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	345403	A. BUILDING _____ B. WING _____	C 02/01/2021

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted 1/26/2021-2/01/2021. The survey team was onsite on 1/26/2021 and 1/27/2021. Additional information was obtained offsite on 1/28/2021, 1/29/2021, and 2/1/2021. Therefore the Exit Date was 2/1/2021. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# MG1611.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and Complaint Investigation were conducted 1/26/2021-2/01/2021. The survey team was onsite 1/26/2021 and 1/27/2021. Additional information was obtained offsite on 1/28/2021, 1/29/2021, and 2/1/2021. Therefore the exit date was 2/1/2021. The facility was found not be in compliance with CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# MG11611. 1 of 10 complaint allegations was substantitated resulting in a deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		2/20/21

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

Electronically Signed | 02/19/2021

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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement planned fall interventions for 1 of 2 residents sampled residents reviewed for falls. (Resident #2) Findings included: Resident #2 was admitted to the facility on 2/19/2020. His diagnoses included an anoxic (lack of oxygen) brain injury, aphasia (unable to speak), dysphagia (unable to swallow), cognitive communication deficit, generalized weakness and abnormalities of gait and mobility. The Fall Risk assessment dated 2/19/2020 revealed Resident #2 was considered low risk for falls. The admission Minimum Data Set Assessment (MDS) assessment dated 2/26/2020 revealed Resident #2 was non-verbal and severely mentally impaired. He required total assistance of one person with bed mobility and all activities of daily living. The MDS further revealed Resident #2 had a history of a fall the month prior to admission and was receiving occupational and physical therapy. A post fall risk evaluation was conducted on 4/28/2020, and Resident #2 was categorized as high risk for falls. The physical therapy summary dated 8/11/2020 revealed Resident 's #2 mobility and engagement in therapy was inconsistent, and he required maximum assistance with bed mobility and transfers.	F 689	Resident#2 was re- assessed on1/27/2021 by RN using at risk Fall Assessment. The interdisciplinary team reviewed the resident at risk fall assessment, falls for previous sixty days and current fall interventions to ensure that each were appropriate. The fall risk care plan was reviewed and updated to reflect the resident current fall interventions on 1/27/2021 by IDT –Interdisciplinary Team members- Director of Nursing, Assistant Director of Nursing, RN Unit Manager, RN MDS, and Director of Rehabilitation. The Interdisciplinary team (to include Director of Clinical services, Assistant Director of Nursing and MDS nurse) on 2/12/2021 reviewed resident's identified with fall last 60 days to ensure that residents fall interventions were appropriate and reflected on the resident at risk for falls care plans. The facility direct care staff to include agency staff (licensed nurses and nursing assistants) will be provided re- education regarding fall management policy to include ensuring that resident care planned fall interventions are in place. The re- education will also include the process to review the residents current fall inventions. Staff identified as not receiving the education will receive prior to working their next scheduled shift. The Director of Clinical Service /design will complete Quality Monitoring Review on five residents identified at risk for falls to ensure that appropriate fall	

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F 689	Continued From page 2 A quarterly MDS assessment dated 10/20/2020 revealed Resident #2 was verbal, usually understood and cognitively intact. He required extensive assistance of one person with bed mobility and was unable to stand without human assistance and required two persons assistance for transfers. The MDS further revealed Resident #2 had experienced two falls since his last re-admission on 9/9/20 with no injury and was receiving occupational and physical therapy. On 1/19/2021, Resident #2 was re-admitted to the facility to the COVID unit. On 1/19/2021, Resident #2 was assessed as being a high risk for falls. Resident #2 's care plan, reviewed by staff on 1/19/21 and in place on 01/26/21 and 1/27/21, revealed he was at a risk for falls and had experienced actual falls. The care plan's goal was to minimize Resident's #2 risk for falls. Interventions included bed in low position, a mat on the side of the bed while in bed, use of a wider bed, use of an air mattress, increased monitoring, anticipating and meeting the needs of the resident, keeping the resident's call light within reach and encouraging the resident to use the call light for assistance as needed. On 1/26/2021 at 11:43am, Resident ' s #2 door was observed closed. Upon entering the room, Resident #2 was observed positioned in the middle of the bed lying on his back with his head of the bed elevated 75 degrees and the foot of his bed elevated 30 degrees. No staff were observed in the resident ' s room. Both side rails at the head of the bed was elevated. A Derma float air	F 689	interventions were initiated , in place and reflected on the resident care plan weekly for 4 weeks, bi- monthly for two months. The Director of Clinical Services will report findings of the Quality Monitoring Review to The Quality Assessment Improvement Committee monthly for three months. The Committee will review the findings and determine if further action is needed. Date of compliance will be 2/20/2021	

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mattress was on the bed, and the bed frame was in a high position. No fall mats were observed in the room. No voluntary movement or conversation was observed from Resident #2.

On 1/26/21 at 1:36pm upon opening the closed door, Resident #2 was observed lying on his back with the head of bed elevated. The bed frame was observed in high position and no fall mats were observed on the floor. Nurse Aide (NA) #1 entered with his meal tray and stood beside the bed to assist in feeding Resident #2 the entire meal.

On 1/26/2021 at 1:45pm in an interview with NA #1, she stated she had only worked for the facility for three days and had not observed Resident #2 moving his arms but stated he did move his feet. She stated she had not received an orientation from the facility, and the nurse only told her which residents needed assistance with feeding. When asking NA#1 questions about Resident #2, she replied, "I don ' t know." She stated the nurse was using the only computer on the unit, and she had not received information to log into the electronic medical records yet, so she was not able to document or access information about the resident ' s care.

On 1/26/2021 at 1:55pm, NA #1 exited Resident ' s #2 room to get him a soft oatmeal cookie from the kitchen and left his bed frame in a high position. NA #2 was gone from his room for 2 minutes.

On 1/26/2021 at 2:05pm, NA #1 exited Resident ' s #2 room leaving the head of the bed elevated in a high position, and the bed frame was left in a high position. Resident ' s #2 flat call light was left

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lying on his abdomen. Resident #2 was observed wiggling both of his feet. No fall mats were observed next to the resident ' s bed or in his room.

On 1/26/2021 at 2:20pm Resident #2 was in bed with the bed frame in a high position, NA #1 provided incontinent care to Resident #2. Resident #2 was repositioned up in the bed and turned on his left side with a pillow positioned to his back in the middle of the bed. NA #1 was observed exiting Resident ' s #2 room with his bed frame left in a high position and a flat call light lying on his abdomen. No fall mats were positioned next to the resident ' s bed.

On 1/26/2021 at 2:31pm in a follow up interview with NA #1, She denied knowing Resident #2 had a history of falls and stated when leaving a resident ' s room, the bed should be left in the low position.

On 1/26/2021 at 2:45pm, NA #1 entered Resident ' s #2 room and lowered the bed to the lowest position and stated she was not aware he needed fall mats beside the bed.

On 1/27/2021 at 5:19am, Resident #2 was observed lying directly on the floor next to his bed and he was making a groaning noise. The bed was observed in a high position and no fall mats were observed on the floor next to the bed. The nursing staff, including Nurse #2, entered Resident ' s #2 room, assessed Resident #2 to have no injuries and assisted him back to bed.

On 1/27/2021 at 6:20am in an interview with Nurse #2, she stated Resident ' s #2 was in the middle of the bed at 5:10am when she was in his

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room and administered a bolus through the feeding tube. She stated she had raised the resident ' s bed to administer the bolus. She further stated she was called away for another resident and forgot to lower the resident ' s bed prior to leaving the room. She stated the resident ' s bed being in high position was her fault. In a follow up phone interview on 2/1/2021 at 5:15pm, Nurse #2 stated the 7pm to 7am shift on 1/26/2021 was her second shift at the facility and stated she had received no orientation during the two days. She explained she had access to Resident ' s #2 electronic medical record and was familiar with the facility ' s medical records program, but stated she was unaware Resident #2 ' s plan of care included fall mats beside the bed.

On 1/27/2021 at 6:25am, an interview was conducted with NA #2. She stated she was in Resident ' s #2 room about one hour prior to the fall on 1/27/21. She stated the bed was in low position at that time, and there were no fall mats on the floor.

On 1/27/2021 at 10:50am, an interview was conducted with Nurse #3. She stated she didn ' t know how the facility prevented falls for high risk residents because it was only her second day working for the facility. When asked if she had received an orientation prior to beginning work, she stated, "No." Nurse #2 stated she was able to access the resident ' s electric medical record for individual information as needed. She stated generally if residents were at a risk for falls, the bed was left in a low position and sometimes mats are used beside the bed.

On 1/27/2021 at 11:00am in an interview with the

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Director of Nursing (DON), she stated the facility had used different interventions to prevent falls with Resident #2 over the last several months. She stated the bed was to be in the lowest position at all times. She further stated fall mats were an intervention on Resident ' s #2 care plan used prior to his admission to the COVID unit that had not been executed. She stated it was an oversight with the facility ' s current outbreak of COVID as a reason why the fall mats had not been placed in Resident ' s #2 COVID room.

On 1/27/2021 at 2:23pm, an interview was conducted with the Assistant Director of Nursing (ADON). She stated the orientation checklists were left at the nursing station for the new staff and was unsure why the new staff did not receive the materials. She stated nurse aides were able to visualize resident tasks and document care on the electronic medical record.

On 1/27/2021 at 2:28pm, the DON stated the Kardex on the electronic medical record provided information for the staff on individual resident care and nurses exchange a report at the beginning of a shift and have access to the electronic medical record for resident information. She stated NA #1 had worked at the facility for 2 days, and Nurse #3 arrived late for work at 8:30am on her first day and a walk through the department was provided. She further stated the facility was working on providing NA #1 with access to login into the electronic medical records.

On 2/21/2021 at 11:20am in a phone interview with the DON, she stated after a resident falls the nursing staff assessed the resident before assisting back to bed. The physician and

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F 689	Continued From page 7 responsible party were notified, and if needed, the resident was sent to the emergency room for an evaluation. She stated an incident report was completed, neurological assessments were completed per the policy, staff looked for interventions to prevent future falls, and the interdisciplinary team met the next day to discuss interventions to prevent falls. She stated Resident #2's falls were sporadic and multiple interventions had been activated to assist in preventing his falls. She stated Resident #2 had not experienced an injury from a fall.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		2/20/21

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F 880	Continued From page 8 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 9 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement the Centers for Disease Control and Prevention (CDC) guidelines for hand hygiene and PPE use when a nurse did not perform hand hygiene when changing gloves during wound care and did not remove her PPE before exiting a resident ' s room for 1 of 1 residents (Resident #1) who resided on the facility ' s quarantine unit and was on Enhanced Droplet Isolation Precautions. These failures occurred during a COVID-19 pandemic. Findings included: The Centers for Disease Control and Prevention (CDC) "Hand Hygiene Recommendations: Guidance for Healthcare Providers about Hand Hygiene and COVID-19" dated May 17, 2020 stated gloves were not a substitute for hand hygiene and to perform hand hygiene immediately after removing gloves. The guidance further stated to change gloves and perform hand hygiene during patient care if moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. The Centers for Disease Control and Prevention (CDC) "Using PPE: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19" dated June 9, 2020 stated gloves and gown were removed before exiting the patient ' s room.	F 880	A Quality Assurance Performance Improvement (QAPI) Committee meeting was held on 2/16/2021. A root cause analysis was conducted regarding the plan of care for Resident # 2□s wound care and infection control processes to include hand hygiene and don/ doff Personal Protective Equipment (PPE). Wound Doctor assessed wound on 2/10/2021, no changes in wound. Physician orders for Resident #2 were reviewed; no new orders obtained. The Nurse was re-educated on 2/17/2021 by the Assistant Director of Nursing regarding proper donning and doffing of PPE and hand hygiene per CDC guidelines. A wound care observation of the wound Nurse was completed on 2/19/2021. The Director of Clinical Services/ Assistant Director of Nursing conducted a Quality Review with Wound Care Doctor on 2/10/2021 of current facility residents with physician orders for treatments for wounds. Follow up to the findings included: 0 of 22 resident had no newly identified infections of wounds. Any new orders were documented and care plans updated accordingly. The Director of Clinical Services/Assistant Director of Nursing provided re-education to the licensed nursing staff completed by 2/19/2021 regarding donning and doffing PPE and hand hygiene during wound care. Licensed staff and certified nursing	

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F 880	Continued From page 10 On 1/14/2021, Resident #1 was re-admitted to the facility and resided on the quarantine unit at the facility. Diagnoses included a sacral and left buttock wound. Resident #1 was readmitted from the hospital and placed on the facility ' s COVID19 quarantine unit upon readmission for 14 days for monitoring before he could be moved to a general population unit. On 1/26/2021 at 2:29pm, Nurse #1 was observed in Resident #1 ' s room on the quarantine unit changing the resident ' s sacral and left buttocks wound vacuum dressing. Contact and droplet precautions signage was posted outside the resident ' s room. After Nurse #1 cleansed the skin around the wound with soap and water, she removed her gloves and reapplied a new pair of gloves without performing hand hygiene. After Nurse #1 cleansed the wound with a saline gauze, inserted a dry gauze over an exposed tendon and inserted black foam into the wound, she removed her gloves and reapplied a new pair of gloves without performing hand hygiene. Nurse #1 applied a transparent dressing to the sacral wound. After using scissors to cut another transparent dressing to apply to the wound area, Nurse #1 removed her gloves and reapplied a new pair of gloves without performing hand hygiene. After using the scissors to cut a hole in the transparent dressing for the wound vacuum tubing, she applied a second large transparent dressing, removed her gloves and reapplied a new pair of gloves without performing hand hygiene. On 1/26/2021 at 3:00pm, Nurse #1 was observed exiting Resident ' s #1 room wearing gloves and the two isolation gowns worn during wound care. She walked approximately 12 feet and used her	F 880	assistants, therapy, housekeeping, dietary, and maintenance were re-educated regarding CDC guidelines for donning and doffing PPE and hand hygiene for isolation precautions. Staff that were unavailable for in-servicing will be re-educated prior to returning to work and all newly hired staff and agency staff will be educated as part of the orientation process. An Ad Hoc QAPI Committee meeting was conducted with the Divisional Clinical Quality Specialist/RN and Divisional Executive Director/ LNHA on 2/17/2021 to discuss system change and Quality Monitoring for infection control practices regarding wound care, hand hygiene, and don/doff PPE. The root cause analysis (5 why□s) was reviewed at the QAPI meeting. The Director of Clinical Services/designee will complete Quality Monitoring using a Quality Improvement Monitoring tool of residents with treatments to ensure treatments are rendered utilizing proper infection control practices relating to donning and doffing PPE and hand hygiene. Residents with isolation precautions will be monitored to ensure staff adhere to CDC guidelines for donning and doffing PPE and hand hygiene. The monitoring will be 3 sampled residents 3x a week for 4 weeks, then weekly for 4 weeks, and then monthly for 2 months. Finding will be reviewed and discussed at monthly QAPI meetings and modifications to monitoring as appropriate. Date of compliance is 2/20/2020.	

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gloved hand to open the door into a room labeled the nourishment room at the nurse ' s station, removed and discarded the gloves and the outer isolation gown into the trash can. Nurse #1 washed her hands with soap and water.

On 1/26/2021 at 3:08pm, an interview was conducted with Nurse #1. She stated she was unable to give a reason why she didn ' t perform hand hygiene when changing gloves during the wound care or remove the gloves and gown before exiting Resident ' s #1 room.

On 1/27/2021 at 12:40pm in a follow up interview, Nurse #1 stated Resident #1 was on a quarantine unit that required her to wear two isolation gowns into Resident ' s #1 room. She stated the plastic gowns she was wearing caused her to sweat profusely and was the reason she changed her gloves so many times during the wound care. She stated she needed to prepare for hand sanitization during wound care when changing gloves by having hand sanitizer available. She further stated she should have removed her gloves and gown before exiting Resident ' s #1 room and not in the nourishment room. She stated she was so hot in the two gowns and didn ' t think about it.

On 1/27/2021 at 11:09am in an interview with the Director of Nursing (DON), she stated staff were to sanitize their hands after removing gloves, and gowns and gloves were removed prior to exiting the resident ' s room after conducting resident care.