

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345124</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-ELKIN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>560 JOHNSON RIDGE ROAD</b> <b>ELKIN, NC 28621</b>		
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E 000	Initial Comments	E 000			
F 000	<p>An unannounced Recertification survey was conducted on 3/29/21 through 4/1/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # O5Y111.</p> <p>INITIAL COMMENTS</p> <p>A recertification and complaint investigation survey was conducted from 3/29/21 through 4/1/21. Event ID# 05Y111</p> <p>1 of the 6 complaint allegation(s) was/were substantiated resulting in deficiency.</p>	F 000			
F 550 SS=D	<p>Resident Rights/Exercise of Rights</p> <p>CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p>	F 550		5/12/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/22/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	<p>Continued From page 1</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, resident representative interview, staff interviews and record review, the facility failed to provide a dignified dining experience by standing over a resident while providing assistance with feeding for 2 of 9 residents (Resident #25 and Resident #53) reviewed for dining.</p> <p>Findings included:</p> <p>1. Resident #25 was admitted to the facility on 12/19/16 with diagnoses that included, in part, dysphagia and diabetes.</p> <p>The quarterly Minimum Data Set assessment dated 1/22/21 revealed Resident #25 had moderately impaired cognition. She required extensive assistance with eating.</p> <p>A nutrition care plan updated 2/5/21 revealed,</p>	F 550	<p>F550 IMMEDIATE CORRECTIVE ACTION</p> <p>In serviced CNA's that fed resident #25 and resident #53 On 3/29/21 in proper feeding technique: including sitting position bedside patient at eye level.</p> <p>METHODS TO IDENTIFY ANY OTHER RESIDENTS THAT MAY BE AFFECTED:</p> <p>Upon discussion of CNA's and random walking rounds during meal times, did not identify any other residents affected.</p> <p>SYSTEMIC CHANGES</p> <p>3/30/21 CCC began staff education on proper feeding technique's: including</p>		

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F 550	<p>Continued From page 2</p> <p>"assist with eating."</p> <p>On 3/29/21 at 12:37 PM Resident #25 was observed in her bed in an upright seated position. Nurse Aide (NA) #3 stood next to the resident's bed as she provided the resident with feeding assistance. NA #3 stood above eye level of the resident for the duration of the meal while she fed Resident #25. A straight back chair was observed in the room against the wall near the foot of Resident #25's bed. At 12:45 PM, NA #3 covered the plate of food and exited the resident's room.</p> <p>An interview was completed with NA #3 on 3/29/21 at 2:41 PM, during which she stated Resident #25 needed to be fed her meal. She said staff either sat in a chair or stood when they fed a resident and added, "When we train they tell us to either sit or stand when feeding a resident."</p> <p>Resident #25 was interviewed on 3/31/21 at 3:06 PM. She said staff fed her during meal times and some staff sat when they fed her and some stood when they assisted her. Resident #25 shared when she lived at home she was accustomed to family being seated during a meal and preferred staff sat at bedside when they fed her.</p> <p>During an interview with the Clinical Competency Coordinator (CCC) on 4/1/21 at 9:49 AM, she said staff were educated to be seated when they fed a resident so they could be at eye level. The CCC explained staff were educated as needed on being seated when they assisted residents with meals and added, "They should have had it back in their NA training before they came to work. The NA should have been seated when she fed the resident."</p>	F 550	<p>feeding patients at eye level in seated position at all times. This education will be included in all new hire orientation for CANs and licensed nurses.</p> <p>Dept. managers will monitor by walking rounds during meals that all patients are being fed correctly, random interviews with alert and oriented patients as follow up: daily x 5 days then weekly x 4 weeks then monthly x 3 months.</p> <p><b>MONITERING PROCESS</b></p> <p>Administrator will tract and analyze the information and monitoring tools and report findings to Quality assurance meeting monthly x 3, then quarterly then after</p> <p>Compliance Date: May 12, 2021</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 550	<p>Continued From page 3</p> <p>An interview was completed with the Administrator on 4/1/21 at 12:52 PM during which she said staff were supposed to be seated when they fed residents. "We tell staff they have to be eye level with the resident. We never tell them to either sit or stand."</p> <p>2. Resident #53 was admitted to the facility on 3/17/19 with diagnoses that included, in part, dysphagia and hemiplegia following cerebral infarction.</p> <p>The quarterly Minimum Data Set assessment dated 3/1/21 revealed Resident #53 had severe cognitive impairment. She required extensive assistance with eating.</p> <p>A nutrition care plan updated 3/1/21 revealed, "provide assistance for meals."</p> <p>On 3/29/21 at 12:37 PM Resident #53 was observed in her bed in an upright seated position. NA #4 stood next to the resident's bed as she provided the resident with feeding assistance. NA #4 stood above eye level of the resident for the duration of the meal while she fed Resident #53. A straight back chair was observed in the room against the wall near the foot of Resident #53's bed. At 12:55 PM, NA #4 covered the plate of food and exited the resident's room.</p> <p>An interview was completed with NA #4 on 3/29/21 at 12:48 PM, during which she stated Resident #53 needed to be fed her meal. NA #4 explained she typically either sat in a chair or stood when she fed the resident. NA #4 stated the facility had not specified whether to sit or stand when she fed a resident.</p>	F 550			

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F 550	Continued From page 4  Resident #53's representative was interviewed on 3/30/21 at 3:08 PM. He typically came to the facility daily and fed Resident #53 during the lunch and supper meals. He shared he was unable to visit on 3/29/21. The representative explained he sat in a chair by the bed when he fed Resident #53. He thought staff should also be seated and at eye level when they fed the resident.  During an interview with the Clinical Competency Coordinator (CCC) on 4/1/21 at 9:49 AM, she said staff were educated to be seated when they fed a resident so they could be at eye level. The CCC explained staff were educated as needed on being seated when they assisted residents with meals and added, "They should have had it back in their NA training before they came to work. The NA should have been seated when she fed the resident."  An interview was completed with the Administrator on 4/1/21 at 12:52 PM during which she said staff were supposed to be seated when they fed residents. "We tell staff they have to be eye level with the resident. We never tell them to either sit or stand."	F 550			
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)  §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident	F 554	IMMEDIATE CORRECTIVE ACTION	5/12/21	

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F 554	<p>Continued From page 5</p> <p>and staff interviews, the facility failed to assess the ability of a resident to self-administer medications that were kept at bedside for 1 of 1 sampled resident (Resident #192) reviewed for self-administration of medications.</p> <p>The findings included:</p> <p>Resident #192 was admitted to the facility on 3/17/21 with a diagnosis of allergic rhinitis.</p> <p>An admission Minimum Data Set (MDS) assessment dated 3/21/21 revealed Resident #192 was cognitively intact.</p> <p>Review of Resident #92's physician's orders revealed an order dated 3/17/21 for Flonase allergy relief spray 50 micrograms/actuation 2 sprays each nostril daily.</p> <p>An observation on 3/29/21 at 12:03 PM revealed a bottle of fluticasone propionate on Resident #192's bedside table. The surveyor asked Resident #192 if she administered the nasal spray herself and the resident responded "yes". Resident #192 stated she used the nasal spray at home prior to her admission and was unsure if an assessment was done by the facility staff to assess her ability to self-administer medications safely.</p> <p>A comprehensive medical record review conducted on 3/31/21 did not reveal an assessment was completed for the resident to self-administer medications.</p> <p>An observation on 3/31/21 at 11:28 AM revealed the bottle of fluticasone propionate remained at Resident #192's bedside.</p>	F 554	<p>Resident #92 was immediately assessed by clinical care coordinator on 3/31/2021 and self-administration of medication form was completed which allowed patient to self-administer nasal spray.</p> <p>METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED</p> <p>Thirty four residents admitted or readmitted, within the last 30 days still remaining in the facility from 03/01/2021 to 04/01/2021, was assessed to ensure there were no meds at bedside and that the patient did not wish to self-administer any of their meds. There were no other meds found by bedside nor did any resident wish to self-administer own medications. This mainly involved patient rooms on 100/200 hall but we also did room audits on entire facility.</p> <p>Nurses and CNA'S were interviewed and in-services started on what they are to do if they see meds at bedside, which includes reporting to nurse for CNA'S and admin nurse for licensed staff. All in-services will be completed by May 12th 2021 and any staff that was not educated will receive education prior to their shift. This will be added to general orientation for all staff.</p> <p>No other patients were noted to be affected by this practice</p> <p>SYSTEMIC CHANGES</p>		

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F 554	Continued From page 6  On 3/31/21 at 1:48 PM, an interview was conducted to NA#1 who stated if he saw medication in a resident's room, he brought it to the nurse's attention. He stated he was unaware Resident #192 had medication on her bedside table.  On 3/31/21 at 1:55 PM, an interview was conducted with Nurse #1 who stated she did not know of any residents on the hall that self-administered their medications. She stated Resident #192 did not have an order to self-administer her medications and she was unaware the nasal spray was at the bedside in her room.  On 4/1/21 at 4:00 PM, the acting Director of Nursing was interviewed. She stated if a resident wants to self-administer medications, an assessment had to be completed to assess the resident's ability to safely self-administer medications. She stated she was unaware Resident #192 had medications at the bedside.	F 554	All new admits will have self-- administration of med form completed on admission and at any time patient wishes to self -administer own meds All staff will be in-serviced to monitor patient room for any meds at bedside. All rooms of new admits will be monitored within 24hrs of admission Room audits will be done of entire facility weekly times 4 then monthly thereafter.  MONITORING PROCESS  DHS will monitor compliance of completion of self- administration form at admission at clinical meeting following day of admit. All rooms of new admits will be monitored times within 24 hrs of admission. Room audits will be done of entire facility weekly times 4 then monthly thereafter. DHS will take all findings to quality assurance committee meeting monthly times 3 then quarterly thereafter  Compliance Date: May 12, 2021		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to ensure the Minimum Data Set (MDS) was accurate for three of twenty-one residents	F 641	IMMEDIATE CORRECTIVE ACTION  The MDS nurse correct the assessment for res #62 on 3/29/21	5/12/21	

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F 641	<p>Continued From page 7 (Resident #62, Resident #80 and Resident #87) reviewed for accuracy of assessment.</p> <p>The findings included:</p> <p>1. Resident #62 was admitted to the facility on 12/17/2020 with a diagnosis that included Atrial Fibrillation, recurrent urinary tract infections and viral pneumonia.</p> <p>A review of the admission comprehensive Minimum data set (MDS), dated 12/17/2020, revealed</p> <p>Resident #62 had moderate cognitive impairment, had an order for regular consistency meals and was coded to have no dental issues assessed.</p> <p>A review of the nursing progress note, dated 12/17/2020, written by the Clinical Competency Coordinator (CCC), documented Resident #62 had her own teeth in poor condition.</p> <p>Observed Resident #62's teeth, on 3/29/21 at 11:13 AM to be black on the back lower teeth and broken in multiple places with fragments at the gum line.</p> <p>An interview was conducted with Resident #62, during the observation on 3/29/21 at 11:13 AM and she stated that someone had looked in her mouth when she was first admitted, and she did not know who. She stated her teeth have been broken with cavities for several years. She denied any pain.</p> <p>An interview was conducted with the MDS nurse on 3/31/2021 at 2:19 PM and she revealed a</p>	F 641	<p>For res #80 his d/c plan was to return home in which SW answered Q 0400 active plan in place to return to community, when Q0400 is coded yes O Q500 becomes a skip pattern. This was answered correctly For res #87 MDS nurse keyed wrong answer in section A2 100. And this was corrected on 4/1/21.</p> <p>METHODS OF IDENTIFY ANY OTHER RESIDENT AFFECTED</p> <p>Audit was completed on all new admits in past 90 days on 3/31/21 with no issues identified with oral assessment. Res #80 the SW did code section Q correctly the section in question is a skip pattern</p> <p>Res #87 Case mix director audited all discharges in past 90 days for accuracy of discharge status no issues identified.</p> <p>SYSTEMIC CHANGES</p> <p>All dental assessments are completed at time of admission and again by MDS nurse on assessment of ARD date. Any issues identified will be reported to SW and administrator with appropriate follow up as needed.</p> <p>Upon completion of d/c assessments CMD will compare A2100 discharge status to census event prior to close of assessment.</p> <p>MONITORING SYSTEM</p>		



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F 641	<p>Continued From page 8</p> <p>dietary manager completed the Dental section of the MDS. She stated she signed the 12/17/2020 MDS as the registered nurse and was responsible for the accuracy of the assessment. She made a correction to the assessment during the interview.</p> <p>An interview was conducted with the Administrator on 4/1/2021 and she revealed the nursing staff did a complete resident assessment on teeth the night of 3/31/2021 and no other inaccurate teeth assessments had been found. She stated it was her expectation that assessments be submitted accurate and by the qualified staff member.</p> <p>2. Resident #80 was admitted to the facility on 3/12/21 with diagnoses of osteomyelitis.</p> <p>An admission Minimum Data Set (MDS) assessment dated 3/16/21 revealed Resident #80 was cognitively intact. A review of Section Q - Participation in assessment and goal setting revealed Resident #80 participated in the assessment and goal was for return to community. Further review of Section Q revealed Question Q0500 regarding returning to the community were unanswered.</p> <p>An interview was conducted on 4/1/21 at approximately 2:30 PM with the facility ' s social worker. She stated she was responsible for completing Section Q on the MDS assessment and failing to answer the return to community question on Resident #80's MDS was an oversight.</p>	F 641	<p>CMD will monitor audit results and bring finding to Quality assurance meeting monthly x 3 and quarterly after</p> <p>Interim began Inservice for admitting nurses for oral assessments on 3/31/21</p> <p>All discharges are reviewed in morning clinical meeting and verified with set assessment for accuracy of discharge location.</p> <p>Compliance Date: May 12, 2021</p>		

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F 641	<p>Continued From page 9</p> <p>3 of 21 residents reviewed for MDS accuracy</p> <p>3. Resident #87 was admitted to the facility on 2/22/21 with diagnoses of Paroxysmal Atrial Fibrillation and Non-ST Elevation (NSTEMI) Myocardial Infarction.</p> <p>Resident #87's Minimum Data Set (MDS) assessment dated 3/1/21 revealed Resident #87 was cognitively intact and was able to complete all activities of daily living independently. A review of Section A2100 Discharge Status shows that Resident #87 was discharged to acute hospital.</p> <p>Record review on 4/1/21 at 10:30 AM revealed the following nurse note:</p> <p>03/01/2021 05:15 PM Discharge note; VS: Bp 118/62, SPO2-99%-room air, P-65, R=16, denies pain. Respirations even and unlabored. Skin warm and dry. Discharged to home with Kindred home health for skilled nursing and PT/OT/St eval and treat; released in house meds at discharge. Called in 2week supply of routine meds at Walmart Mt Airy on Rockford road. Personal belongings packed by staff and taken to family for transport in family vehicle. Reviewed discharge summary with family and resident along with medications and wound care. Reviewed signs/symptoms excessive bleeding. Verbalized understanding. Will have 24/7 support at home with wife and son will stay a few days. Transported via w/c to family vehicle for transport home.</p> <p>An interview was conducted on 4/1/21 at 11:13 AM with the MDS nurse who stated that Section A2100 was inadvertently marked at discharged to acute hospital instead of community and that was</p>	F 641			

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F 641	Continued From page 10 an oversight. The discharge MDS was corrected at the time of interview.	F 641			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)  §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and  §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to provide restorative services to one of three residents (Resident #62) reviewed for range of motion and Mobility services.  The findings included:  Resident #62 was admitted to the facility on 12/17/2020 with a diagnosis that included Atrial Fibrillation, recurrent urinary tract infections, viral pneumonia, abnormalities of the gait and unsteadiness on the feet with falls prior to	F 688	IMMEDIATE CORRECTIVE ACTION  Res # 62 Discussed with therapy outcome coordinator patient mobility/ambulation status and set goals for restorative program following discharge from therapy case load.  METHODS TO IDENTIFY OTHER RESIDENTS THAT MAY BE AFFECTED  Audit performed by therapy outcome coordinator on all patients discharged	5/12/21	

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F 688	<p>Continued From page 11 admission.</p> <p>A review of the admission comprehensive Minimum data set (MDS), dated 12/17/2020, revealed Resident #62 had moderate cognitive impairment, no wandering and required extensive assistance of two people with bed mobility, transfers, dressing and toilet use. The assessment coded the Resident was not steady with balance and could only stabilize with help.</p> <p>A review of the discharge from therapy MDS, dated 2/4/2021, coded Resident #62 required Supervision/touch assist only for transfers and walking. The documentation revealed the Resident completed greater than 150 feet of ambulation with a therapist during the 7-day lookback period.</p> <p>A review of the therapy discharge paperwork, dated 2/3/2021, revealed a recommendation that Resident #62 receive restorative services to include supervision with walking to maintain current levels of mobility.</p> <p>A review of the quarterly MDS, dated 2/19/2021, coded Resident #62 as having moderate cognitive impairment with an increase in the score of the cognitive assessment. The Resident was coded to not be steady with transfers or walking, only able to stabilize with assistance of staff, required extensive assistance of two staff with bed mobility, dressing and toileting and one-person assistance with transfers and walking. The Resident was coded that walking in the corridor did not occur during the 7-day look back period.</p> <p>An interview was conducted on 3/29/21 at 11:13</p>	F 688	<p>from therapy case load in last 30 days on 4/6/21 for communication of restorative programs. From audit no other patients were affected.</p> <p>Therapy will communicate with appropriate nursing staff each restorative program patient specific.</p> <p><b>SYSTEMIC CHANGES</b></p> <p>Therapy outcome coordinator in serviced therapy staff beginning on 4/6/21 on importance of recommendations at time of therapy discharge will continue to discuss in morning clinical meetings and weekly IDT meetings.</p> <p><b>MONITORING PROCESS</b></p> <p>Therapy outcome coordinator will review therapy discharge pt. when transitioning to long term care in our weekly clinical meeting to ensure adequate programs are in place.</p> <p>Therapy outcome coordinator/ facility administrator will review all findings and take to Quality assurance meeting monthly x 3 then quarterly x 3</p> <p>Compliance Date: May 12, 2021</p>		

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F 688	<p>Continued From page 12</p> <p>AM with Resident #62. She stated she stopped going to therapy last month but had started back with exercises this month. She stated she had two falls trying to go to the bathroom and was told she needed to walk with the therapy department more. She stated that nobody helps her to walk in the hall except for the "girls" down the hall in the gym and there was not enough room to walk in her room because her roommate was in a wheelchair and prefers to remain in the room too.</p> <p>An interview was conducted on 3/31/21 at 10:52 AM, with the Director of Rehabilitation (DOR). She opened the discharge recommendations dated 2/3/2021 for the discharge from therapy date of 2/4/2021 and stated the plan of care was for Resident #62 to receive restorative therapy to maintain mobility. She demonstrated the method a referral would be placed to the team. She stated the Resident would be discussed weekly in the interdisciplinary team meetings that included MDS nursing team, social worker, interim Director of Nursing and the administrator (intermittently). She added the goals of care for a smooth transition would be added to the plan of care for the resident. She revealed that she did not see documentation that a restorative referral for this Resident was completed. She stated this could be because the resident was to discharge to the community and that was changed just prior to discharge home. She added that the named Resident suffered two falls without injury that flagged in a Radar Report she runs weekly and a recommendation to be screened and restart therapy was placed on 2/25/2021.</p> <p>A review of the Interdisciplinary team (IDT) notes, dated 2/03/2021, revealed Resident #62's therapy discharge recommendations had been discussed.</p>	F 688			

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F 688	Continued From page 13  A review of the therapy documentation for Resident #62 assessed, on 2/25/2021, the Resident could walk 75 feet with a rolling walker and continued to require supervision/touch assistance of one staff member. The notes added the Resident needed a restorative program and the Resident's handouts, provided at discharge from therapy on 2/4/2021, for exercises were not available after a room change earlier in the month.  A review of the MDS, dated 3/9/2021 documented Resident #62 had two or more falls and was continuing to receive Occupational therapy at the time of the assessment.  An interview was conducted on 3/31/21 at 4:29 PM, with the hall nurse # 02 and he demonstrated where restorative services that involved the nursing staff, would be in the Matrix system. He denied ever having an assignment for nursing to walk the named resident and revealed the Nursing assistants have an icon for ordered therapy on their tablets. He stated that over the month of March, facility residents had been allowed to leave their rooms to walk or locomote in the hallway, if they follow the recommended guidelines from CDC and facility.  An interview was conducted on 3/31/21 at 4:37 PM, with NA # 05 and she noted that Resident #62 was a resident on her assigned hall. She stated that the nursing assistants (NA) use an iPad for documentation. She added that the Matrix system will include an icon for restorative services when a resident had a recommendation, such as a splint to be placed, exercise needs and more. The NA denied seeing a restorative icon for	F 688			

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F 688	Continued From page 14 the named resident during her stay at the facility.	F 688			
F 880 SS=D	<p>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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.</p> <p>§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:</p> <p>§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;</p> <p>§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</p>	F 880		5/12/21	

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F 880	<p>Continued From page 15 reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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:</p> <p>Based on observations, record review and staff interviewed, the facility failed to implement their infection control policies and procedures for personal protective equipment (PPE) when a nurse practitioner (NP #1) and a nursing assistant (NA#1) failed to don PPE prior to entering two</p>	F 880	<p><b>IMMEDIATE CORRECTIVE ACTION</b></p> <p>The infection control nurse immediately in serviced the nurse practitioner and C N A that resident on 100m and 200 halls with isolation signs on wall outside of room</p>		



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F 880	<p>Continued From page 16</p> <p>separate resident rooms who were on enhanced droplet precautions for 2 of 5 staff observed that worked on the 200 hall, which was a quarantine hall. These failures occurred during the COVID-19 pandemic.</p> <p>The findings included:</p> <p>The Centers for Disease Control and Prevention (CDC) guidance entitled, "Responding to Coronavirus (COVID-19) in Nursing Homes" indicated the following statements:</p> <p>*All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves and gown.</p> <p>Review of the facility's COVID-19 Pandemic Isolation and Cohorting Process for Healthcare Centers revised 1/21/21 revealed, "to enter the Level II unit, partners will already have donned mask and eye protection before entering. Multiple isolation carts will be placed at the entrance of the unit and throughout the unit. Gown and gloves are donned at the doorway of the resident room where care will be provided".</p> <p>During an entrance conference conducted by the team coordinator on 3/29/21, the Administrator indicated the 100 and 200 halls were designated as the quarantine hall for new admissions and readmissions. The Administrator stated there were no positive COVID-19 cases in the facility.</p> <p>1. An observation on 3/31/21 at 11:05 AM revealed NP#1 in room 208 on the quarantine hall as she spoke to the resident and listened to her</p>	F 880	<p>were on enhanced precautions and gown and gloves must be worn along with goggles/eye shield along with mask. Also, infection control has began Inservice with all staff on proper PPE.</p> <p><b>METHODS TO IDENTIFY OTHER RESIDENT THAT MAY BE AFFECTED</b></p> <p>Nurse PR actioner only seen one patient on that hall that day and was in serviced and c n a was in serviced that regardless on reason for entering room proper PPE must be worn.</p> <p>The infection control nurse began Inservice all staff that when entering room with isolation signage on outside of room proper PPE (eye protection, gown, mask, gloves) listed on sign must be worn.</p> <p><b>SYSTEMIC CHANGES</b></p> <p>On 3/31/21 infection control nurse began Inservice on all staff on type of isolation and what PPE is required. This must be done regardless of reason for entering room. Education of all staff will be completed by 5/12/21 and will be added to general orientation of all staff including outside vendors whom visit patients.</p> <p><b>MONITORING PROCESS</b></p> <p>Infection control nurse along with department managers will track and analyzes finding and will taking to Quality assurance committee monthly x 3 and Quarterly x 3</p>		

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F 880	<p>Continued From page 17</p> <p>heart and lungs with her stethoscope. NP #1 was observed with a face mask and eye protection on. NP#1 did not have a gown or gloves on. Signage for enhanced droplet and contact precautions was observed close to the door frame on the wall outside the room. The signage indicated gown and gloves were to be donned prior to entering the room. NP#1 was observed as she exited the room without gloves and gown and sanitized her hands.</p> <p>During an interview with NP#1 on 3/31/21 at 11:10 AM, she stated she was not aware the resident in room 208 was on precautions. She added she knew a resident was on precautions if there was a sign on the door to the resident's room and a PPE cart outside the room. NP#1 observed the sign posted on the wall outside the room and stated she didn't see it because it wasn't on the door.</p> <p>2. An observation on 3/31/21 at 01:30 PM revealed NA #1 entered room 204 on the quarantine hall with only a face mask and eye protection on. NA #1 did not have a gown or gloves on. Signage for enhanced droplet and contact precautions was observed close to the door frame on the wall outside room 204. The signage indicated gown and gloves were to be donned prior to entering the room. NA #1 was observed as he picked up the resident's meal tray and exited the room.</p> <p>During an interview with NA#1 on 3/31/21 at 1:31 PM, he stated he didn't know if the resident in room 204 was on precautions; he hadn't worked in several days. He stated even if resident was on precautions, he wouldn't put on PPE just to pick up a tray.</p>	F 880	<p>Contagious disease monitoring sheets will be completed by infection control nurse/ department heads.</p> <p>ICAR will be at facility May 3rd to assist in assessing infection control program.</p> <p>Compliance Date: May 12, 2021</p>		

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F 880	Continued From page 18  On 3/31/21, the Infection Control Nurse was interviewed. She stated NA #1 was correct, staff did not have to done PPE prior to entering resident rooms on enhanced droplet precautions just to pick up meal trays. She stated it would make it difficult to pick up the tray then have to put it down to remove the gloves and gown prior to exiting the room and then picking up the tray again.  A follow up interview was conducted on 4/1/21 at 10:36 AM with the Infection Control Nurse. She stated she spoke to NP#1 on 3/31/21 and she stated she didn't see the signage that the resident in room 208 was on enhanced droplet precautions. She added the residents on 100 and 200 halls were on quarantine for 14 days and full PPE including gown and gloves were to be worn except during tray collecting. The Infection Control Nurse returned to the surveyor after consulting with the Nurse Consultant who stated staff entering rooms of residents on enhanced droplet precautions were to don full PPE prior to entering the rooms.	F 880			