STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

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E 000	Initial Comments An unannounced recertification survey was conducted on 5/17/21 through 5/20/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Prepardness. Event ID I91611	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted on 5/17/20 through 5/20/21. The facility was found out of compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities. 2 of 5 complaint allegations were substantiated resulting in deficiencies.	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 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	F 561		6/29/21

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

Electronically Signed | 06/11/2021

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F 561	Continued From page 1 with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to allow independent/safe smokers to smoke without supervision and whenever they wanted for 2 of 2 residents reviewed for choices. (Resident #23 and #32). Findings included: A review of the facility ' s designated smoking times revealed the following times: · 10:00 AM, 11:30 AM, 2:00 PM, 4:00 PM, 6:00 PM and 8PM. Resident #23 was admitted to the facility on 03/18/2021. A review the admission Minimum Data Set (MDS) dated 03/25/2021 for Resident #23 revealed the resident was cognitively intact. A review of Resident #23 ' s safe smoking evaluation dated 03/21/2021 revealed the facility had assessed the resident as a safe smoker that could smoke independently. A review of Resident # 23 ' s care plan dated 03/24/2021 revealed the resident was care planned to smoke independently per his smoking	F 561	Greendale Forest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Greendale Forest Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greendale Forest Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 6/9/21, the Social Worker (SW) initiated interviews and education with all residents who smoke to include resident	

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F 561	Continued From page 2 assessment. The goal was for the resident to smoke safely for 90 days. The interventions included: 1. Ensure smoking materials are placed in secured storage area. 2. Assist resident in obtaining smoking materials from secured storage area upon request. 3. Educate resident on the facility ' s smoking policy. Resident #32 was admitted to the facility on 11/09/2020. A review the annual MDS dated 01/21/2021 for Resident #32 revealed the resident had mild cognitive impairment. A review of Resident #32 ' s safe smoking evaluation dated 03/25/2021 revealed the facility had assessed the resident as a safe smoker that could smoke independently. A review of Resident # 32 ' s care plan dated 03/24/2021 revealed the resident was care planned to smoke independently per his smoking assessment. The goal was for the resident to continue to smoke safely in designated areas thru next review. The interventions included: 1. Evaluate resident's continued ability to smoke safely on a consistent and regular basis. 2. Resident may smoke at times of own choice in designated smoking areas. 3. Resident may smoke independently without supervision. Observations made on 05/17/2021 at 11:16 am and 05/18/2021 at 4:04 pm revealed Resident #23 and #32 in the designated smoking area with other smokers and being supervised by Nurse #2. Resident #23 and #32 were observed lighting their own cigarette.	F 561	#23 and resident #32 in regards to Smoking with emphasis on smoke times for supervised and independent smokers. The Social Worker and/or Unit Managers will address any concerns identified during the interviews. Interviews will be completed by 6/29/21. On 6/10/21, the Quality Assurance Nurse (QA) amended the signage posted at entrance of the smoking area. New signage identified scheduled smoke times for supervised smokers and independent/ safe smokers will be allowed access to smoke area per resident preference. Staff will continue to monitor smoke area to ensure residents who smoke maintain social distancing per facility protocol. On 6/11/21, the Staff Facilitator initiated an in-service for all staff to include Administrator, nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, maintenance staff, Accounts Payable, Accounts Receivable, Social Worker, Admissions, receptionists, laundry staff, activity staff and Medical Records in regards to Resident Preferences/Smoking. Emphasis is on smoke times for supervised residents and choices on smoking time preference for independent and safe smokers. In-service will be completed by 6/29/21. All newly hired Administrator, nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, maintenance staff, Accounts Payable, Accounts Receivable, Social Worker, Admissions, receptionists, laundry staff, activity staff and Medical	

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F 561	Continued From page 3 An observation on 05/17/2021 at 11:31 am, of the entrance to the outdoor smoking area revealed a posted sign, red in color, that stated in part, "All residents are to be supervised by staff while smoking." The observation also revealed the door was locked with a keypad requiring a "code" to be entered by staff to open the door to the smoking area. An interview with Nurse #2 on 05/19/21 10:03 am revealed all smoking sessions for residents were supervised by facility staff. An interview with the Director of Nursing on 05/19/2021 at 10:41 am revealed all resident smoking sessions were supervised by facility staff.	F 561	Records will be in-serviced by the Staff Facilitator during orientation in regards to Resident Preferences/Smoking. The Resource Nurse, Social Worker, Medical Records Director and/or Accounts Receivable will observe smoking area 10 times a week x 4 weeks then monthly x 1 month utilizing the Smoking Observation Audit Tool. This audit is to ensure residents who are safe and independent smokers to include resident #23 and #32 are allowed to smoke per resident preference and without supervision. The Resource Nurse, Social Worker, Medical Records Director and/or Accounts Receivable will address all areas of concern identified during the audit to include re-education of staff. The Director of Nursing (DON) will initial the Smoking Observation Audit Tool for completion and to assure all areas of concern were addressed weekly x 4 weeks then monthly x 1 month. The DON will forward the results of the Smoking Observation Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Smoking Observation Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		6/29/21

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F 656	Continued From page 4 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 5 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to provide splint placement according to the care plan for 1 of 2 residents (Resident #62) reviewed for limited range of motion. The findings included: Resident #62 was admitted to the facility on 12/5/17 with a diagnosis of hemiplegia following cerebral infarction affecting the left side and dementia. The annual Minimum Data Set (MDS) dated 4/9/21 revealed Resident #62's cognition was severely impaired. She required total assistance with bed mobility and toilet use. She needed extensive assistance with eating and transfers did not occur. The MDS revealed she had functional limitation in range of motion to the upper extremity on one side. The current care plan identified Resident #62 required assistance/potential to restore or maintain function of self-sufficiency for mobility as characterized by the following functions: positioning and locomotion/ambulation related to risk for development of further contractures. Resident #62 will be able to tolerate (left wrist cock up with digit separator every day for 4 hours) without pain/discomfort/skin breakdown. Resident to wear left wrist cock up with digit separator every day for 4 hours. Perform stretch to left wrist and all fingers before splint application. Stretching and splinting to be done after AM activities of daily living (ADL) and monitor skin	F 656	On 6/2/21, therapy staff assessed resident # 62 for changes in range of motion (ROM) to left wrist with no concerns identified. The splint was applied to left wrist per resident care plan. On 6/11/21, the Nurse Managers initiated an audit of all residents care planned for use of splint to include resident # 62. This audit is to ensure that splint was applied per resident plan of care to prevent decrease in ROM. The therapy staff, Administrative Nurses and/or assigned hall nurse will address all areas of concern identified during the audit. Audit to be completed by 6/29/21. On 6/11/21, the QA nurse initiated an audit of all residents care planned for use of splints. This audit is to ensure splint application was identified on the Point of Care (POC) Task Listing for nursing assistant to document application of splint when indicated. Audit will be completed by 6/29/21. On 6/11/21, the Staff Facilitator initiated an in-service with all nurses to include nurse #6 and nursing assistants to include nursing assistant (NA) #2 in regards Range of Motion/Splints with emphasis on applying splints per resident plan of care to prevent a decrease in ROM ability.	

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F 656	Continued From page 6 integrity under applied splint/brace daily. On 5/19/21 at 11:00 AM, Resident #62 was observed not wearing her splint on her left hand. On 5/19/21 at 3:00 PM, Resident #62 was observed not wearing her splint on her left hand. On 5/20/21 at 11:30 AM, Resident #62 was observed not wearing her splint on her left hand. An interview with Therapy Staff #1 was conducted on 5/20/21 at 11:45 AM and she stated Resident #62 should be wearing her splint as instructed when she was discharged from therapy on 10/15/20. On 5/20/21 at 12:00 PM an interview was conducted with Nurse Aide (NA) #2 who worked with Resident # 62 on a regular basis and she stated she had never seen Resident #62 with a splint and never knew she needed to have a splint placed. NA #2 confirmed that a splint was not on Resident #62's task list. On 5/20/21 at 12:01 PM Nurse #6 was interviewed, and she stated she never knew Resident #62 needed to have a splint placed. An interview was conducted with the Director of Nursing on 5/20/21 at 5:05 PM and she stated the current care plan was not followed for Resident #62 and it should have been.	F 656	In-service to be completed by 6/29/21. All newly hired nurses and nursing assistants will be in-serviced by the Staff Facilitator during orientation in regards to Range of Motion/Splints. 10% of all residents care planned for use of splints, to include resident # 62 will be audited by the Minimum Data Set Nurse (MDS) utilizing Splints Audit Tool two times a week x 2 weeks then weekly x 2 weeks then monthly x 1 month to ensure that splint is applied per the plan of care to prevent a decrease ROM ability with documentation in POC. The MDS nurse will address all areas of concern identified during the audit to include application of splint per plan of care and re-education of staff. The Director of Nursing (DON) will review and initial the Splints Audit Tool two times a week x 2 weeks then weekly x 2 weeks then monthly x 1 month to ensure completion and that all areas of concerns were addressed. The DON will forward the results of the Splints Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Splints Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		6/29/21

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F 688	Continued From page 7 §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 observation, interviews and record review the facility failed to provide splint application for 1 of 1 sample resident (Resident #62) reviewed for range of motion/contractures. The findings included: Resident #62 was admitted to the facility on 12/5/17 with a diagnosis of hemiplegia following cerebral infarction affecting the left side and dementia. The annual Minimum Data Set (MDS) dated 4/9/21 revealed Resident #62 was impaired cognitively. She required total assistance with bed mobility and toilet use. She needed extensive assistance with eating and transfers did not occur. The MDS revealed she had functional limitation in range of motion to the upper extremity on 1 side.	F 688	On 6/2/21, therapy staff assessed resident # 62 for changes in range of motion (ROM) to left wrist with no concerns identified. The splint was applied to left wrist per resident care plan. On 6/11/21, the Nurse Managers initiated an audit of all residents care planned for use of splint to include resident # 62. This audit is to ensure that splint was applied per resident plan of care to prevent decrease in ROM. The therapy staff, Administrative Nurses and/or assigned hall nurse will address all areas of concern identified during the audit. Audit to be completed by 6/29/21. On 6/11/21, the QA nurse initiated an	

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F 688	Continued From page 8 The current care plan identified Resident #62 required assistance/potential to restore or maintain function of self-sufficiency for mobility as characterized by the following functions: positioning and locomotion/ambulation related to risk for development of further contractures. Resident #62 will be able to tolerate left wrist cock up splint with digit separator every day for 4 hours, without pain/discomfort/skin breakdown. Resident to wear left wrist cock up splint with digit separator every day for 4 hours. Perform stretch to left wrist and all fingers before splint application. Stretching and splinting to be done after AM activities of daily living (ADL) and monitor skin integrity under applied splint/brace daily. A Nursing Training Sheet from therapy was reviewed and showed 3 staff members were trained in September 2020: Please put patient's left wrist cock up splint with digit separators on patients left hand every day for 4 hours each day to prevent further contractures and to maintain skin integrity. Please stretch patient's left wrist and all fingers of left hand in preparation for splinting to increase joint mobility. On 5/19/21 at 11:00 AM, Resident #62 was observed not wearing her splint on her left hand. On 5/19/21 at 3:00 PM, Resident #62 was observed not wearing her splint on her left hand. On 5/20/21 at 11:30 AM, Resident #62 was observed not wearing her splint on her left hand. An interview with Therapy Staff #1 was conducted on 5/20/21 at 11:45 AM and she stated Resident #62's therapy was discontinued on 10/15/20 and	F 688	audit of all residents care planned for use of splints. This audit is to ensure splint application was identified on the Point of Care (POC) Task Listing for nursing assistant to document application of splint when indicated. Audit will be completed by 6/29/21. On 6/11/21, the Staff Facilitator initiated an in-service with all nurses to include nurse #6 and nursing assistants to include nursing assistant (NA) #2 in regards Range of Motion/Splints with emphasis on applying splints per resident plan of care to prevent a decrease in ROM ability. In-service to be completed by 6/29/21. All newly hired nurses and nursing assistants will be in-serviced by the Staff Facilitator during orientation in regards to Range of Motion/Splints. 10% of all residents care planned for use of splints, to include resident # 62 will be audited by the Minimum Data Set Nurse (MDS) utilizing Splints Audit Tool two times a week x 2 weeks then weekly x 2 weeks then monthly x 1 month to ensure that splint is applied per the plan of care to prevent a decrease ROM ability with documentation in POC. The MDS nurse will address all areas of concern identified during the audit to include application of splint per plan of care and re-education of staff. The Director of Nursing (DON) will review and initial the Splints Audit Tool two times a week x 2 weeks then weekly x 2 weeks then monthly x 1 month to ensure completion and that all areas of concerns were addressed.	

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F 688	Continued From page 9 she was to wear a splint on her left hand to prevent further contracture. She reported staff were trained on placing the splint for 4 hours a day and Resident #62 should be wearing her splint as instructed. An interview with NA #3 was conducted on 5/20/21 at 11:55 AM and she stated she was trained in September 2020 to place the splint on Resident #62, but she doesn't work with that resident any longer. She stated she was unable to locate in the resident care task list for Resident #62 a splint was required. On 5/20/21 at 12:00 PM an interview with NA #2, who works with resident on a regular basis, was conducted and she stated she had never seen Resident #62 with a splint and never knew she needed to have a splint placed. It was not on the resident task list. On 5/20/21 at 12:01 PM Nurse #6, who worked with the resident on a regular basis, was interviewed, and she stated she never knew Resident #62 needed to have a splint placed. On 5/20/21 at 12:30 Nurse # 10 was observed locating Resident #62's splint in her bedside table. The facility consultant was interviewed on 5/20/21 at 3:24 PM and she stated she was unable to locate documentation the splint was placed on Resident #62. She was able to show me in the NA task record it was there, but 2 other NA's looked, and it wasn't there. An interview was conducted with the Director of Nursing on 5/20/21 at 5:05 PM and she stated the splint should have been placed as recommended	F 688	The DON will forward the results of the Splints Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Splints Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 688	Continued From page 10 and they failed to place it. She stated it was a computer problem.	F 688		
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 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 staff interview and record review, the facility failed to administer an enteral flush for one of one resident reviewed for enteral feeding (Resident #79). Findings included: A review of the medical record revealed Resident #79 was admitted 11/28/2020 with diagnoses	F 693	On 6/11/21, the assigned hall nurse provided resident flush per physician order and assessed resident #79 for signs/symptoms of dehydration with no concerns identified. On 6/11/21, the Administrative nurses initiated an audit of medication administration records (MAR) for all	6/29/21

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F 693	Continued From page 11 including Dysphagia, Gastrostomy tube (a tube enabling nutrition and medication to be administered for someone who cannot take anything by mouth), and Dementia. The Admission Minimum Data Set (MDS) dated 12/5/2020 noted Resident #79 was severely impaired for cognition and needed total assistance for all daily care with the help of one person. A review of the Medication Administration Record (MAR) for March 2021 revealed an order dated 11/30/2020 for Enteral Feed Order every six hours for hydration flush peg tube with 150 milliliters (ml) of water every six hours. The flush was scheduled for midnight, 6:00 AM, 12 noon and 6:00 PM. On March 14,2021 the 6:00 PM flush was not documented as administered. On 5/20/2021 at 3:45 PM the Director of Nursing was interviewed and stated the facility should have called her and she would have come to the facility and passed the medications.	F 693	residents with gastrostomy feeding tube to include resident #79 from 6/1/21-6/10/21. This audit is to ensure that residents received flushes via gastrostomy tube per physician orders. The assigned hall nurse will address all areas of concern identified during the audit to include assessment of the resident and notification of the physician. Audit will be completed by 6/29/21. On 5/20/21, 100% Med Pass Audits were initiated by the Director of Nursing and Staff Facilitator with all nurses to include nurse #15 to ensure all residents with gastrostomy feeding tubes were provided flushes per physician orders. The Director of Nursing and Staff Facilitator will address all areas of concern identified during the audit. Audit will be completed by 6/29/21. On 6/11/21, the Staff Facilitator initiated an in-service with all nurses in regards to Rights of Medication Administration to include but not limited to flushes via PEG tube. In-service will be completed by 6/29/21. All newly hired nurses will be in-serviced by the Staff Facilitator in regards to Rights of Medication Administration during orientation. The QA nurse, staff facilitator and Nurse Managers will review MARs for all residents with gastrostomy feeding tube to include Resident #79 three times a week x 2 weeks, weekly x 2 weeks then monthly x 1 month to ensure residents received flushes via gastrostomy tube per	

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F 693	Continued From page 12	F 693		

physician orders. The QA nurse, staff facilitator and Nurse Managers will address all concerns identified during the audit to include assessment of resident, providing flushes per physician order, and re-education of staff. The DON will review the MARs three times a week x 2 weeks, weekly x 2 weeks and then monthly x 1 month to ensure audit was complete and all concerns addressed.

The QA nurse, staff facilitator and Nurse Managers will complete med pass audit with 5 nurses to include nurse #15 utilizing the Med Pass Audit Tool weekly x 4 weeks then monthly x 1 month to ensure residents with gastrostomy feeding tubes were provided flushes per physician orders . The QA nurse, staff facilitator and Nurse Managers will address all concerns identified during the audit to include assessment of resident, providing flushes per physician order, notification of the physician and re-education of staff. The DON will review Med Pass Audit Tool weekly x 4 weeks then monthly x 1 month to ensure audit was complete and all concerns addressed.

The DON will forward the results of the Med Pass Audit Tool and MAR Audit to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Med Pass Audit Tool and MAR Audit to determine trends and/or issues that may need further interventions put into place and to determine the need

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F 693	Continued From page 13	F 693	for further and/or frequency of monitoring.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide sufficient staff for two halls reviewed for staffing on March 14, 2021 from 3:00 PM to 7:00 PM, when no nurse was present.	F 725	On 6/10/21, the Administrator reviewed the daily staff sheet and determined there was sufficient staffing to meet resident needs and to administer resident medications/gastrostomy feedings and	6/29/21

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F 725	Continued From page 14 Findings included: 1a. This citation is cross referenced to F760: Based on staff interviews and record review, the facility failed to administer scheduled medications for four of five residents reviewed for medication administration (Resident #6, Resident #35, Resident #28, and Resident #33). b. This citation is cross referenced to F693: Based on staff interview and record review, the facility failed to administer an enteral flush for one of one resident reviewed for enteral feeding (Resident #79). A review of records revealed a nursing assignment sheet for March 14, 2021, which noted a nurse who was assigned to work from 3:00 PM to 7:00 PM had called out. A second nurse who was scheduled to work 3:00 PM to 11:00 PM also called out. The sheet listed the on-call nurse as Nurse #10 and Nurse #10 was also written in as the nurse from 7:00 PM to 11:00 PM. On 5/20/2021 at 12:06 PM, in an interview, Nurse #10 stated she came in at 7:00 PM on 3/14/2021. Nurse #10 stated she administered all medications from 7:00 PM until 11:00 PM and checked all blood sugars. In an interview on 5/20/2021 at 3:12 PM Nurse #14 stated she worked the 300 - 400 halls on 3/14/2021 from 7:00 AM until 3:00 PM. Nurse #14 indicated she reported off to Nurse #15 and gave the keys to the medication cart to her. Nurse #15 was interviewed on 5/20/2021 at 3:17	F 725	flushes per physician□s order to include resident # 6, #35, #28, #33 and # 79. On 6/11/21, the Administrator and Director of Nursing (DON) reviewed the clinical staffing schedule for the next 7 days. This review is to ensure daily staffing is sufficient based on the staff□s ability to provide needed care to residents to include administering resident medications/gastrostomy feedings and flushes per physician□s order and to enable them to reach their highest practicable physical, mental, and psychosocial well-being. There were no concerns identified. On 6/11/21, the Administrator verified the facility contracts with staffing agencies. The facility will utilize on-call Administrative nurses and agency staffing to ensure daily staffing is sufficient based on the staff□s ability to provide needed care to residents to include administering resident medications/gastrostomy feedings and flushes per physician□s order and to enable them to reach their highest practicable physical, mental, and psychosocial well-being. On 6/11/21, the Staff Facilitator initiated an in-service with all nurses, Administrator, and Scheduler to include nurse #10, #14 and #15 in regards to Sufficient Staff with emphasis on staffing expectations, ensuring the schedule is reviewed daily for adequate staffing patterns and notification of On-Call nurse, DON and/or Administrator when sufficient	

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F 725	Continued From page 15 PM, and stated she got report, counted the narcotics on the medication cart, and took the cart keys from Nurse #14 on 3/14/2021. Nurse #15 stated she took the keys and report because she was told that someone was coming to work the 300 - 400 halls. In an interview with the Director of Nursing (DON) on 5/20/2021 at 3:45 PM, the DON stated she was called and told that both nurses scheduled for the 300 - 400 hall for evening shift (one for 3:00 PM to 7:00 PM and one for 3:00 PM to 11:00 PM) had called out and the on call nurse would be coming in. The DON indicated she spoke with Nurse #10, who was on call, and who told the DON as soon as she got her car, she would be there. The DON stated she did not realize Nurse #10 would not get there until 7:00 PM. The DON stated she could have gone to the facility and passed medications until Nurse #10 arrived.	F 725	staff is not available. The All newly hired Administrators, DON, nurses and schedulers will be in-serviced by the Staff Facilitator during orientation in regards to Sufficient Staff. The Director of Nursing, Administrative Nurse and/or Administrator will review staffing schedule 5 x a week x 4 weeks then monthly x 1 month to include weekends utilizing the Sufficient Staff Audit Tool. This audit is to ensure daily staffing is sufficient based on the staff□s ability to provide needed care to residents to include administering resident medications/gastrostomy feedings and flushes per physician□s order and to enable them to reach their highest practicable physical, mental, and psychosocial well-being. The Director of nursing, Administrative Nurse and/or Administrative staff on Duty will address all concerns identified during the audit to include but not limited to notification of the Administrator/DON and obtaining required nursing coverage. The Administrator will review the Sufficient Staff Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will forward the results of Sufficient Staff Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Sufficient Staff Audit Tool to determine trends and / or issues that	

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F 725	Continued From page 16	F 725	may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 760 SS=E	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 and resident interviews and record review, the facility failed to administer scheduled medications for four of five residents reviewed for medication administration (Resident #6, Resident #35, Resident #28, and Resident #33). Findings included: 1.A review of the medical record revealed Resident #6 was admitted 1/29/2019 with diagnoses including Diabetes Mellitus, and Asthma. The Quarterly Minimum Data Set (MDS) dated 2/12/2021 noted Resident #6 was cognitively intact and needed extensive assistance for all daily care with the help of one person. A review of orders noted on 12/2/2020 there was an order for sliding scale insulin with blood sugar checks at meals and insulin coverage as required. Inject as per sliding scale: if 200 - 250 = 3 units; 251 - 300 = 6 units; 301 - 350 = 9 units; 351 - 400 = 12 units. Call MD if Finger Stick Blood Sugar (FSBS) is over 400, subcutaneously four times a day for Diabetes.	F 760	On 6/11/21, the Director of Nursing assessed resident #6 finger stick blood sugar and ensured medications were administered per physician□s order. On 6/11/21, the Director of Nursing assessed resident #35 finger stick blood sugar and ensured medications to include Haldol were administered per physician□s order. On 6/11/21, the Director of Nursing assessed resident #28 and ensured medications to include Eliquis were administered per physician□s order. On 6/11/21, the Director of Nursing assessed resident #33 and ensured medications to include Hydralazine were administered per physician□s order. On 5/21/21, the Medical Director was notified of medication omissions for resident #6, #35, #28 and #33 with no new orders. On 6/11/21, the Director of Nursing	6/29/21

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F 760	Continued From page 17 A review of the Medication Administration Record (MAR) dated March 2021 indicated on March 14, 2021 there was no documented reading for the FSBS, and no documented amount of insulin administered for the time of 4:30 PM. The next scheduled time for a FSBS was 8:30 PM and the FSBS was documented at 312, also documented were 9 units of insulin administered. On 5/20/2021 at 2:30 PM, Resident #6 was interviewed and stated she did not remember getting checked that day or receiving insulin. On 5/20/2021 at 3:45 PM, the Director of Nursing stated she could have given the medications on the hall if she had been notified. 2. A review of the medical record revealed Resident #35 was admitted 12/3/2020 with diagnoses including Schizophrenia, Post Traumatic Stress Disorder, Major Depressive Disorder, Diabetes Mellitus, and other impulse disorders. The Quarterly Minimum Data Set (MDS) dated 4/2/2021 noted Resident #35 was severely impaired for cognition and needed extensive to total assistance for all care with the help of one person. Resident #35 was care planned on 6/25/2020 for Diabetes Mellitus and interventions included Finger Stick Blood Sugar (FSBS) as ordered by physician. The care plan for use of psychotropic drugs, dated 6/25/2020 included intervention of administer medications per physician orders. A review of orders for Resident #35 revealed an	F 760	initiated an audit of all MARS from 6/1/21-6/10/21. This audit is to ensure all medications were administered per physician□s order. The assigned hall nurse, unit manager and staff facilitator will address all concerns identified during the audit. Audit will be completed by 6/29/21. On 5/20/21, 100% Med pass audits were initiated by the Director of Nursing and Staff Facilitator with all nurses to include nurse #15 to ensure all residents medications were administered per physician orders. The Director of Nursing and Staff Facilitator will address all areas of concern identified during the audit. Audit will be completed by 6/29/21. On 6/11/21, the Staff Facilitator initiated an in-service with all nurses and medication aides in regards to Rights of Medication Administration. Emphasis is on administering medications per physician order and notifying the Director of Nursing if at any time a nurse is unavailable or unable to administer medications per physician□s order. In-service will be completed by 6/29/21. All newly hired nurses will be in-serviced by the Staff Facilitator in regards to Rights of Medication Administration during orientation. The QA nurse, staff facilitator and Nurse Managers will review MARs for 15 residents to include Resident #6, Resident #35, Resident #28, and Resident #33 three times a week x 2 weeks, weekly x 2	

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F 760	Continued From page 18 order, dated 1/25/2021, for Haloperidol tablet 5 milligram (mg), give 1 tablet by mouth two times a day related to Schizophrenia, unspecified. An order dated 12/3/2020 noted Humalog solution 100 unit/milliliter (ml) (Insulin Lispro) Inject as per sliding scale: if 150 - 200 = 1 unit; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 =4 units; 351 or higher = 5 units and call MD, subcutaneously four times a day for type 2 Diabetes Mellitus. a. A review of the Medication Administration Record (MAR) for March 14, 2021 for Resident #35 revealed an order for Haldol 5 mg give one tablet by mouth two times a day. The scheduled times were 8:00 AM and 4:00 PM. There was no documented check mark (denoted given) and no documented signature for the 4:00 PM dose. b. Further review of the MAR for 3/14/2021 revealed an order for Humalog solution 100 units/ml (insulin Lispro) Inject as per sliding scale. This FSBS and medication was scheduled at 6:30 AM, 11:30 AM, 4:30 PM and 9:00 PM. In the column for the FSBS no reading was documented. In the column for amount of insulin given, there was none documented as administered. For the 9:00 PM column the FSBS was documented as 247 and Resident #35 was administered 2 units of insulin. On 5/20/2021 at 3:45 PM, the Director of Nursing (DON) stated if the facility had called, she could have gone to the facility and passed the medications that evening. The DON said she felt it was a communication issue as much as anything.	F 760	weeks then monthly x 1 month to ensure medications were administered per physician□s order. The QA nurse, staff facilitator and Nurse Managers will address all concerns identified during the audit to include assessment of resident, notification of the physician for further instructions and re-education of staff. The DON will review the MARs three times a week x 2 weeks, weekly x 2 weeks and then monthly x 1 month to ensure audit was complete and all concerns addressed. The QA nurse, staff facilitator and Nurse Managers will complete med pass audit with 5 nurses to include nurse #15 and medication aides utilizing the Med Pass Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all residents with gastrostomy feeding tubes were provided flushes per physician orders . The QA nurse, staff facilitator and Nurse Managers will address all concerns identified during the audit to include assessment of resident, providing flushes per physician order, notification of the physician and re-education of staff. The DON will review Med Pass Audit Tool weekly x 4 weeks then monthly x 1 month to ensure audit was complete and all concerns addressed. The DON will forward the results of the Med Pass Audit Tool and MAR Audit to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months	

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F 760	Continued From page 19 3. The medical record review revealed Resident #28 was admitted 11/27/2020 with diagnoses of Atrial Fibrillation and hypertension. The Quarterly Minimum Data Set (MDS) dated 3/12/2021 noted Resident #28 to be cognitively intact and needed extensive assistance only for toilet use and personal hygiene, all other daily care was independent of help or supervision only. The care plan dated 3/26/2021 noted a focus for potential for bleeding related to anticoagulant therapy for Atrial fibrillation. Interventions included Administer medication as ordered by the physician. A review of orders revealed an order on 12/9/2020, for Eliquis tablet (Apixaban) give 2.5 milligrams (mg) by mouth two times a day for anticoagulant. A review of the Medication Administration Record (MAR) for 3/14/2021 noted Eliquis tablet (Apixaban). Give 2.5 mg by mouth two times a day for anticoagulant. The scheduled times for the medication were 8:00 AM and 4:00 PM. The 4:00 PM column was not documented as administered. On 5/20/2021 at 3:45 PM, the Director of Nursing (DON) stated if the facility had called, she could have gone to the facility and passed the medications that evening. The DON said she felt it was a communication issue as much as anything. 4. A review of the medical record indicated Resident #33 was admitted 12/3/2020 with diagnoses including hypertension, Diabetes	F 760	to review the Med Pass Audit Tool and MAR Audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 760	Continued From page 20 Mellitus and peripheral vascular disease. The Significant Change Minimum Data Set (MDS) dated 3/26/2021 noted Resident #33 was moderately impaired for cognition and needed extensive to total assistance for all daily care with the help of one person. Order review revealed an order dated 12/15/2020 for Hydralazine Hydrochloride tablet 50 milligram (mg) give 1.5 tablet by mouth three times a day for hypertension. A review of the Medication Administration Record (MAR) for March 2021 revealed the Hydralazine 50 mg 1.5 tablet by mouth was scheduled for midnight, 8:00 AM and 4:00 PM. On 3/14/2021 the 4:00 PM dose was not documented as administered. On 5/20/2021 at 3:45 PM, the Director of Nursing (DON) stated if the facility had called, she could have gone to the facility and passed the medications that evening. The DON said she felt it was a communication issue as much as anything.	F 760		
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	F 880		6/29/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21	F 880		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 05/20/2021

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F 880	Continued From page 22 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 observation and staff interview and record review, the facility failed to screen two state surveyors who entered the building after hours for signs and symptoms of COVID - 19. This failure occurred during a global pandemic. Findings included: The Center for Medicare Services (CMS) Memorandum on Guidance under Infection Control, revised 4/27/2021, stated "Regardless of the frequency of testing being performed or the facility ' s COVID-19 status, the facility should continue to screen all staff (each shift), and all persons entering the facility such as vendors, volunteers, and visitors, for signs and symptoms of COVID-19". In an interview on 5/17/2021 at 9:15 AM, the facility Director of Nursing (DON) stated staff, visitors, vendors and anyone else who comes	F 880	On 6/11/21, the Infection Preventionist and Administrator under the oversight of the Facility Consultant initiated an audit of all assigned screeners. This audit is to ensure that all staff and/or visitors were screened per facility protocol to include but not limited to instructing staff/ visitors to sanitized hands prior to screening process, review of Covid screening questions, temperature monitoring and completion of the screening log with staff/visitor signature. The Administrator and/or Staff Facilitator will address all areas of concern identified during the audit to include re-training of staff. The audit will be completed by 6/29/21. The Infection Preventionist and DON addressed all concerns identified during the audit. On 6/10/21, The Infection	

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F 880	Continued From page 23 inside the facility are screened for temperature, questions pertaining to COVID -19 signs and symptoms are asked and recorded. The DON indicated certain staff have been trained to screen and if anyone leaves the parking lot and returns, they are screened again. NA #3 came to the door and the surveyors entered. NA #3 left immediately. The surveyors stood in the lobby at the screening station. No one came to screen them. Nurse #11 was standing at a medication cart, facing the surveyors, but did not come toward them. The surveyors approached Nurse #11 who stated he would be with them as soon as he called his Director of Nursing. One surveyor asked what they should do, and Nurse #11 again stated he would be with them as soon as he called his Director of Nursing. Surveyors began their observations and interviews and, when completed, were accompanied to the door by Nurse #11. On 5/20/2021 at 9:00 AM the Director of Nursing stated in an interview Nurse #11 should have screened the surveyors, and Nurse #11 had been trained in the screening process.	F 880	Preventionist/Staff Facilitator initiated an in-service with all assigned staff in regards to Screening Process with emphasis on instructing staff/ visitors to sanitized hands prior to screening process, review of Covid screening questions, temperature monitoring and completion of the screening log with staff/visitor signature. In-service to be completed by 6/29/21. All newly hired screeners will be in-serviced by the Staff Facilitator during orientation in regards to Screening Process Facility leadership staff to include the Infection Preventionist, Medical Records Director, Social Worker and/or Minimum Data Set Nurse (MDS) will observe the screening process 10 times weekly x 4 weeks then monthly x 1 month to include all shifts and weekends utilizing the Screening Audit Tool. The Infection Preventionist, Medical Records Director, Social Worker and/or MDS nurse will address all areas of concern identified during the audit. The Director of Nursing will review and initial the Screening Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were identified. The Administrator will forward the results of the Screening Audit Tool the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI committee will meet monthly x 2 months and review the Screening Audit Tool to determine trends and / or issues that may	

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F 880	Continued From page 24	F 880	need further interventions put into place and to determine the need for further and / or frequency of monitoring.	