin tear to the resident's arm for 1 of 4 resident reviewed for accidents (Resident #27). Findings included: Resident #27 admitted to the facility on 4/10/18 with diagnoses of spinal stenosis, cervical disc disorder and falls. A Quarterly Minimum Data Set (MDS)	F 580	1. Corrective action accomplished for those residents found to have been affected by deficient practice. On February 11, 2020 the responsible party of resident #27 was made aware of resident□s fall on December 17, 2019 which resulted in as skin tear. Nurse #3 was re-educated on February 13th, 2020 by the Director of Nursing and/or the Assistant Director of Nursing on notifying the responsible party of a resident□s change in condition including a fall and/or a skin tear. 2. Identify other residents who have the	

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F 580	Continued From page 9 assessment dated 11/12/2019 revealed Resident #27 was cognitively intact and required extensive assistance with transfer. The assessment further revealed she had one fall since admission. A Nurse's Note dated 12/17/19 at 7:00 am, written by Nurse #3, revealed Resident #27 was found on the floor between the wall and the bed lying on her right side with her right hand behind her back at 6:30 am. A skin tear was noted to Resident #27's right forearm. An Incident Report dated 12/17/19 at 6:30 am revealed Resident #27 had a fall with a skin tear to her right forearm. During an interview with a family member on 2/11/2020 at 11:36 am the family member stated Resident #27 had a fall one month ago and no one notified her of the fall or of the skin tear to Resident #27's arm which occurred as a result of the fall. During a phone interview on 2/13/2020 at 11:18 am Nurse #3 stated she was working on 12/17/19 when Resident #27 fell from the bed. Nurse #3 stated Resident #27 had a skin tear to her right forearm. Nurse #3 stated she had not called the Responsible Party regarding Resident #27's fall and skin tear to her right arm. An interview with the Director of Nursing on 2/13/2020 at 11:30 am revealed she did not know if anyone called the Responsible Party when Resident #27 fell on 12/17/19 and sustained a skin tear to her right forearm. The Director of Nursing stated Nurse #3 should have called the Responsible Party and notified them of the fall and the skin tear.	F 580	potential to be affected by the same deficient practice and the actions taken; all residents who have a change in condition are at risk for deficient practice, therefore all licensed nurses were re-educated on notifying the responsible party with changes in condition of the resident. This re-education was provided by the Director of Nursing and/or Assistant Director of Nursing. This re-education beginning on March 6, 2020. 3. Measure/Systemic changes put in place to ensure the deficient practice does not reoccur; The licensed nurses were re-educated to notify the responsible party with any changes in condition including falls and skin tears, document on the 24-hour report and complete an incident report as indicated. Document in nurses□ note and/or on incident report notification of responsible party. This re-education was provided by the Director of Nursing and/or the Assistant Director of Nursing. This education beginning on March 6, 2020. New hires will receive education upon hire. 4. Monitoring of the corrective action to ensure the deficient practice does not reoccur; Effective March 6, 2020 ,the Director of nursing and/or the Assistant Director of Nursing will audit, incident reports, nurses□ notes, and 24-hour reports for any changes in residents□ condition and notification of the responsible party. This audit will be completed 5xper for 4weeks and then 3xper for 2 months. The Director of nursing will present results of audits to the Quality Assurance Performance	

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F 580	Continued From page 10 The Administrator was interviewed on 2/13/2020 at 3:27pm and he stated the nursing staff should notify the Responsible Party when a resident has a fall, especially when the resident received an injury.	F 580	Improvement Committee monthly for 3months. The QAPI committee can make changes to ensure facility remains in compliance. The administrator will oversee this process.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code a comprehensive Minimum Data Set (MDS) for the area of anticoagulant medications for 1 of 3 residents reviewed (Resident #25). Findings include: Resident #25 was admitted to the facility on 01/07/2020 with diagnoses that included hypertension and hyperlipidemia (high level of fats in the blood). A physician's (MD) order dated 01/08/2020 revealed that Resident #25 was to receive Plavix (an antiplatelet medication) 5 milligrams (mg) orally every day for hyperlipidemia. The medication administration record (MAR) for Resident #25 dated for January 2020 revealed that Resident #25 received Plavix 5 mg by mouth daily. There was no anticoagulant medication noted on the MAR for Resident #25.	F 641	1. Corrective action accomplished for those residents found to have been affected by the deficient practice. For resident #25 the Minimal Data Set Coordinator completed a modification(correction) for the MDS dated on 01/14/20 on 02/11/20 that resident did not receive an anticoagulant. Resident #25 care plan was corrected on 02/11/20. 2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken. All residents are at risk therefore a 100% audit was conducted by the Director of Nursing on 02/11/20 to identify all residents receiving Plavix and the correct coding on MDS. Two other residents were identified. The MDS were modified for correction and care plans were updated. 3. Measure/systemic changes put in place to ensure the deficient practice does not reoccur; Effective on 03/02/20 the Minimal Data Set Coordinator was	3/11/20

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F 641	Continued From page 11 A comprehensive admission MDS dated 01/14/2012 revealed that Resident #25 had severe cognitive impairment and received an anticoagulant medication for 7 days of the MDS review period. An interview conducted with the MDS nurse on 02/11/2020 at 12:15 PM revealed that the MDS nurse thought that she had been told in either an MDS training class that Plavix was to be coded as an anticoagulant medication. The MDS nurse revealed that she would review the MDS and medication documentation for Resident #25 dated for the MDS review period in January of 2020 and would complete a modification of the MDS for Resident #25 dated 01/14/2020 if the medication was not coded accurately. On 02/11/2015 at 4:15 PM the MDS nurse reported that on review of the MAR for Resident #25 dated for the 7-day review (look back) period of the MDS dated 01/14/2020 that Resident #25 did not receive an anticoagulant medication and that it was an error on her part that she coded Plavix as an anticoagulant medication. The MDS nurse revealed that she completed a modification (correction) of the MDS dated 01/14/2020 for Resident #25 on 02/11/2020 and revealed that she would be careful to code medications correctly as required by the MDS Resident Assessment Manual for medications. On 02/13/2020 at 2:51 PM an interview was conducted with the facility administrator who revealed that the expectation was that the MDS nurse ensure that MDS assessments are coded accurately.	F 641	re-educated on the accuracy of assessment and coding on the MDS using the Resident Assessment Instrument guide by the Regional Director of Clinical Services. Education will be a part of orientation for new hire Minimal Data Set Coordinator. 4. Monitoring of the corrective action to ensure deficient practice does not reoccur; Effective March 6, 2020, the Director of Nursing and/or the Minimal Data Set Coordinator will audit new admits and physician orders for residents receiving Plavix and verify correct coding on MDS. Audit will be conducted 5x per week for 4 weeks, then 3x per week for 2 months. The Director of Nursing will present results of audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance. The Administrator will oversee this process.	
F 689	Free of Accident Hazards/Supervision/Devices	F 689		3/11/20

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F 689 SS=J	Continued From page 12 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with the resident and staff and record review, the facility failed to secure a resident's wheelchair according to manufacturer's instructions resulting in the wheelchair moving during transport causing the resident to strike her head on the window in 1 of 2 resident sampled for facility van transport (Resident #11). The facility also failed to maintain a safe environment by utilizing electric drop cords, which were not Ground Fault Circuit Interceptor protected and had resident care equipment plugged into them, in two of eight areas reviewed for environment (Resident #35's room and the Dining Room), not covering glass fluorescent light tubes in three of four areas reviewed for protected lighting (dining room, 100 Hall, and 200 Hall), and failed to secure a package of disinfectant bleach wipes for 1 of 3 wound care observations. Immediate Jeopardy began on 1/30/20 when Resident #11 was not secured in her wheelchair according to manufacturer's instructions while being transported in the facility's transport van and she hit her head on a van window. Immediate Jeopardy was removed on 02/07/20, the date of the facility's alleged removal of the immediate	F 689	1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident was assessed by the Director of nursing for injury. No injuries were noted on January 30th, 2020. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents that are transported by the facility are at risk for the deficient practice. All other residents on the van at the time Resident #11 hit her head had their securing checked by both the driver and the Activity assistant when the van stopped to respond to Resident #11. All wheelchairs were properly secured and residents who were seated had their seat belts secured. All were able to state that they had not hit or bumped anything or felt their chairs move. During investigation, the Regional Director of Clinical Services 1/30/20 interviewed each resident who	

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F 689	Continued From page 13 jeopardy, the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) for findings #2, #3, #4 and #5 to correct the deficient practice and to ensure monitoring systems put in place to remove the Immediate Jeopardy are effective. Findings included: 1. A review of the manufacturer's tie-down user instructions revealed all wheelchairs should be restrained with four tie-down hooks to the solid frame and the combination lap/shoulder belt should be attached to the rear tie-down pin connector. The manufacturer's tie-down user instructions further revealed the tie-downs should be fixed at approximately 45 degrees and properly tensioned by using the manual tension retractor knobs to take up additional webbing slack. A review of the Facility Transportation Vehicle Policy and Procedure dated 10/2018 revealed wheelchairs are faced forward, locked and secured at four points (two front and two back) such that the chair does not move from its parked position. Resident #11 was admitted to the facility on 8/26/19. A Quarterly Minimum Data Set (MDS) assessment dated 12/31/2019 revealed Resident #11 was cognitively intact and required no assistance with transfer to her wheelchair.	F 689	was on the van at the time and confirmed that each was fine, had not experienced anything like bumping or hitting or movement of their chairs or person 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Accordius Health Van Certifier is an employee of Accordius Health who was trained directly by the manufacturer's representative for the van and the Q-Straint, the securing device manufacturer, in proper techniques and strategies for safest securing, lift use and transport. All devices, seat belts and accessories used to properly secure the residents were evaluated for proper function and to assure the correct number and type of devices were available on 2/3/20 by the Accordius Health Van Certifier. All items were accounted for and in good working condition. The Maintenance Director of the Monroe facility was retrained by the Accordius Health Van Certifier on 2/3/2020. The Maintenance Director will utilize the transport safety education from Accordius Certifier to re-educate all future van drivers. Prior to a new driver being permitted to transport residents, that driver will undergo screening of age and driving history, be trained in proper securing through the Q-straint training series as well as 1:1 by the Maintenance Director, be required to provide a return	

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F 689	Continued From page 14 During an interview with Resident #11 on 2/10/2020 at 10:53 am she stated on 1/30/2020 during an activity outing she was not strapped into the van correctly, and when the Van Driver turned, her wheelchair moved and her head struck the window. Resident #11 stated during the incident she was afraid she would fall to the floor of the transport van but she remained in the wheelchair. During a follow up interview on 2/11/2020 at 4:25 pm Resident #11 stated she hit the right side of her head on the window when the van turned and the whole wheelchair turned to the right. Resident #11 stated she did not have a bruise or knot on her head, but she did have a headache and nausea that subsided by bedtime. An interview with the Van Driver on 2/11/2020 at 4:54 pm revealed she was scheduled to take several residents to an activity outing on 1/30/2020 for lunch at a restaurant. The Van Driver stated the Activity Director and Nurse Aide #1 accompanied her on the outing. The Van Driver stated she was rushed when she was loading the residents on the van and failed to place the front two manufacturer's tie-down on Resident #11's wheelchair. The Van Driver stated she had applied the two rear tie-downs to the chair and the chest/waist belt. The Van Driver stated she pulled out of the facility's parking lot and turned right, and as she got to the end of the road on an incline she heard a wheelchair moving and turned right into a business and applied the front two manufacturer's tie-downs to Resident #11's wheelchair. The Van Driver stated Resident #11 did not tell her she had hit her head and she stated she was okay. The Van Driver stated she texted her supervisor, the Maintenance Director,	F 689	demonstration of proper securing of all devices. New drivers will be trained by the Maintenance director in the utilization of the daily observation tool that requires the driver to inspect the vehicle and devices used for securing residents to ensure safe transports. 4. New drivers will be closely supervised with daily observation of securing techniques for a full week of transportation duties by the maintenance director and a determination will be made about continuing daily observation based on that assessment. Monitoring; Effective March 6, 2020 the maintenance director will observe securing of residents on both the facility van and contract transport 5 x week for 4 weeks then 3 x week for 2 months and report the results of observations to the Quality Assurance Performance Improvement Committee x3 months. The QAPI committee can make changes to ensure the facility remains in compliance. The Administrator will oversee this process. Met compliance on 02/13/2020. _____ _____ _____ 1. Corrective action accomplished for	

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F 689	Continued From page 15 and told him about the incident. A review of Resident #18's chart revealed he admitted to the facility on 11/30/18. A Quarterly Minimum Data Set (MDS)assessment dated 1/2/2020 revealed Resident #18 was cognitively intact. During an interview with Resident #18 on 2/12/2020 at 2:44 pm he stated he was positioned in his electric wheelchair to the left, front side of the van and could not see the lower half of Resident #11's wheelchair and did not know if the tie-downs were applied to Resident #11's wheelchair. Resident #18 stated he did hear a thump and looked back at Resident #11. He stated Resident #11's wheelchair was turned almost on two wheels with the front of the chair toward the window. He stated Resident #11 stated she had hit her head when the incident happened. Resident #18 stated the Van Driver pulled into a parking lot and placed the tie downs (Qstraints) on Resident #11's wheelchair. Resident #18 stated they continued to the restaurant. Resident #18 stated his electric wheelchair was strapped down properly by the Van Driver when he was loaded on the van. A Transport Driver Skills Assessment for the Van Driver on 12/10/2019 revealed she had passed all skills needed to transport residents including viewing of the vehicle tie-down video and demonstration of how to use wheelchair (Qstraint) tie-downs correctly. An interview with Nurse Aide #1 on 2/13/2020 at 10:01 am revealed she was sitting in the front passenger's seat of the van when she heard a wheelchair moving around in the back of the van.	F 689	those residents found to have been affected by the deficient practice; On February 13, 2020 the electric cords were removed from resident #35□s room and the dining room, on February 13, 2020 the fluorescent light bulbs were replaced and covered with protective sleeve in the dining room, and on the 100 and 200 halls, and the bleach wipes were secured upon notification on February 12, 2020. 2. Identify other residents who have the potential to be affected by the deficient practice and the actions taken; On March the 6, 2020 the Maintenance Director completed a visual audit in 100% residents rooms and resident care areas to remove all electrical cords that were not ground fault circuit interceptor No other electrical cords were observed. On March 6, 2020 the maintenance Director completed a visual audit in 100% resident care areas to identify uncovered exposed fluorescent light tubes. No other exposed light tubes were observed. On March 6, 2020 a 100% visual audit was conducted by the Assistant Director of Nursing to identify any inappropriate storage of bleach wipes. None were identified. 3. Measures put into place or systemic changes On March 6, 2020 Current staff including licensed nurses, certified nursing assistants, housekeeping staff, dietary staff and rehabilitation staff will be re-educated by the licensed nursing home administrator on the use of electric drop cords and securing bleach wipes. New hires will be educated upon hire. On March 6, 2020 the Maintenance	

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F 689	Continued From page 16 Nurse Aide #1 stated the Activity Director stated Resident #11 was not strapped down, but she was not able to see Resident #11 from where she was sitting. On 2/11/2020 at 3:37 pm the Activity Director was interviewed. She stated she was sitting directly in front of Resident #11 during the activity outing and did not see her roll about in the van but did hear her roll about in the van when the van went into a curve less than a mile from the facility. The Activity Director stated she told the Van Driver Resident #11 was not secured. The Activity Director stated the Van Driver pulled over and applied the two restraints to the front of Resident #11's wheelchair. The Activity Director stated Resident #11 did not state she hit her head on the window until they arrived at the restaurant. The Activity Director stated she called the Administrator and reported the incident when it happened. The Activity Director stated Resident #11 stated she was nauseous at the restaurant but she refused to leave. The Activity Director stated the Director of Nursing came to the restaurant and encouraged Resident #11 to go to the Emergency Room to be evaluated but she refused, but she did agree to return to the facility. An interview with the Director of Nursing on 2/11/2020 at 2:49 pm revealed Resident #11 had bumped her head on the window but no one else witnessed Resident #11's head hitting the window. The Director of Nursing stated Resident #11 was not strapped into the van correctly and the Van Driver was suspended and terminated after the incident was investigated by the Administrator. The Director of Nursing stated the Activity Director was present on the facility's van when the incident happened, and she had	F 689	director was re-educated by the administrator on how to conduct daily facility rounds to include looking at lights and monitoring for electric drop cords 4. Monitoring of the corrected actions to ensure the deficient practice does not reoccur; Facility environmental rounds will be completed by the maintenance director beginning March 6, 2020 by using a formal round sheet that includes monitoring light bulbs and electric drop cords. This auditing will be completed 5xper week for 4 weeks, then 3xper week for 2months. The Maintenance director will report results of audit to the Quality Assurance Performance Improvement Committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance. Beginning March 6, 2020The director of nursing will complete visual audits of wound care 5xper week for 4 weeks then 3xper week for 2 months to ensure bleach wipes are secure. The Director of Nursing will present results of audit monthly x3 months to the Quality Assurance Performance Improvement Committee. The QAPI committee can make changes to ensure the facility remains in compliance. The administrator will oversee this process.	

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reported the incident to the Administrator.
On 2/11/2020 at 3:48 pm an interview with the Administrator revealed he had received a call from the Activity Director on 1/30/2020 and she reported Resident #11 had not been secured during transport to the activity at the restaurant.

During a follow up interview with the Administrator on 2/12/2020 at 9:45 am he stated the Van Driver was suspended immediately and terminated after the investigation regarding Resident #11 not being transported properly. The Administrator stated they had not hired another van driver. The Administrator stated they had used a transport company to transport the facility's residents since the incident happened. The Administrator stated the contract company trained and monitored their drivers per their own policies.
On 2/13/2020 at 3:27 pm the Administrator stated the Van Driver should have followed the facility's policy and the education she had been given on locking Resident #11's wheelchair down and ensuring she was protected from accidents.

An observation of the facility's transport van on 2/12/2020 at 2:31 pm revealed the tie-downs were in working order. During the observation the Maintenance Director placed a wheelchair on the right, posterior side of the van, where Resident #11 was positioned on 1/30/2020, and locked it into place with four manufacturer tie-downs per the van company's directions. The wheelchair remained in place when pushed back and forward and to each side. The two front manufacturer tie-downs were removed and the wheelchair was pushed back and forward, and to each side and did not move.

The Administrator was notified of the Immediate

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F 689	Continued From page 18 Jeopardy (IJ) on 02/12/2020 at 5:05 pm. On 02/13/2020 at 2:17 pm, the facility provided the following Credible Allegation of Immediate Jeopardy Removal: Credible Allegation of Immediate Jeopardy removal for F689 - Free of Accidents Hazards/Supervision/Devices " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " The deficient practice of failing to prevent an accident occurred when a driver, trained and experienced in the transporting of residents, failed to follow the proper policy and procedures for safely securing the resident while transporting, including the proper management of fastening wheelchairs to facility van using straps. " On January 30th while Resident #11 was being transported on the facility van to an outing, she hit her head on window due to driver failure to fasten front straps of resident wheelchair to the floor. Wheelchair straps were secure on the back of wheelchairs and the shoulder strap but not the front of resident #11's wheelchair. This failure to follow both facility safety transport policy and the manufacturers' safety recommendations, resulted in the resident's bumping her head on the window. The resident was assessed for injuries with no apparent injuries. " An analysis of the incident was initiated immediately by the Administrator and the Regional Director of Clinical Services and the Regional Director of Operations and included a re-enactment of the driver's account of what transpired (Driver attributed the incident of the resident hitting her head on the window to her	F 689		

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forgetting to fasten anchorages to floor) and gathering statements from all staff members/ residents who were on van during transport to restaurant. There was a total of 6 people present on van during incident.

" Equipment failure/malfunction was not a cause of the incident. The incident was due to driver improper fastening of floor straps to wheelchair.

" Upon completion of statements and reenactment on 1/30/20, the driver was immediately removed from all duties and responsibility and was sent home until facility investigation.

" Family of resident #11 was notified, along with the Medical Director by the Director of Nursing.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

" All other residents on the van at the time Resident #11 hit her head had their securing checked by both the driver and the Activity assistant when the van stopped to respond to Resident #11. All wheelchairs were properly secured and residents who were seated had their seat belts secured. All were able to state that they had not hit or bumped anything or felt their chairs move. During investigation, the Regional Director of Clinical Services 1/30/20 interviewed each resident who was on the van at the time and confirmed that each was fine, had not experienced anything like bumping or hitting or movement of their chairs or person.

" Address what measures will be put into place or systemic changes made to ensure that the

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F 689	Continued From page 20 deficient practice will not recur; " The facility van was taken immediately upon return on 1/30/20 out of service until all retraining and confirmation of van and equipment integrity are confirmed removing the risk for residents and preventing any further incidents. As of 2/12/20, the van remains out of service. " A commercial medical transporter has provided resident transportation in place of the facility van since the accident occurred on 1/30/20. " The Accordius Health Van Certifier examined the van for potential malfunction and certified it to be properly operating on 2/3/20. The van was not operated with residents on board and has not been used to transport residents since 1/30/20. The Accordius Health Van Certifier is an employee of Accordius Health who was trained directly by the manufacturer's representative for the van and the Q-Straint, the securing device manufacturer, in proper techniques and strategies for safest securing, lift use and transport. " All devices, seat belts and accessories used to properly secure the residents were evaluated for proper function and to assure the correct number and type of devices were available on 2/3/20 by the Accordius Health Van Certifier. All items were accounted for and in good working condition. " The conclusion of the Accordius Health Van Certifier was that equipment failure/malfunction was not a factor in the incident. The incident was due entirely to the driver failing to secure the front two wheels of Resident #11's wheelchair to the floor. " The Maintenance Director of the Monroe	F 689		

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F 689	Continued From page 21 facility was retrained by the Accordius Health Van Certifier on 2/3/2020. " The Maintenance Director will utilize the transport safety education from Accordius Certifier to re-educate all future van drivers. " Prior to a new driver being permitted to transport residents, that driver will undergo screening of age and driving history, be trained in proper securing through the Q-straint training series as well as 1:1 by the Maintenance Director, be required to provide a return demonstration of proper securing. Be trained in the daily observation tool that requires the driver to inspect the vehicle and devices used for securing residents. " New drivers will be closely supervised with daily observation of securing techniques for a full week of transportation duties and a determination will be made about continuing daily observation based on that assessment. " When the van is placed back in service, Activity staff will also be trained in properly securing residents in the van. The removal of the Immediate Jeopardy was determined as of 2/7/2020, the date facility's alleged removal of the immediate jeopardy. Validation of the credible allegation of removal: A review on 2/13/2020 of the plan to ensure those affected by the deficient practice revealed the facility had investigated regarding the failure to prevent an accident that occurred when the facility's Van Driver failed to place two tie-down straps to the front of Resident #11's wheelchair on 1/30/2020 causing the resident 's chair to move and Resident #11 to strike her head on the window of the van. The facility immediately	F 689		

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investigated the incident by re-enacting the accident and ensuring there was no faulty equipment. The facility also suspended and later terminated the Van Driver. The facility put systemic changes into place to ensure the deficient practice would not recur. The transport van was taken out of service until a Van Driver could be hired and trained. The training of Van Drivers was evaluated and improvements were made to the education. The facility hired a contract transport company to ensure residents would be able to meet their scheduled appointments. The facility also monitored the contract transport staff for appropriate securing of residents to ensure no further incidents. The Administrator stated he would bring the auditing of the securing of residents in the contracted transport van and the auditing of the facility's transport van to QAPI for three months or longer until compliance is met.

2. An observation conducted of room 104 on 2/10/20 at 9:56 AM revealed Resident #35 was in bed. It was also observed that an electric drop cord reel was behind the resident ' s bedside table which had 4 outlets and had the following devices plugged into it: an air Compressor, nebulizer, and bed. The drop cord was plugged into a wall outlet behind the bedside table. Observations of the drop cord revealed it did not specify that it was Ground Fault Circuit Interceptor (GFCI) cord.

A second observation conducted of room 104 on 2/11/20 at 10:41 AM revealed Resident #35 was in bed. An electric drop cord reel was observed behind the resident ' s bedside table which had 4 outlets and had the following devices plugged into it: an air compressor, nebulizer, and bed. The

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drop cord was plugged into a wall outlet behind the bedside table. Observations of the drop cord revealed it did not specify that it was a GFCI protected cord.

A third observation conducted of room 104 on 2/12/20 at 9:12 AM revealed Resident #35 was in bed. An electric drop cord reel was observed behind the resident ' s bedside table which had 4 outlets and had the following devices plugged into it: an air Compressor, nebulizer, and bed. The drop cord was plugged into a wall outlet behind the bedside table. Observations of the drop cord revealed it did not specify that it was a GFCI protected cord.

Observations made during an environmental round conducted in conjunction with an interview with the maintenance director (MD) on 2/12/20 which started at 4:05 PM revealed the MD was aware of the electric drop cord reel with four outlets was being utilized in Resident #35 ' s room and he did not believe it was a GFCI protected cord, but he stated would replace it with a GFCI power strip.

During an interview conducted on 2/13/20 at 3:35 PM with the Director of Nursing (DON) she stated the electrical drop cord reel in room 104 was put into use due to resident utilizing more electrical equipment and they do not typically use extension cords or drop cords.

3. An observation made during an environmental round conducted on 2/10/20, which started at 12:43 PM, revealed a non-GFCI electric drop cord with three outlets plugged into a wall outlet to the left of cabinet and counter in the dining room. There were two Universal Series Bus

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(USB) chargers plugged into two of the cord ' s outlets and an oxygen concentrator plugged into the cord ' s third outlet. The oxygen concentrator was observed to be running and there was no resident utilizing the running oxygen concentrator.

A second observation made during an environment round conducted on 2/11/20, which started at 12:56 PM, revealed a non-GFCI electric drop cord with three outlets plugged into a wall outlet to the left of cabinet and counter in the dining room. There were two USB chargers plugged into two of the cord ' s outlets and an oxygen concentrator plugged into the third outlet. The oxygen concentrator was observed to be running and there was no resident utilizing the running oxygen concentrator.

Observations made during an environment round conducted in conjunction with an interview with the maintenance director (MD) on 2/12/20 which started at 4:05 PM revealed a non-GFCI electric drop cord with three outlets plugged into a wall outlet to the left of cabinet and counter in the dining room. There were two USB chargers plugged into two of the cord ' s outlets and an oxygen concentrator plugged into the cord ' s third outlet. The oxygen concentrator was observed to be running and there was no resident utilizing the running oxygen concentrator. The MD stated he believed the three outlet drop cord in the dining room was OK to use for an oxygen concentrator and other devices plugged into the drop cord. The MD further stated he was aware it was not GFCI protected. He stated he had purchased it for one of the residents who was utilizing it for his items, including charging a computer tablet, and charging a cellular phone. The additional outlets provided the extra plugs

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needed to charge the resident ' s personal items.

During an interview conducted on 2/13/20 at 3:48 PM with the Administrator he stated would replace the non-GFCI drop cords with a GFCI protected electrical device.

4. Observations made during an environmental round conducted on 2/10/20 which started at 12:43 PM revealed no cover and exposed glass fluorescent light tubes in ceiling lights at the following areas: between rooms 103 and 104, between rooms 209 and 21, between rooms 213 and 214, and in the dining room to the left of the main entrance.

Observations made during an environmental round conducted on 2/11/20 which started at 12:56 PM revealed no cover and exposed glass fluorescent light tubes in ceiling lights at the following areas: between rooms 103 and 104, between rooms 209 and 21, between rooms 213 and 214, and in the dining room to the left of the main entrance.

Observations made during an environmental round conducted in conjunction with an interview with the Maintenance Director (MD) on 2/12/20 which started at 4:05 PM revealed no cover and exposed glass fluorescent light tubes in ceiling lights at the following areas: between rooms 103 and 104, between rooms 209 and 21, between rooms 213 and 214, and in the dining room to the left of the main entrance. The MD stated the light fixtures in the facility were in the process of being replaced as part of a renovation. The MD stated he was unaware the fluorescent light tubes were not covered and the lights needed to be covered with plastic sleeves. The MD further stated he

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would apply protective plastic sleeves to the fluorescent lights.

During an interview conducted on 2/13/20 at 3:48 PM with the Administrator he stated they were in the process of remodeling and the light fixtures were going to be replaced but until the light fixtures were replaced, he expected the fluorescent light bulbs to be protected.

5. The packaging for the disinfectant bleach wipes that were used by the facility was reviewed and read in part: "Active ingredient: sodium hypochlorite (bleach) 0.65%" and "causes moderate eye irritation; avoid contact with eyes; wash [hands] thoroughly with soap and water after handling".

Observation of the 200 hallway on 2/12/2020 at 9:12 AM revealed numerous residents were noted to use the hallway. Disoriented residents were observed to self-propel or ambulate on the 200 hallway.

Observations of the Assistant Director of Nurses (ADON) on 2/12/2020 at 9:12 AM revealed she used disinfectant wipes on the wound treatment tray prior to providing Resident #24's wound care and placed the container of disinfectant bleach wipes on the top of the treatment cart which was on the 200 hallway. The ADON was observed at 9:18 AM to enter Resident #24's room and to leave the disinfectant wipes unattended on top of the treatment cart.

Wound care for Resident #24 was observed on 2/12/2020 from 9:18 AM until 10:10 AM. The container of disinfectant bleach wipes remained unattended on the top of the treatment cart that was in the 200 hallway for the duration of the

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F 689	Continued From page 27 wound care provided for Resident #24. Observation of the 200 hallway on 2/12/2020 at 10:30 AM revealed numerous residents were noted to be on the hallway. Disoriented residents were observed to self-propel or ambulate in the hallway. The ADON was interviewed on 2/12/2020 at 10:53 AM. The ADON reported she was not aware she had left the container of disinfectant bleach wipes on top of the treatment cart, and she usually locked them up in the treatment cart. The ADON reported there were many confused and ambulatory residents on the hallway who wander, as well as alert and oriented residents who use the hallway frequently. The ADON reported the disinfectant bleach wipes could cause skin irritation if used on the skin. The Director of Nursing (DON) was interviewed on 2/13/2020 at 3:34 PM. The DON reported she had assisted the ADON with wound care in the past and had not noticed any issues with leaving the bleach disinfectant wipes unlocked. The DON reported the ADON was responsible for training staff. The DON reported it was her expectation the ADON followed proper procedures and locked up potentially harmful chemicals.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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	F 693		3/11/20

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F 693	Continued From page 28 ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to keep a resident ' s head elevated or stop a tube feeding from infusing during wound care for 1 of 2 residents reviewed for tube feeding (Resident #15). Findings included: Resident #15 was admitted to the facility on 1/11/2017 with diagnoses to include cerebral vascular accident (stroke), gastrostomy (feeding tube) and hypertension. The most recent quarterly Minimum Data Set assessment dated 2/3/2020 assessed Resident #15 to have a feeding tube and to receive 51% or more calories from the tube feeding. Resident #15 ' s current plan of care, which was most recently reviewed on 2/3/2020 addressed the tube feeding with an intervention to elevate the head of the bed 30-45 degrees during	F 693	1. Corrective action accomplished for those residents found to have been affected by the deficient practice. Related to resident # 15 it was immediately corrected when bought to our attention. 2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken. The 3 residents in the facility receiving Enteral Nutrition are at risk for the same deficient practice therefore on 03/10/2020 The Assistant Director of Nursing was re-educated by the Director of Nursing on the facility□s policy on administering enteral nutrition and to always place the tube feeding on hold/pause when the head of bed is lowered. 3. Measure/ systemic changes put in place to ensure the deficient practice does not reoccur; Effective March 6, 2020 the Director of Nursing educated all licensed	

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F 693	Continued From page 29 feedings. A physician order for Resident #15 dated 11/29/2018 ordered for the head of the bed to be elevated to 60 degrees during the day. A physician order for Resident #15 dated 1/20/2020 ordered the tube feeding to infuse by gastrostomy tube at 75 milliliters (ml) per hour from noon until 10:00 AM (on hold from 10:00 AM to noon daily). Resident #15 was observed on 2/11/2020 at 9:02 AM receiving wound care by the Assistant Director of Nursing (ADON) and the Nurse Practitioner (NP). The tube feeding was noted to be infusing at 75 ml/hour and Resident #15 ' s head of the bed was flat during the wound care. The wound care was completed and Resident #15 was repositioned in bed and the head of the bed was elevated to 60 degrees. The ADON was interviewed on 2/11/2020 at 10:53 AM and she reported she had thought the NP had paused the feeding prior to the wound care. The ADON reported she should have checked to make certain the tube feeding was paused while Resident #15 ' s head was laying flat. An interview was conducted with the Director of Nursing (DON) on 2/13/2020 at 3:34 PM. The DON reported she had not observed any nurse not pausing the tube feeding when a resident ' s head of the bed was lowered. The DON reported it was her expectation that if a resident was receiving tube feedings, the feeding was paused when the head of the bed was lowered flat for care.	F 693	and certified nursing staff on the facility □s policy of administering enteral nutrition and to place the tube feeding on hold if lowering of the bed is required while providing care. New hires will receive education upon hire. 4. Monitoring of the corrective action to ensure the deficient practice will not reoccur; Effective March 6, 2020, the Director of Nursing and/or the Assistant Director of nursing will conduct random audits to verify that residents receiving enteral nutrition (Tube feeding) the tube feeding is being placed on hold/ pause when the head of the bed is lowered while providing care. This auditing will be conducted 5xper for 4 weeks and then 3x per week for 2 months. The Director of Nursing will present the results of this audit to the Quality Assurance Performance Improvement Committee monthly for 3 months. The QAPI committee can make changes to ensure the facility remains in compliance. The administrator will oversee this process.	

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F 693	Continued From page 30 The Administrator was interviewed on 2/13/2020 at 4:11 PM. The Administrator reported he expected all nursing staff to follow the facility procedures for tube feeding.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, manufacturer ' s manual review, and staff interviews, the facility failed to clean respiratory equipment for 2 of 2 residents reviewed for respiratory care (Resident #35 and Resident #15). The findings included: 1. The manufacturer ' s operator ' s manual for the oxygen concentrator contained a Caring for your oxygen concentrator section. The manufacturer ' s recommended cleaning interval for cleaning the air filter located on the back of the unit was every 7 days. The manufacturer ' s operator ' s manual for the compressor utilized for the humidifier contained a Cleaning/Maintenance section. The	F 695	1. The corrective action will be accomplished for the residents found to have been affected by the deficient practice. On 2/13/20 the filters on the oxygen concentrators and compressors were removed and cleaned for residents #15 and #35. Nurse #1 was re-educated on providing oxygen therapy for residents and that the filters on the concentrators and the compressors must be cleaned weekly. This re-education was provided by the Director of Nursing on February 13, 2020 2. All eleven residents currently on oxygen therapy are at risk for the deficient practice having unclean concentrator filters. Completed on March 6, 2020 a 100% audit was performed by the Assistant Director of Nursing and/or the	3/11/20

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F 695	Continued From page 31 manufacturer ' s recommended cleaning interval for cleaning the filter was weekly. The instructions included to check the air inlet filters for dust buildup. If dust buildup were to occur, the air filters were to be removed and washed in warm soapy water. The instructions contained a section titled, "Caution," and stated "Excessive dust buildup on filter will reduce performance of compressor. If this occurs, clean or replace with a new filter." Resident #35 was readmitted to the facility on 1/17/20. The resident ' s cumulative diagnoses included: persistent vegetative state, traumatic brain injury, chronic respiratory failure with hypoxia, tracheostomy status, congestive heart failure, acute and chronic respiratory failure. Review of Resident #35 ' s most recent Minimum Data Set assessments revealed a quarterly assessment with an Assessment Reference Date of 1/24/20. Review of the assessment revealed the resident was coded as having severe cognitive loss and was coded as having received oxygen therapy, suctioning, and tracheostomy (a hole in the neck utilized for breathing) care at the facility. Resident #35 ' s Medication Administration Record (MAR) for 2/1/20 through 2/10/20 was reviewed. The review revealed the resident had an order, dated 11/27/19, to receive continuous oxygen via a tracheostomy (T) collar at 35% every shift. The administration of the oxygen was signed by the nurse for the reviewed period. An observation conducted in the room of Resident #35, on 2/10/20 at 9:56 AM, revealed the oxygen concentrator in operation and the	F 695	Director of Nursing identifying residents currently on oxygen therapy. Oxygen concentrators and compressor filters were observed for cleanliness. Those found not to be clean were removed, cleaned, and placed back in use for oxygen concentrator and compressors. All eleven residents had orders created on the Medication Administration Record for weekly cleaning of oxygen concentrator and compressor filters. 3. The following measures were put in place as of March 6, 2020 to ensure the Plan of Correction is effective and remains in compliance. All Licensed Nursing staff were re-educated by the Director of Nursing and/or the Assistant Director of Nursing to ensure all residents who require oxygen therapy are provided the necessary services needed to maintain and receive oxygen in accordance with the physician order by ensuring the concentrator and compressor filters are clean and free of whitish gray dusty debris. An order must be placed on Medication Administration Record or Treatment Administration Record to clean the oxygen concentrator and compressor filters weekly. New hire will be educated upon hire. 4. Monitoring: Beginning March 6, 2020, the Assistant Director of Nursing and/or the Director of nursing will audit 5 residents daily requiring oxygen therapy to verify the oxygen concentrators and compressors filters are clean. This audit will occur 5x weekly for 4 weeks, then 3 times weekly for 2 months. The results of audits will be discussed monthly in the	

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F 695	Continued From page 32 resident was wearing a T collar connected to the oxygen concentrator and the compressor while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the rear of the machine. Further observation revealed the compressor had a larger filter and a smaller filter at the rear of the machine which was observed to have a buildup of whitish/gray dust and debris on each of the filters. A sticker was observed with arrows pointing at each filter with the following, "Clean Filters Weekly." A second observation conducted in the room of Resident #35, on 2/11/20 at 10:41 AM, revealed the oxygen concentrator in operation and the resident was wearing a T collar connected to the oxygen concentrator and the compressor while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of whitish/gray dust and debris on the filter on the rear of the machine. Further observation revealed the compressor had a larger filter and a smaller filter at the rear of the machine which was observed to have a buildup of whitish/gray dust and debris on each of the filters. A sticker was observed with arrows pointing at each filter with the following, "Clean Filters Weekly." A third observation conducted in the room of Resident #35 in conjunction with an interview with Nurse #1, on 2/12/20 at 9:12 AM, revealed the oxygen concentrator in operation and the resident was wearing a T collar connected to the oxygen concentrator and the compressor while the resident was resting in bed. Closer observation of the oxygen concentrator revealed a buildup of	F 695	Quality Assurance and performance improvement committee meeting by the Director of Nursing for 3 months. The QAPI committee can make changes to plan to ensure facility compliance. The administrator will oversee this process.	

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whitish/gray dust and debris on the filter on the rear of the machine. Further observation revealed the compressor had a larger filter and a smaller filter at the rear of the machine which was observed to have a buildup of whitish/gray dust and debris on each of the filters. A sticker was observed with arrows pointing at each filter with the following, "Clean Filters Weekly." The nurse stated the night nurses were supposed to clean the filters on the oxygen concentrator and the compressor weekly. The nurse stated the filters on the oxygen concentrator and concentrators did not appear clean and needed to be cleaned. The nurse stated there was a sticker on the rear/top of the compressor, and it was written in red letters the filters for the compressor were to be cleaned weekly.

An interview with the Director of Nursing (DON) was conducted on 2/13/20 at 3:35 PM. The DON stated the filters on the oxygen concentrator and compressor should be clean and they should be cleaned weekly or when there is an accumulation of dust or debris. The DON clarified the filter could be cleaned by the nurses or by one of the respiratory therapists who come to the facility. The DON stated there was not a weekly sign off area for the nurses to sign off for the filters having been cleaned in the MAR or the Treatment Administration Record (TAR) but the DON stated it was her expectation for a nurse to clean the filters if they were observed to be in need of being cleaned, such as having dust and debris. The DON stated she believed if the nurses were prompted to check the filters such as when the oxygen tubing was changed weekly there would be no further issues.

An interview conducted on 2/13/20 at 3:48 PM

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F 695	Continued From page 34	F 695		

with the facility Administrator revealed his expectation was for the filters on the oxygen concentrators and the compressor to be cleaned according to manufacturer ' s guidelines.
2. Resident #15 was admitted to the facility on 1/11/2017 with diagnoses to include cerebral vascular accident (stroke), tracheostomy and hypertension. The most recent quarterly Minimum Data Set (MDS) dated 2/3/2020 assessment assessed Resident #15 to use oxygen.

A physician order dated 2/10/2020 ordered Resident #15 to receive oxygen by a tracheostomy at 2 liters per minute continuously. No physician order was in place to clean the oxygen concentrator filter.

Resident #15 was observed on 2/10/2020 at 10:17 AM. Resident #15 was observed wearing a tracheostomy collar and the oxygen was administered at 2 liters per minute by the tracheostomy collar. The oxygen concentrator was noted to have a filter that was covered in light grey, fluffy material that was imbedded in the filter.

An observation of Resident #15 was conducted on 2/11/2020 at 8:58 AM. Resident #15 was observed wearing a tracheostomy collar and the oxygen was administered at 2 liters per minute by the tracheostomy collar. The filter on the oxygen concentrator was noted to be covered with a light, fluffy, grey material that was imbedded in the filter.

An interview was conducted with Nurse #1 on 2/12/2020 at 9:12 AM. Nurse #1 reported the oxygen concentrators were supposed to be cleaned weekly on night shift.

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F 695	Continued From page 35 The Director of Nurses (DON) was interviewed on 2/13/2020 at 3:34 PM. The DON reported the oxygen concentrator filters should be cleaned weekly by night shift. The DON further reported she was not certain how the order to clean the oxygen concentrator filters was omitted for Resident #15. The DON reported it was her expectation that the oxygen concentrator filters were cleaned weekly.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		3/11/20

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F 732	Continued From page 36 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of required posted nursing staffing sheets revealed the facility failed to accurately post the facility's skilled nursing resident census information for 14 of 15 dates the daily staffing information was reviewed. Findings included: On 02/10/2020 at 10:01 AM an observation of a form titled SNF (Skilled Nursing Facility) Daily Staff Posting that was posted in the hall across from the nurse station revealed that the facility census was 49 residents. On 02/10/2020 at 4:30 PM the facility administrator informed the survey team that the census of skilled nursing residents in the facility was 47 not 49 as recorded on the daily staff posting form which included 2 Home for the Aged (HA) residents that currently resided in the facility. The facility's SNF daily nursing staff forms from 1/30/2020 to 2/11/2020 revealed the following resident census information:	F 732	1. Corrective action accomplished for those residents found to have been affected by the deficient practice: 14 of the 15 daily nurse staffing sheets were corrected to accurately reflect census on 02/12/2020. 2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken: Director of Nursing went back 30 days from 02/01/2020 to correct census on each daily nurse staffing sheet. 3. Measure / systemic changes put in place to ensure the deficient practice will not reoccur; The Director of Nursing was educated by the state surveyor on 02/12/2020 on how to write the daily nursing staffing sheets. Regional Clinical Nurse Consultant informed Director of Nursing on 03/09/2020 on how to write the daily nurse staffing sheet. Rn Supervisor, Medical Records were educated on 03/11/2020 by the Director of Nursing on how to fill out properly the Daily Staffing sheet. 4. Monitoring of the corrected action to	

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F 732	Continued From page 37 The SNF Daily Staff Posting form dated 01/30/2020 specified the posted census was 42 residents. The SNF Daily Staff Posting form dated 01/31/2020 specified the posted census was 41 residents. The SNF Daily Staff Posting form dated 02/01/2020 specified the posted census was 43 residents. The SNF Daily Staff Posting form dated 02/02/2020 specified the posted census was 44 residents. The SNF Daily Staff Posting form dated 02/03/2020 specified the posted census was 44 residents. The SNF Daily Staff Posting form dated 02/04/2020 specified the posted census was 44 residents. The SNF Daily Staff Posting form dated 02/05/2020 specified the posted census was 44 residents. The SNF Daily Staff Posting form dated 02/06/2020 specified the posted census was 44 residents. The SNF Daily Staff Posting form dated 02/07/2020 specified the posted census was 46 residents. The SNF Daily Staff Posting form dated 02/08/2020 specified the posted census was 50 residents.	F 732	ensure deficient practice will not reoccur; Beginning 03/09/2020 The Administrator will audit daily nurse staffing sheet weekly for 4 weeks, then monthly thereafter for compliance with correct census on form. The Administrator will ensure staff compliance with POC monthly in monthly Quality Assurance Performance Improvement meeting.	

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The SNF Daily Staff Posting form dated 02/09/2020 specified the posted census was 50 residents.

The SNF Daily Staff Posting form dated 02/09/2020 specified the posted census was 50 residents.

The SNF Daily Staff Posting form dated 02/10/2020 specified the posted census was 49 residents.

The SNF Daily Staff Posting form dated 02/11/2020 specified the posted census was 49 residents.

Observations on 02/12/2020 at 08:35 AM revealed the facility census was posted on the wall across from the nurse station was 49 residents. The facility administrator and assistant director of nurses (ADON) were present and confirmed that the posted SNF resident census of 49 was correctly recorded on the form.

An interview with the Director of Nurses (DON) conducted on 02/12/2020 at 2:57 PM revealed she completed the SNF Daily Staff Posting form since she became the DON at the beginning of December of 2019. The DON revealed that she had not received any education about completing the staffing form. The DON stated the census on the daily staffing forms reviewed from 1/30/2019 to 2/11/2020 were incorrect because when she filled out the forms, she included the resident census in both the facility skilled nursing beds and the the combined census of both the residents in the skilled nursing beds and the facility's HA beds. The DON also revealed that

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F 732	Continued From page 39 the facility census number was not changed or updated on the posted form to reflect any census changes in the facility during the 24-hour time frame that the form was posted. The DON revealed that when she completed the form each morning, she updated the facility census that combined the skilled nursing resident census and the HA resident census present in the facility at the time she posted the form. The DON stated she was not aware the HA resident census should not be included in the resident census on the SNF staffing form. On 02/13/2020 at 2:49 PM an interview with the facility administrator revealed that he expected the posted daily nursing staffing staff forms reflect the correct skilled nursing resident census number and that the HA resident census not be recorded with the skilled nursing resident census.	F 732		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		3/11/20

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F 757	Continued From page 40 consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow the physician orders to obtain the blood test for a weekly Vancomycin trough level for antibiotic level monitoring or follow the order to fax trough results for dose adjustments to the Infectious Disease physician in 2 of 2 orders reviewed for 1 of 1 resident (Resident #295). Findings included: Resident# 295 was admitted on 2/6/20 for 6 weeks of intravenous(IV) antibiotics. Her diagnoses included pneumonia, methicillin-resistant Staphylococcus aureus(MRSA) and bacteremia. A review of the medical record was conducted. Physician orders were written on 2/7/20 for a weekly Vancomycin trough level to be drawn every Monday, beginning on 2/10/20. There was also an order that the results were to be faxed to the Infectious Disease Specialist. An interview with the Director of Nursing(DON) was done on 2/12/20 at 11:14 AM which followed the surveyor's request for the Vancomycin trough results. The DON stated that after some investigation she realized the order was never entered in the electronic medical record system for the lab work to be completed. She stated she had spoken with the Medical Director about the omission and the physician reordered the test to be done the following day on 2/13/20.	F 757	1. Corrective action accomplished for those affected by deficient practice. For resident #295 an order was obtained to draw a Vancomycin trough on February 13, 2020. With results called on February 13, 2020. 2. Identify other residents who have the potential to be affected by the same deficient practice. All residents receiving vancomycin IV are at risk. At this time no other residents are receiving Vancomycin IV. 3. Measure/Systemic changes put in place to ensure the deficient practice does not reoccur; Effective March the 6, 2020 Physician orders and new admits will be reviewed each morning during clinical morning meeting to follow up on labs that have been ordered. The Director of Nursing and/or the Assistant Director of Nursing will verify that the order was put in the computer, and the physician was notified of results. Effective March 6, 2020 the licensed nursing staff were re-educated by the Director of Nursing and/or the Assistant Director of Nursing on following physician orders regarding drawing labs and calling the results to the physician, entering labs orders in the computer. 4. Monitoring of the corrective action to	

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F 757	Continued From page 41 On 2/13/20 at 4:03 PM a phone interview was conducted with the Nurse Practitioner(NP) regarding the vancomycin level not being drawn on Monday 2/10/20 as ordered. The NP stated the vancomycin level is important to be drawn when ordered to determine the antibiotic level so it could be adjusted if needed based on the resident's kidney function. She stated the medication could be toxic. She stated this was an important indicator due to the toxicity and the vancomycin dose would be adjusted based on the blood level. On 2/13/20 at 2:14 PM an interview with the DON was done regarding the orders for the Vancomycin level and the physician notification not being completed. She stated the orders did not get entered into their computer system and she would be following up with her staff to correct the problem.	F 757	ensure the deficient practice does not reoccur; Effective March 6, 2020, the Director of Nursing and/or the Assistant Director of Nursing will audit new admission orders and new orders for labs to be to be drawn and results called to the physician. This audit will be conducted 5xper week for 4 weeks, and then 3x per week for 2 months. The Director of nursing will present the findings of this audit to the monthly Quality Assurance Performance Improvement Committee monthly x3 months. The QAPI committee can make changes to ensure the facility remains in compliance. The administrator will oversee this process.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff, family member, and resident interviews, observations, and record review the facility failed to ensure a resident's medication was available that was ordered for nerve pain in 1 of 6 residents reviewed for unnecessary medication (Resident #27). Findings included: Resident #27 admitted to the facility on 4/10/18	F 760	1. Corrective action accomplished for those residents found to have been affected by the deficient practice. For resident #27 the physician was notified on February 10, 2020 that Pregabalin 100mg was not available, an order was sent to pharmacy and the medication was sent for administration on February 10, 2020. On February 13, 2020 the Director of Nursing re-educated the Assistant	3/11/20

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F 760	Continued From page 42 with diagnoses of spinal stenosis and cervical disc disorder. A Quarterly Minimum Data Set (MDS) assessment dated 1/15/2020 revealed Resident #27 was cognitively intact. The MDS assessment further revealed Resident #27 had complained of moderate pain occasionally. A physician's order dated 6/11/2019 stated Resident #27 should receive Pregabalin 100 milligrams by mouth three times a day for cervical disc disorder. A review of the physician's orders revealed Resident #27 had an order for Hydrocodone-Acetaminophen Tablet 7.5-325 milligrams one tablet by mouth every 6 hours as needed for pain which was ordered on 8/1/2019. Resident #27's Medication Administration Record for February 2020 revealed Resident #27 was given Hydrocodone -Acetaminophen Tablet 7.5-325 milligrams one tablet at 7:15 pm on 2/10/2020. On 2/11/2020 at 11:45 am an interview with Resident #27 revealed she had not received an ordered medication for nerve pain, Pregabalin 100 milligrams, on 2/9/2020 at 9:00 pm. Resident stated the facility did not have the medication available and her legs had hurt that evening and the next day until the medication arrived at the facility and was administered. During an interview with the Assistant Director of Nursing on 2/11/2020 at 3:11 pm she stated she was the nurse that provided care for Resident #27 on 2/9/2020 on 3:00 am to 11:00 pm shift.	F 760	Director of Nursing on Notifying the physician when a medication is not available, obtaining an order to hold medication and/or to replace the medication with another until medication arrives from pharmacy. 2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken. All residents are at risk for deficient practice therefore a 100% MAR to Cart audit to verify medications are available as ordered was completed by pharmacy on March 9, 2020. 3. Measure/systemic changes put in place to ensure the deficient practice does not reoccur. Effective March 6, 2020 re-education was provided by the Director of Nursing and/or the Assistant Director of Nursing for all Licensed Nurses and Certified Medications Aides to re-order medications as indicated on the medication card, contact the physician if a hard script is needed, contact physician when a medication is not available, obtain an order to hold medication and/or replace with another medication until medication is available. Notify the Director of Nursing and/or the Assistant Director of Nursing when a medication is not available. New hires will receive education upon hire. 4. Monitoring of the corrected action to ensure the deficient practice will not reoccur; the Director of Nursing and/or the Assistant Director of Nursing will audit 5 residents Mar to Cart to verify that medications are available as ordered. The audit will be conducted 5xper week for 4	

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F 760	Continued From page 43 The Assistant Director of Nursing stated the Pregabalin 100 milligrams was not available for the 9:00 pm dose on 2/9/2020. The Assistant Director of Nursing stated she did not notify the physician regarding the Pregabalin 100 milligrams not being available on 2/9/2020. The Assistant Director of Nursing stated the physician was notified on Monday morning, 2/10/2020, the Pregabalin 100 milligrams was not available. The Assistant Director of Nursing stated Resident #27 did not complain of pain during the 3:00 pm to 11:00 pm shift on 2/10/2020. On 2/12/2020 at 8:39 am the Physician stated she was not made ware Resident #27 did not have Pregabalin 100 milligrams available until the morning of 2/10/2020. The Physician stated Resident #27 could have experienced pain from not receiving the Pregabalin 100 milligrams as ordered. During an interview with the Director of Nursing on 2/13/2020 at 3:17 pm she stated the Director of Nursing should have called the Physician regarding Resident #27's Pregabalin being unavailable. The Director of Nursing stated the Physician could have held the Pregabalin or given a different medication that was available for Resident #27's nerve pain.	F 760	weeks, then 3xper week for 2 months. The Director of Nursing will present results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance. The administrator will oversee this process.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		3/11/20

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F 761	Continued From page 44 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to secure of a container of antifungal powder for 1 of 3 wound care observations. Findings included: The 200 hallway was observed on 2/12/2020 at 9:12 AM and 10:30 AM. Numerous residents were noted to use the hallway. Disoriented residents were noted to self-propel or ambulate in the hallway. At the completion of wound care on Resident #24, the Assistant Director of Nursing (ADON) removed the equipment from Resident #24 ' s room, including a container of powdered antifungal medication. The ADON placed the	F 761	1. Corrective actions accomplished for those residents found to have been affected by deficient practice. On February 12, 2020 the unattended medication observed on the 200-hall treatment cart (Antifungal Medication) was removed immediately. On February 12, 2020 the Assistant Director of Nursing was re-educated on medication storage by the Director of Nursing. The education provided was do not leave medication unattended on top of the mediation or treatment carts 2. Identified other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken. All residents are at risk for deficient practice. By March 6,	

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F 761	Continued From page 45 antifungal powder on the top of the treatment cart and transported Resident #24 to an activity. The antifungal powder remained on top of the treatment cart in the 200 hallway from 10:10 AM until 10:32 AM. The ADON was interviewed on 2/12/2020 at 10:53 AM. The ADON reported she was not aware she had forgotten to lock up the antifungal powder. The ADON reported there were many confused and ambulatory residents on the hallway who wander, as well as alert and oriented residents who use the hallway frequently. The Director of Nursing (DON) was interviewed on 2/13/2020 at 3:34 PM. The DON reported she had assisted the ADON with wound care in the past and had not noticed any issues with locking up medications. The DON reported the ADON was responsible for training staff. The DON reported it was her expectation the ADON followed proper procedures and locked up medications after use.	F 761	2020 a complete observation of all resident care areas was observed for inappropriate storage of medication (unattended medication medications left on top of medication or treatment carts) and all inappropriately storing of medications in reach of any residents. This audit was completed by the Director of nursing and/or the Assistant Director of Nursing No other areas of concerns were observed. 3. Measures/ systemic changes put in place to ensure the deficient practice does not reoccur. Beginning March 6,2020, the Director of Nursing and /or the Assistant Director of Nursing re-educated the licensed nursing staff and the Certified Medication Aides on the proper medication storage process. All medications must be stored in a locked medication cart, treatment cart or medication room in all resident care areas when unattended, and only authorized personnel have access to the keys to the medication rooms, medication carts, and treatment carts. 4. Monitoring of corrected actions to ensure the deficient practice will not reoccur. To ensure that medications are properly stored and locked in the medication carts, treatment carts and/ or medication rooms when unattended. The Director of Nursing and/or the Assistant Director of will audit resident care areas 5x per week for 4 weeks and 3x per week for 2 months for compliance. The Director of Nursing will report findings of audits to the Quality Assurance Performance improvement committee meeting monthly	

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F 761	Continued From page 46	F 761	x3 months. The QAPI committee can make changes to ensure facility compliance of deficient practice. The administrator will oversee this process.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to label food in the nourishment room refrigerator with residents ' names for 1 of 1 nourishment room observed. Findings included: The facility policy Food Receiving and Storage dated 2001 and revised July 2014 was reviewed and it read, in part: "All foods belonging to the	F 812	1. Corrective action accomplished for those residents found to have been affected by the deficient practice: On February 13,2020 3 frozen meals, a box of pizza, a box of fast food biscuits, and ice cream were removed from the nourishment room refrigerator by the Assistant Director of Nursing. Items were not labeled with date or a resident□s name.	3/11/20

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F 812	Continued From page 47 residents must be labeled with the resident ' s name, the item and the ' use by ' date". 1. An observation of the nourishment room was completed on 2/12/2020 at 3:53 PM with Nurse #1. a. The freezer had three frozen meals with the date 2/10/2020 and without a resident name. b. A box of pizza was in the refrigerator with the date 2/11/2020 and without a resident name. c. A large box from a fast food restaurant with breakfast biscuits was in the refrigerator without a date or resident name. Nurse #1 was interviewed on 2/12/2020 at 3:53 PM and she reported the food in the refrigerator and freezer should be labeled with the date and the resident ' s name. Nurse #1 reported the box of biscuits was purchased for staff on 2/12/2020 and she was not certain why the box with the biscuits was in the resident ' s refrigerator. 2. An observation of the nourishment room on 2/13/2020 at 8:07 AM with the dietary manager (DM). a. A frozen meal was in the freezer dated 2/10/2020 but did not have a label with a resident ' s name. b. A container of ice cream wrapped in a plastic bag was without a date or a resident ' s name. The Dietary Manager (DM) was interviewed on 2/13/2020 at 8:07 AM and he reported the nourishment room was cleaned daily by the dietary staff. The DM reported that facility staff	F 812	2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken; On March 6, 2020 the Dietary Manager audited 100% of nourishment refrigerators for proper storage to include labeling with dates and residents□ names. No other food was identified. 3. Measure/ systemic changes put in place to ensure the deficient practice will not reoccur; Beginning March 6, the Administrator re-educated 100% of the dietary staff and 100% of nursing staff on the facility□s policy on Food Receiving and Storage. Food placed in the nourishment refrigerators must be properly labeled with resident□s name and must be dated. New hires will be educated upon hire. 4. Monitoring of the corrected action to ensure deficient practice will not reoccur; Beginning March 6,2020 the Dietary Manager began monitoring of the nourishment refrigerators for proper storage. The food stored in the residents□ nourishment refrigerator should be labeled with the resident□s name and must be dated. Audit will be conducted 5xper week for 4 weeks, then 3xper week for 2 months. The Dietary Manager will present results of audit to the Quality Assurance Performance Improvement Committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance. The administrator will oversee this process.	

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F 812	Continued From page 48 have a refrigerator in the breakroom for their food. An interview was conducted with the DM on 2/13/2020 at 2:43 PM and he reported he had dated the frozen meals on 2/10/2020 but did not label the food with a residents ' name. The DM reported he didn ' t know if the frozen meals were resident food or employee food. The DM further reported he did not know who put the pizza and the biscuits in the nourishment room refrigerator. The Director of Nursing (DON) was interviewed on 2/13/2020 at 3:34 PM. The DON reported staff had their own refrigerator in the breakroom. The DON reported she was not certain why the food in the nourishment room refrigerator was not labeled and dated. The DON was not certain why the pizza and biscuits were not put in the employee refrigerator. The Administrator was interviewed on 2/13/2020 at 4:14 PM. The Administrator reported the pizza was purchased on 2/11/2020 for lunch for the staff and the biscuits had been purchased on 2/12/2020. The Administrator reported he was not certain why the pizza and the biscuits were placed in the resident refrigerator in the nourishment room. The Administrator reported the food should have been dated and labeled and employee food should have been put in the employee refrigerator.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		3/11/20

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F 880	Continued From page 49	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other 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

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F 880	Continued From page 50 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 record review, observations and staff interviews, the facility failed to perform hand hygiene between residents receiving wound care, failed to remove gloves and perform hand hygiene between wounds on a resident with multiple wounds, placed wound care equipment on a tray that was still wet from disinfectant, placed the wound care tray on a wheelchair seat, used a pair of scissors to cut off a soiled wound dressing and did not sanitize the scissors before using on a roll of tape that was used for multiple residents for 2 of 3 residents reviewed for wound care (Resident #15 and #24). Findings included:	F 880	1. Corrective action accomplished for those residents found to have been affected by deficient practice. On February 13, 2020 the Director of Nursing re-educated the Assistant Director of nursing on the facility□s policy on hand hygiene and hand hygiene for wound care, sanitizing of wound care equipment and following the manufacture recommendations f for use of disinfectant for drying times. 2. Identify other residents who have the potential to be affected by deficient practice and what corrective actions were taken. All residents are at risk for deficient	

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F 880	Continued From page 51 The packaging for the disinfectant bleach wipes was reviewed and read in part: "Active ingredient: sodium hypochlorite (bleach) 0.65%" and "Apply [to surface], allow to dry; 30 second contact for bacteria and viruses, 1-minute contact for Candida albicans (a fungal skin infection)." The facility policy for hand hygiene dated 2001 and revised 8/2015 was reviewed and it read in part: "use an alcohol-based hand rub or soap and water for the following situations: before and after direct contact with residents ... before performing any non-surgical invasive procedures ...before handling clean or soiled dressings ... after handling used dressings, contaminated equipment ... after removing gloves ..." 1. Wound care was observed on 2/12/2020 at 9:07 AM for Resident #15. The Assistant Director of Nursing (ADON) assisted the Wound Care Nurse Practitioner (NP) to perform wound care. The ADON was noted to wear gloves during the wound care and she assisted the NP by holding Resident #15 on his side and handing the NP supplies. The NP was noted to complete the wound care on Resident #15 and the ADON removed her gloves, returned to the treatment cart and prepared for wound care for Resident #24. The ADON did not perform hand hygiene. A constant observation of the ADON was completed on 2/12/2020 from 9:12-9:18 AM during which time she went to the medication room and obtained a container of disinfectant bleach wipes. The ADON did not perform hand hygiene while in the medication room. The ADON used the disinfectant wipes on the	F 880	practice therefore all Licensed nurses and Certified Nursing Assistants were re-educated on the facility□s policy on Hand hygiene. All licensed nurses were re-educated on following Manufacture recommendations for drying times for a disinfectant, and properly sanitizing of wound care equipment. This re-education was provided by the Director of Nursing and/or the Assistant Director completed on March 9,2020 3. Measures/ systemic changes put in place to ensure deficient practice does not reoccur. The Director of Nursing and/or the Assistant Director of Nursing re-educated the all Licensed Nurses and the Certified Nursing Assistants on the facility□s Hand Hygiene policy and the licensed nurse on following the manufacture recommendations on drying times for a disinfectant, and proper sanitizing of wound care equipment. This education was completed on March 9, 2020. Education will be provided upon hire for new hires. 4. Monitoring of corrected action to ensure the deficient practice will not reoccur. Beginning March 9, 2020, the Director of Nursing will visually audit proper handwashing technique during dressing changes, following manufacture recommendations for proper drying time when using a disinfectant, and proper sanitizing of wound care equipment. This auditing will be conducted 5xper week for 4 weeks, then 3xper weeks for 2 months. The Director of Nursing will present results of audits to the Quality Assurance	

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F 880	Continued From page 52 wound treatment tray. The wound treatment tray was left to dry for less than a minute. 2. The ADON prepared the wound care equipment and placed on the still wet wound treatment tray, entered Resident #24 ' s room and placed the tray down onto the seat of his wheelchair. The ADON removed Resident #24 ' s wound dressing on the right leg using her scissors to cut away the dressing. The wound dressing was noted to be stained with a serous (light yellow) wound drainage and a slight foul odor was noted. The ADON placed the scissors in her pocket after cutting through the dressing. The ADON did not clean the scissors. The NP removed the dressings on Resident #24 ' s left leg. The ADON performed wound cleaning to Resident #24 ' s right leg and removed her gloves and applied clean gloves to cleanse the wounds on Resident #24 ' s left leg. The ADON did not perform hand hygiene. The ADON removed her gloves after cleaning the wounds on the left leg and foot and applied new gloves. The ADON did not perform hand hygiene. The ADON then applied a medicated antifungal cream to the right leg over open areas and then applied cream to the left leg over open areas without changing her gloves between the application to each leg. The ADON removed her gloves. The ADON did not perform hand hygiene. The ADON required additional tape for the wound care and she returned to the treatment cart and removed the scissors from her pocket and cut a	F 880	Performance Improvement Committee monthly for 3 months. The QAPI Committee can make changes to ensure the facility remains in compliance. The administrator will oversee this process.	

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F 880	Continued From page 53	F 880		

section of tape off with the scissors she had used to cut off the soiled wound dressing for Resident #24. The ADON did not sanitize the scissors prior to cutting the tape. The ADON returned to complete wound care on Resident #24 and reapplied her gloves. The ADON did not complete hand hygiene.

The ADON was interviewed on 2/12/2020 at 10:32 AM and she reported the disinfectant bleach wipes were used to clean equipment and after using, the equipment needed to air dry for 2 minutes.
The ADON was interviewed again on 2/12/2020 at 10:53 AM. The ADON reported the tape she used for Resident #24 ' s dressing was a multi-use tape she used on other residents. The ADON explained she usually had two pairs of scissors, one for dirty dressing removal and one for cutting clean dressings. The ADON reported she usually wrapped the dirty scissors in a disinfectant bleach wipe for 2 minutes, but she had forgotten. The ADON explained that scissors on her treatment cart were missing and she used the dirty scissors without thinking about it. The ADON reported she was not aware she had not performed hand hygiene after assisting with the wound care for Resident #15 and was not aware she had not performed hand hygiene during the wound care for Resident #24.
The Director of Nursing (DON) was interviewed on 2/13/2020 at 3:34 PM. The DON reported she had assisted the ADON with wound care in the past and had not noticed any issues with infection control, hand hygiene, or cleaning equipment. The DON reported the ADON had infection control in-services in the past year and was responsible for training employees in infection control. The DON reported it was her expectation

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F 880	Continued From page 54 the ADON followed proper procedures for wound care, including hand hygiene, and disinfecting equipment. An interview was conducted with the Administrator on 2/13/2020 at 4:11 PM. The Administrator reported he expected the ADON and all nurses to follow the facility policy on infection control.	F 880		