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	345567	A. BUILDING _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification and Complain survey was conducted on 05/23/21 through 05/27/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9JMQ11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 05/23/21 to conduct a recertification survey and exited on 05/27/21. Additional information was obtained on 06/04/21. 8 of the 18 complaint allegations were substantiated. Therefore, the exit date was changed to 06/04/21.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		6/23/21

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

Electronically Signed | 06/21/2021

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to promote a dignified dining experience by standing over residents while feeding for 2 of 8 residents reviewed for dignity (Resident #9 and #39). The findings include: 1. Resident #9 was admitted to the facility on 08/14/20 with diagnoses that included Alzheimer's Disease. The recent quarterly Minimum Data Set assessment dated 01/28/21 indicated Resident #9 had severe cognitive impairment and required extensive assistance with eating. On 05/24/21 from 9:52 AM to 10:12 AM a continuous observation was made of Nurse Aide	F 550	Resident #39 remains needing extensive assistance for all activities of daily living, remains in the facility and have suffered no obvious adverse effects from the deficient practice. Resident #9 no longer resides in the facility. All residents have the potential to be affected, therefore facility Administrator completed rounding observations on 5/27/2021 at supper time, for the next 3 meals to ensure all other residents were fed with dignity, no other deficient practice was observed. To prevent this from recurring on 6/3/21, the Assistant Director of Nursing completed dignity education for all staff responsible for feeding, specifically	

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F 550	Continued From page 2 (NA) #7 standing at Resident #9's bedside while feeding the Resident her breakfast meal. There was an empty facility chair on the roommate's side of the room. An interview was conducted with Nurse Aide #7 on 05/24/21 at 10:31 AM. The NA explained Resident #9 required a lot of encouragement to feed and she only ate small bites at a time. The NA continued to explain that she could see where being at eye level of Resident #9 while feeding her was important as to not make her feel rushed but stated she thought the empty facility chair belonged to the roommate and she could not use it. An interview was conducted with Nurse #7 on 05/24/21 at 10:19 AM. The Nurse explained that it was important for the staff to be seated at eye level while feeding the residents because it made the resident feel more comfortable and not rushed during the dining experience. The Nurse stated the facility chair in Resident #9's room was available for use on either resident that resided in the room. On 05/24/21 at 5:28 PM during an interview with the Director of Nursing (DON) she explained it was her expectation that the staff be seated at eye level of the resident while feeding them in order to promote a positive dining experience. During an interview with the Administrator on 05/27/21 at 2:47 PM he stated it was his expectation that the staff be seated while feeding the residents. 2. Resident #39 was admitted to the facility on 02/22/18 with diagnoses that included	F 550	addressing standing while feeding residents. Effective 6/3/2021, all new hires responsible for feeding or any agency staff working will receive this education. During routine rounds and assistance provided during meal times, the facility interdisciplinary staff will monitor for residents being assisted with meals and ensure that staff are sitting while feeding. Any negative findings will be addressed at that time. To monitor and maintain ongoing compliance, beginning 6/21/2021, the facility Administrator or their designee will audit 10 residents per week, that require staff assistance to be fed, for 12 weeks to validate dignity compliance. Beginning 06/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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F 550	Continued From page 3 non-Alzheimer's Dementia. The significant change Minimum Data Set assessment dated 03/28/21 indicated Resident #39 had severe cognitive impairment and required extensive assistance with eating. On 05/25/21 from 9:04 AM to 9:20 AM a continuous observation was made of the Business Office Manager (BOM) standing while feeding Resident #39 her breakfast meal. There was no available chair to use in the Resident's room. An interview conducted with the BOM on 05/25/21 at 3:56 AM revealed the BOM confirmed she stood while she fed Resident #39 her breakfast meal and stated there was no chair available in the Resident's room to sit in while she fed the Resident. The BOM explained she knew it was important to feed Resident #39 at eye level and added she did not want to make Resident #39 wait any longer for her breakfast while she looked for a chair. On 05/27/21 at 10:48 AM during an interview with the Director of Nursing (DON) she explained that her expectation was that the staff sit at eye level of the resident while feeding the resident in order to prevent the resident from feeling rushed and it promoted a more comfortable dining experience. During an interview with the Administrator on 05/27/21 at 2:47 PM he stated it was his expectation that the staff be seated while feeding the residents.	F 550		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		6/23/21

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F 578	Continued From page 4	F 578		

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

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

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

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F 578	Continued From page 5 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain accurate advance directives throughout the medical record for 7 of 30 residents reviewed for advance directives (Resident #1, Resident 36, Resident #60, Resident #135, Resident #137, Resident #21, and Resident #16). The findings included: 1. Resident #1 was admitted to the facility on 05/05/21 with diagnoses that included pathological fracture of femur, post hemorrhagic anemia, Parkinson's disease, anxiety, and others. A physician order dated 05/05/21 read, Full Code. The comprehensive Minimum Data Set (MDS) dated 05/11/21 indicated that Resident #1 was cognitively intact for daily decision making. A care plan dated 05/12/21 read in part, Resident is full code. The goal of the care plan stated, Resident's wishes will be followed. The interventions include document the resident's advance directives, involve the physician in advanced directive conversation, and review advanced directive with resident and family periodically. The Resident Code status book located at the nurse's station on 05/23/21 revealed Resident #1 had a Do Not Resuscitate (DNR) in place. An interview was conducted with the Social	F 578	Resident #1, Resident #36, Resident #60, Resident #135, Resident #21 and Resident #16 Advance Directives orders, care plans and nurse station books were corrected on 6/3/2021. No adverse events occurred due to discrepancies in advance directives. Resident #137 no longer resides in the facility. All residents have the potential to be affected, therefore an audit was complete on 5/25/21 for all current residents, to ensure all code status orders match the care plan and the binders at the nurses stations. To prevent this from recurring on 6/3/21, the Administrator completed education to the Social Worker, Social Worker Assistant and Director of Medical Records on the facility policy and procedures for Advance Directives. Education will be provided for any staff responsible for updating and maintaining medical records upon hire. Code status will be reviewed quarterly by the social services worker or designee to ensure the code status order matches the care plan and the binder at the nurses station. Any discrepancies will be corrected immediately. To monitor and maintain ongoing compliance, beginning 6/21/2021, the facility Administrator or their designee will audit all new admissions and	

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F 578	Continued From page 6 Worker (SW) on 05/24/21 at 3:22 PM. The SW stated that she had worked at the facility for a month and was still learning how things worked within the facility. She stated that she spoke with the resident and/or family and asked what their code status was going to be and then she would get the appropriate form signed and scanned into the system and then placed the paper work in the code status book at each nursing station. The SW stated in the past she had completed the care plan, but she was not sure who was doing it at this facility as she was still very new. She indicated that the Code Status books at the nurse's stations were used in case of an emergency and she had been trying to keep those updated. The SW stated that Resident #1 recently changed from a full code to a DNR and her care plan should have been updated. She stated that she would update that immediately to make sure that the advance directives matched throughout the medical records. An interview was conducted with the Director of Nursing (DON) and the Administrator on 05/27/21 at 2:48 PM. The DON stated that in case of emergency the nurses would refer to the electronic medical record and if the computer system was down they would refer to the Code Status books at the nurse's station. The DON and Administrator both stated that they expected the electronic medical record and Code Status book to all match 2. Resident #36 was admitted to the facility on 06/23/19 with diagnoses that included: heart disease, diabetes mellites, heart failure, depression, Parkinson's disease, and others. A care plan dated 06/23/19 read in part, Resident	F 578	readmissions from the week prior and 5 random resident charts per week for 12 weeks to validate accuracy that orders match the care plan and that the binders at the nurses station has the correct information available. Beginning 6/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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has advance directives. Resident is a full code. The goal read; Resident's wishes will be followed. The interventions included: document the resident's advance directives, involve physician in advance directive conversation, and review advance directives with resident/family periodically.

A physician order dated 07/15/19 read Do Not Resuscitate (DNR).

The comprehensive Minimum Data Set (MDS) dated 03/20/21 indicate that Resident #36 was cognitively intact for daily decision making.

The Resident Code Status book at the nurse's station was made on 05/23/21 and revealed Resident #36 had a DNR in place.

An interview was conducted with the Social Worker (SW) on 05/24/21 at 3:22 PM. The SW stated that she had worked at the facility for a month and was still learning how things worked within the facility. She stated that she spoke with the resident and/or family and asked what their code status was going to be and then she would get the appropriate form signed and scanned into the system and then placed the paper work in the code status book at each nursing station. The SW stated in the past she had completed the care plan, but she was not sure who was doing it at this facility. She indicated that the Code Status books at the nurse's station were used in case of an emergency and she had been trying to keep those updated. The SW stated she did not know anything about Resident #36's code status but she would go and talk with her and make sure to correct the discrepancy between the medical records.

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An interview was conducted with the Director of Nursing (DON) and the Administrator on 05/27/21 at 2:48 PM. The DON stated that in case of emergency the nurses would refer to the electronic medical record and if the computer system was down they would refer to the Code Status books at the nurse's station. The DON and Administrator both stated that they expected the electronic medical record and Code Status book to all match.

3. Resident #60 was admitted to the facility on 04/15/21 and most recently readmitted to the facility on 05/21/21 with diagnoses that included: diabetes, hypertension, dysphagia, and others.

A comprehensive Minimum Data Set (MDS) dated 04/17/21 revealed that Resident #60 was cognitively intact for daily decision making.

A physician order dated 05/22/21 indicated Resident #60 was a Do Not Resuscitate (DNR). Review of Resident #60's medical record revealed no care plan for advance directives.

The Resident Code Status book at the nurse's station was made on 05/23/21 and revealed no documentation indicating whether Resident #60 was a full code or a DNR.

An interview was conducted with the Social Worker (SW) on 05/24/21 at 3:22 PM. The SW stated that she had worked at the facility for a month and was still learning how things worked within the facility. She stated that she spoke with the resident and/or family and asked what their code status was going to be and then she would get the appropriate form signed and scanned into

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the system and then placed the paper work in the code status book at each nursing station. The SW stated in the past she had completed the care plan, but she was not sure who was doing it at this facility. She indicated that the Code Status books at the nurse's station were used in case of an emergency and she had been trying to keep those updated. The SW stated she did not know anything about Resident #60's code status but she would go and find out and correct the discrepancy so that the Resident #60's code status matched through all the locations.

An interview was conducted with the Director of Nursing (DON) and the Administrator on 05/27/21 at 2:48 PM. The DON stated that in case of emergency the nurses would refer to the electronic medical record and if the computer system was down they would refer to the Code Status books at the nurse's station. The DON and Administrator both stated that they expected the electronic medical record and Code Status book to all match.

4. Resident #135 was admitted to the facility on 05/21/21 with diagnoses that included: non traumatic intracranial hemorrhage, heart disease, history of falls, and others.

A physician order dated 05/21/21 read, Full Code.

Resident #135's care plan on 05/23/21 revealed no care plan for advance directives.

The Resident Code Status book at the nurse's station on 05/23/21 revealed no documentation indicating whether Resident #135 was a Full Code or a Do Not Resuscitate (DNR).

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The comprehensive Minimum Data Set (MDS) dated 05/27/21 was not completed.

An interview was conducted with the Social Worker (SW) on 05/24/21 at 3:22 PM. The SW stated that she had worked at the facility for a month and was still learning how things worked within the facility. She stated that she spoke with the resident and/or family and asked what their code status was going to be and then she would get the appropriate form signed and scanned into the system and then placed the paper work in the code status book at each nursing station. The SW stated in the past she had completed the care plan, but she was not sure who was doing it at this facility. She indicated that the Code Status books at the nurse's station were used in case of an emergency and she had been trying to keep those updated. The SW stated that Resident #135's paperwork was on her desk and she was going to get it signed by the physician and place it in the Resident Code Status book at the nurse's station. She added she would then update the care plan so that the advance directives matched throughout the medical records locations.

An interview was conducted with the Director of Nursing (DON) and the Administrator on 05/27/21 at 2:48 PM. The DON stated that in case of emergency the nurses would refer to the electronic medical record and if the computer system was down they would refer to the Code Status books at the nurse's station. The DON and Administrator both stated that they expected the electronic medical record and Code Status book to all match.

5. Resident #137 was admitted to the facility on

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05/21/21 with diagnoses that included osteoarthritis, presence of artificial knee joint, malignant neoplasm of prostate, and others.

A physician order dated 05/21/21 read, Full Code.

Resident #137's care plan on 05/23/21 revealed no care plan for advance directives.

The Resident Code Status book at the nurse's station on 05/23/21 revealed no documentation indicating whether Resident #137 was a Full Code or a Do Not Resuscitate (DNR).

An interview was conducted with the Social Worker (SW) on 05/24/21 at 3:22 PM. The SW stated that she had worked at the facility for a month and was still learning how things worked within the facility. She stated that she spoke with the resident and/or family and asked what their code status was going to be and then she would get the appropriate form signed and scanned into the system and then placed the paper work in the code status book at each nursing station. The SW stated in the past she had completed the care plan, but she was not sure who was doing it at this facility. She indicated that the Code Status books at the nurse's station were used in case of emergency and she had been trying to keep those updated. The SW stated that Resident #137's paperwork was on her desk and she was going to get it signed by the physician and place it in the Resident Code Status book at the nurse's station. She added she would then update the care plan so that the advance directives matched throughout the medical records locations.

An interview was conducted with the Director of Nursing (DON) and the Administrator on 05/27/21

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at 2:48 PM. The DON stated that in case of emergency the nurses would refer to the electronic medical record and if the computer system was down they would refer to the Code Status books at the nurse's station. The DON and Administrator both stated that they expected the electronic medical record and Code Status book to all match.

6. Resident #21 was admitted to the facility on 7/11/20 with diagnoses that included a history of falling.

A physician's order dated 7/11/20 indicated Resident #21 admitted to the facility as a "Full Code".

Resident #21's Advanced Directive care plan dated 7/11/20 indicated advanced directive was a full code and her wishes would be followed.

A review of a notebook labeled "Code Status" located at the 500/600 hall nurses revealed a Golden Rod form that had been signed and dated on 7/13/20 indicated Resident #21 was a Do Not Resuscitate (DNR).

An additional physician's order dated 10/27/20 indicated Resident #21 had elected to be a DNR.

A quarterly Minimum Data Set (MDS) dated 2/22/21 revealed Resident #21 was cognitively intact for decision making.

An interview on 05/25/21 at 12:20 PM with the Social Worker (SW) revealed she was new to her position and was still acclimating to her responsibilities. She indicated she was not familiar with Resident #21; however, she was responsible for speaking to each resident and/or

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AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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responsible party to determine if they had an advanced directive they wished to be carried out. She stated upon determination of the Advanced Directive, she and nursing personnel would share the role of obtaining an updated physician's order and the care plan as well as ensuring a Golden Rod or Medical Order for Scope of Treatment (MOST) form was signed and placed in the Code Status book at the nurses station in the event the resident wished to elect to be a DNR or specify what life sustaining measures they wished to be performed at end of life. The SW explained she had not yet been trained to modify the care plans but would ensure it had been updated.

An interview on 05/27/21 at 2:48 PM with the Director of Nursing (DON) and the Administrator revealed they expected the Advanced Directive to be consistent and congruent throughout the electronic medical record and the Code Status book at the nurses' stations to ensure each resident's wishes were observed.

7. Resident #16 was admitted to the facility on 02/04/21 with diagnoses that included heart failure.
Resident #16's Care Plan dated 02/04/21 indicated the Resident had Advanced Directive: DNR (do not resuscitate) with the goal that Resident #16's wishes would be followed by documentation of Advanced Directive, involve Provider in Advanced Directive conversations and the Advanced Directive would be periodically reviewed with the Resident.

Resident #16's admission Minimum Data Set assessment dated 02/10/21 indicated she was cognitively intact.

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F 578	Continued From page 14 On 05/23/21 at 5:48 PM a review of Resident #16's medical record revealed: on 02/17/21 the Code Status Notebook indicated the Resident was a Full Code and on 02/18/21 the Resident's electronic health record (EHR) indicated Resident #16 was a Full Code. On 05/26/21 at 8:48 AM an interview with the Social Worker (SW) revealed that she was responsible for the Advanced Directive process which included ensuring the residents' Advanced Directive information and documents matched throughout the medical record. The SW continued to explain that she was in the process of conducting audits for the Advanced Directives and often she had found other Care Plans that did not match the residents' Advanced Directive. The SW stated she would follow up on the discrepancy. An interview with the Director of Nursing (DON) on 05/27/21 at 10:51 AM revealed the SW was responsible for ensuring the residents' Advanced Directive matched throughout the medical record which included making sure the residents' Care Plan matched the desired Advanced Directive. The DON also revealed the SW should conduct periodic audits to ensure all the information matched. The DON stated it was her expectation that the residents' Care Plan matched their desired Advanced Directive. During an interview with the Administrator on 05/27/21 at 2:47 PM he stated it was his expectation that the residents' Advanced Directive matched throughout the medical record.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		6/23/21

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F 580	Continued From page 15 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 16 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Nurse Practitioner interview the facility failed to notify the medical provider at the onset of a change in condition in a resident that was actively dying and failed to notify the provider that the resident's Morphine had been withheld for 1 of 1 resident (Resident #80) reviewed for death. The findings included: Resident #80 was admitted to the facility on 04/29/21 with diagnoses that included fracture of sacrum, acute/chronic respiratory failure, pneumonitis, adult failure to thrive, dysphagia, and others. Review of the Medication Administration Record (MAR) dated 05/01/21 through 05/31/21 revealed that on 05/22/21 at 8:00 AM, 12:00 PM, and 4:00 PM Resident #80's morphine doses were not administered as documented by Nurse #4 by placing a X on the administration record. Review of the comprehensive Minimum Data Set (MDS) dated 05/05/21 indicated that Resident #80 was cognitively intact for daily decision making and required extensive assistance with	F 580	Resident #80 no longer resides at the facility. All residents have the potential to be affected, therefore a review of the last 72 hours of progress note were reviewed on 5/25/2021, for all current residents. Based on record review, staff interviews and residents interviews on 5/25/2021, any identified change of condition was reviewed to ensure provider and responsible parties were notified and documentation was present in the medical record to reflect the change of condition. To prevent this from recurring, beginning 5/25/2021, the DON or designee educated the licensed nursing staff on the requirement to assess the resident during a change of condition, notify the physician of the change of condition, and document the change and notification in the medical record. Education was completed on 6/3/2021. Effective 5/25/2021, any new licensed staff that are hired or licensed agency staff will receive this education. Beginning 5/26/2021, the clinical team will	

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F 580	Continued From page 17 activities of daily living. Review of a physician order dated 05/07/21 read, Morphine Sulfate 10 milligrams (mg)/5 milliliters (ml). Give 0.25 ml by mouth three times a day for pain. Review of Resident #80's medical record revealed no documentation of any change of condition or notification to the medical provider on 05/21/21 or 05/22/21. An interview was conducted with Nurse #3 on 05/23/21 at 9:59 AM. Nurse #3 indicated she had worked third shift in the facility and was just catching up on her documentation before leaving the facility. Nurse #3 stated, I think he (Resident #80) "is actively dying and we have been watching him very closely." Review of a progress note dated 05/23/21 at 11:20 AM read in part, this nurse into assess Resident #80. He was found to have moderate secretions. The NP was called for atropine (drying agency) drops for secretions at 11:33 AM. This nurse stayed with Resident #80 to continue to assess his breathing. At 11:40 AM Resident #80 took his last breath. NP and family notified. Signed by Nurse #8. An interview was conducted with Nurse #4 on 05/25/21 at 12:03 PM. Nurse #4 confirmed that she had worked the unit where Resident #80 resided on both Saturday 05/22/21 and Sunday 05/23/21. Nurse #4 stated that on 05/22/21 Resident #80 was up in the dining room and began to have "this terrible outpouring of mucus from his mouth and nose and he could not manage them." Nurse #4 stated that she kept	F 580	review progress notes as part of clinical meeting and ensure change of conditions are documented in the medical record as well as verifying that the provider and responsible party were notified of the change. During routine rounds staff will observe for and communicate any change of conditions to the charge nurse and discuss these changes in the clinical meeting. Any deficient practice will be addressed immediately. To monitor and maintain ongoing compliance, beginning 6/21/2021, the DON or designee will audit 10 residents charts per week for 12 weeks including and 10 resident Medication administration to ensure medications were withheld do to a change in condition, to ensure that the chart reflects the assessment of the identified residents change of conditions and notifications to the provider and responsible party. Beginning 6/28/2021, The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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cleaning him up as she traveled through the dining room while passing medications but she stated the mucus was so much that they had to change his clothes and they put a towel across him to catch the mucus because at one point it was running from his mouth and nose to the floor. Nurse #4 stated that they finally laid Resident #80 in his bed and elevated his head of bed and put a towel across his chest to catch the copious amounts of phlegm and instructed the Nurse Aides (NAs) to keep an eye on him and make sure he was clean. Nurse #4 state that after they laid Resident #80 down in the bed which was around 9:30 AM he began to be less responsive and went from mumbling to only fluttering his eyes when they would call his name. Nurse #4 stated she did not notify the medical provider on 05/22/21 or 05/23/21 that Resident #80 was having copious amount of green/yellow phlegm or that he had become less responsive. Nurse #4 did state that on 05/22/21 she called the on-call provider to notify them that Resident #80 was not discharging home. She stated that he was a Do Not Resuscitate (DNR) and believed he was actively dying. Nurse #4 added that she was still very new the facility and did not know that these changes were not normal for Resident #80.

A follow up interview with Nurse #3 was conducted on 05/25/21 at 12:56 PM. Nurse #3 again confirmed that she had worked Friday night 12 hour and again Saturday night 12 hours. Nurse #3 stated that on Friday 05/21/21 Resident #80 was his usual baseline. She stated when she returned on Saturday 05/22/21 the NAs were telling her that Resident #80 had the lots of mucus and loose stools all day long and were having trouble keeping him clean. She stated that the mucus was coming in copious amounts

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and was tan with darker spots in color and she tried to keep him clean. Nurse #3 stated that Nurse #4 had reported that Resident #80 had the mucus and loose stools all day and they had done the best they could to keep him clean. She stated that on Saturday night Resident #80 had rested and had squeezed her hand in response to questions but that was it. Nurse #3 stated she did not reach out to the medical provider because she knew that Resident #80 was a DNR and was transitioning into actively dying.

An interview was conducted with facility's NP on 05/25/21 at 2:12 PM. The NP stated that no one at the facility contacted her on 05/22/21 to report any changes with Resident #80. She stated that Nurse #8 called her Sunday morning for an order for Atropine drops but that was the first she had heard about Resident #80 because she assumed he had discharged home on 05/22/21. She added that when she examined Resident #80 on 05/19/21 he was baseline he was alert and did not have the excessive secretions that were reported on 05/23/21 when Nurse #8 called for atropine drops which would have been a change for Resident #80. The NP stated that had the facility staff called her or the on-call provider they could have managed his secretions by suctioning or the atropine drops and could have made sure he was receiving his scheduled morphine to make his dying process more comfortable for Resident #80. She added Resident #80 was ordered Morphine 5 mg three times a day for pain and comfort and she expected the nursing staff to administer the medications as ordered and to notify the provider if the medications were not administered as ordered.

A follow up interview was conducted with Nurse

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F 580	Continued From page 20 #4 on 05/25/21 at 4:45 PM. Nurse #4 stated on 05/22/21 she had not administered Resident #80's morphine because he did not appear to be any pain and thought the Morphine would make him drowsy and have less control of his bodily functions. Nurse #4 continued to say that on 05/23/21 she was pulled from the medication cart to tend to other duties and had a medication aide passing medications. Nurse #4 stated that she instructed the Medication Aide to not administer Resident #80's morphine because he did not appear to be in pain and was not necessary in her opinion. An interview was conducted with the Director of Nursing (DON) and the Administrator on 05/27/21 at 2:48 PM. The DON stated that she expected that when a staff member identified a change in resident condition that they assessed the resident, notified the family and medical provider, and documented accordingly. The DON further stated that the staff conducted a pain assessment every shift and when administering pain medication they were to document where the pain was located and then go back and document the effectiveness of it. The DON stated that she expected Nurse #4 to administer Resident #80's pain medication as ordered by the physician and if not then to notify the provider for further guidance. The Administrator stated he expected the staff to follow the policy and procedures of the facility in regard to notification to the medical provider and any medical care rendered to the resident.	F 580		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment	F 636		6/23/21

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The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff

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F 636	Continued From page 22 members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Minimum Data Set (MDS) within 14 days of a resident's admission for 1 of 5 sampled residents (Resident #235). Findings Included: Resident #235 was admitted to the facility on 05/08/21. Resident #235's admission Minimum Data Set Assessment dated 05/08/21 revealed it to not be complete. Review of the in-progress assessment revealed sections A, B, G, H, I, J, L, M, N, O, and P were not completed. Additional review of the assessment revealed it was opened and created by MDS Nurse #3. During an interview by phone with MDS Nurse #3	F 636	Resident #241no longer resides in the facility. Resident assessment was complete on 6/1/21. No adverse events occurred due to incomplete admission assessments. All residents have the potential to be affected, therefore an audit was complete on admission assessments from 5/8/2021 to 5/27/21. All identified areas were corrected. To prevent this from recurring on 6/3/2021, the Regional Director of Reimbursement completed education to the Administrator and all nurses. Effective 6/3/2021, any new staff responsible for MDS completion will receive this same education	

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F 636	Continued From page 23 on 05/27/21 at 1:51PM, she stated she had filled in for MDS #1 on 05/08/21, due to MDS Nurse #1 being out of the building. MDS Nurse #3 verified she was the person who created Resident #235's admission Minimum Data Set assessment and set the completion date but stated she was not responsible for the completion of the assessment. She reported it would be the responsibility of MDS Nurse #1 to complete it. An interview with MDS Nurse #1 on 05/27/21 at 2:05PM revealed she was aware that Resident #235's admission Minimum Data Set assessment was late. She stated this was due to her not having any help with the completion of the assessments for approximately 4 months. She stated she had asked the facility multiple times to hire an additional person to assist her, but no help was hired until recently. MDS Nurse #1 stated she was still "playing catch up" and did not know when she would be done. During an interview with the Administrator on 05/27/21 at 3:00PM, he verified that there was an MDS Nurse that had left the facility but reported they had since filled the position. He also stated it was his expectation that Minimum Data Set assessments be completed according to the federal regulations and company policy in regard to completion and timing.	F 636	To monitor and maintain ongoing compliance, beginning 6/21/2021, the facility Administrator or their designee will audit all new admissions charts per week for 12 weeks to validate compliance of timeliness of completion of admission assessments. Beginning 6/28/2021, The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident	F 655		6/23/21

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that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:

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AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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F 655	Continued From page 25 Based on observations, record review, resident and staff interview the facility failed to develop a baseline care plan within 48 hours of admission for a resident that required a mechanically altered diet with thickened liquids for 1 of 7 (Resident #60) residents reviewed for food palatability, failed to develop a baseline care plan within 48 hours of admission for a resident that was fall risk for 1 of 3 (Resident #135) residents reviewed for falls, and failed to develop a baseline care plan within 48 hours of admission in the area of nutrition for 1 of 11 (Resident #137) residents reviewed for nutrition. The finding included: 1. Resident # 60 was readmitted to the facility on 05/21/21 with diagnoses that included dysphagia. The comprehensive Minimum Data Set (MDS) had not been developed yet. Review of a discharge summary from the local hospital dated 05/21/21 indicated Resident #60's diet was mechanically altered with moderately thick liquids. An observation and interview were conducted with Resident #60 on 05/23/21 at 11:06 AM. Resident #60 was resting in bed with his eyes open. He was alert and verbal and had a cup of thickened liquids with a straw in a cup and a cup of thin clear liquids sitting on his bedside table. Resident #60 was observed to pick up the cup of clear thin liquid and take a drink. When asked if he was supposed to have that he stated, "I am supposed to have those thick liquids, but they told me I could have this water."	F 655	F655 – Care Plan – Establish a Base Care Plan A base care plan was started for Resident #60 and Resident #135. Resident #137 no longer resides in the facility. No adverse events occurred due to a base care plan not being started. All residents have the potential to be affected, therefore an audit was complete on 5/27/2021, for all new residents who were admitted to the facility from 5/16/2021 to 5/27/21 to ensure a base care plan was complete. No other discrepancies were noted. To prevent this from recurring on 6/3/21, the Director of Nursing completed education all licensed nurses on completing assessment and initiate baseline care plans within 48 hours of admission. Effective 6/3/2021, any new licensed staff that are hired or licensed agency staff will receive this education. Baseline care plans completion will be reviewed in clinical meeting by the MDS nurse or designee to ensure compliance. To monitor and maintain ongoing compliance, beginning 6/21/2021, the facility Administrator or their designee will audit all new admissions charts per week for 12 weeks to validate accuracy in completion of baseline care plans. Beginning 6/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of	

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F 655	Continued From page 26 Review of Resident #60's medical record on 05/23/21 revealed that no baseline care plan had been opened or initiated. Review of a physician order dated 05/24/21 read, low concentrated sweet/no added salt diet with honey thick liquids. An interview was conducted with Nurse #3 on 05/25/21 at 1:23 PM. Nurse #3 confirmed that she was working on 05/21/21 when Resident #60 readmitted to the facility. Nurse #3 confirmed she had completed Resident #60's admission but had no idea how or what do with baseline care plans. She stated that she had a nurse that would always help her with things like that, but that nurse was no longer employed by the facility. Again Nurse #3 confirmed that she had not opened or initiated any baseline care plans because she did not know how to do so. An interview was conducted with the MDS Coordinator on 05/26/21 at 8:06 AM. The MDS Coordinator stated that when a resident admitted to the facility and the hall nurse completed the admission assessment it auto populated to the baseline care plan. She stated that the hall nurse had to go the care plan tab in the electronic medical record and click a hyperlink to add the triggered items. Then the triggered items from the admission assessment would auto populate into the baseline care plan. The MDS Coordinator stated that the following day that she was at work she would create a duplicate of the baseline care plan and make them more individualized for the resident. The MDS Coordinator confirmed that the baseline care plans were not opened upon admission for Resident #60 including a nutritional care plan that indicated Resident #60's diet and	F 655	auditing. Dates corrective actions will be completed: 6/23/21	

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liquid status, she stated that when she returned to work on 05/25/21 she had completed the baseline care plans which was outside the 48-hour timeframe for completion.

An interview was conducted with the Director of Nursing (DON) and the Administrator on 05/27/21 at 2:48 PM. The DON stated that baseline care plans were created from the admission assessment completed by the hall nurse. The DON was not aware that the hall nurse had to click on a hyperlink to add the triggered items from admission assessment. The DON stated that she expected baseline care plan to be completed within 48 hours of admission. The Administrator stated that he expected the staff to follow the policy and procedures of the facility in regard to baseline care plans.

2. Resident #135 was admitted to the facility on 05/21/21 with diagnoses that included history of falls and others.

An observation and interview were conducted with Resident #135 on 05/23/21 at 10:57 AM. Resident #135 stated that he had admitted from the hospital on 05/21/21 after having a stroke while at home. He stated that on 05/22/21 he fell while in the shower in his room. He stated he was not hurt or injured, and the staff was right outside the shower when he fell.

Review of Resident #135's medical record revealed that his baseline care plan for fall was created on 05/24/21.

An interview was conducted with Nurse #3 on 05/25/21 at 1:23 PM. Nurse #3 confirmed that she was working on Friday 05/21/21 when

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Resident #135 readmitted to the facility. Nurse #3 confirmed she had completed Resident #135's admission but had no idea how or what do with baseline care plans. She stated that she had a nurse that would always help her with things like that, but that nurse was no longer employed by the facility. Again Nurse #3 confirmed that she had not opened or initiated any baseline care plans because she did not know how to do so.

An interview was conducted with the MDS Coordinator on 05/26/21 at 8:06 AM. The MDS Coordinator stated that when a resident admitted to the facility and the hall nurse completed the admission assessment it auto populated to the care plan. She stated that the hall nurse had to go the care plan tab in the electronic medical record and click a hyperlink to add the triggered items. Then the triggered items from the admission assessment would auto populate into the baseline care plan. The MDS Coordinator stated that the following day that she was at work she would create a duplicate of the baseline care plan and make them more individualized for the resident. The MDS Coordinator confirmed that the baseline care plans were opened upon admissions for Resident #135, but no one clicked the hyperlink to add any baseline care plans including a fall care plan or interventions to prevent a fall. She stated that on 05/24/21 the baseline care plans were added and updated to reflect the fall that Resident #135 had on Saturday 05/22/21 which was outside the 48-hour timeframe for completion.

The comprehensive Minimum Data Set (MDS) dated 05/27/21 was not completed.

An interview was conducted with the Director of

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Nursing (DON) and the Administrator on 05/27/21 at 2:48 PM. The DON stated that baseline care plans were created from the admission assessment completed by the hall nurse. The DON was not aware that the hall nurse had to click on a hyperlink to add the triggered items from admission assessment. The DON stated that she expected baseline care plan to be completed within 48 hours of admission. The Administrator stated that he expected the staff to follow the policy and procedures of the facility in regard to baseline care plans.

3. Resident # 137 was admitted to the facility on 05/21/21 with diagnoses that included presence of artificial knee joint, osteoarthritis, diabetes.

Review of a physician order dated 05/23/21 read, regular diet with thin liquids.

An interview was conducted with Resident #137 on 05/24/21 at 9:44 AM. Resident #137 stated that he admitted to the facility on Friday 05/21/21 from the hospital after having a knee replacement. He stated that on Saturday 05/22/21 he did not receive a breakfast tray and the staff stated they would have to find out his diet and get him something to eat. Resident #137 stated that the staff finally verified his diet and got him something to eat.

Review of Resident #137's medical record revealed that his baseline care plans were created on 05/24/21 which is outside of the 48-hour time frame for completion.

An interview was conducted with Nurse #3 on 05/25/21 at 1:23 PM. Nurse #3 confirmed that she was working on Friday 05/21/21 when

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Resident #137 readmitted to the facility. Nurse #3 confirmed she had completed Resident #137's admission but stated she had no idea how or what do with baseline care plans. She stated that she had a nurse that would always help her with things like that, but that nurse was no longer employed by the facility. Again Nurse #3 confirmed that she had no opened or initiated any care plans because she did not know how to do so.

An interview was conducted with the MDS Coordinator on 05/26/21 at 8:06 AM. The MDS Coordinator stated that when a resident admitted to the facility and the hall nurse completed the admission assessment it auto populated to the care plan. She stated that the hall nurse had to go the care plan tab in the electronic medical record and click a hyperlink to add the triggered items. Then the triggered items from the admission assessment would auto populate into the baseline care plan. The MDS Coordinator stated that the following day that she was at work she would create a duplicate of the baseline care plan and make them more individualized for the resident. The MDS Coordinator confirmed that the baseline care plans were opened upon admissions for Resident #137, but no one clicked the hyperlink to add any baseline care plans including a nutritional care plan that specified his diet so the staff would know what diet to serve him. She stated that on 05/24/21 the baseline care plans were added and updated to reflect the current status of Resident #137 which was outside the 48-hour timeframe for completion.

The comprehensive Minimum Data Set (MDS) dated 05/27/21 was not completed.

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F 655	Continued From page 31 An interview was conducted with the Director of Nursing (DON) and the Administrator on 05/27/21 at 2:48 PM. The DON stated that baseline care plans were created from the admission assessment completed by the hall nurse. The DON was not aware that the hall nurse had to click on a hyperlink to add the triggered items from admission assessment. The DON stated that she expected baseline care plan to be completed within 48 hours of admission. The Administrator stated that he expected the staff to follow the policy and procedures of the facility in regard to baseline care plans.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan 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	F 656		6/23/21

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F 656	Continued From page 32 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to develop a comprehensive care plan for a resident with a known history of wandering for 1 of 2 residents reviewed for accidents (Resident #43). Findings included: Resident #43 was admitted to the facility on 07/24/20 with diagnoses that included dementia with behavioral disturbances and a history of falling. A quarterly Minimum Data Set (MDS) dated 01/01/21 indicated under a section titled "behaviors" that wandering had not been assessed for Resident #43. A nursing progress note dated 2/5/21 at 1:32 PM	F 656	Resident #43 remains in the facility and her plan of care has been reviewed and revised to include wandering behaviors. All residents who wander have the potential to be affected, therefore the MDS nurse completed an audit on 6/3/2021, for all residents identified as having wandering behaviors, to ensure their plan of care included wandering and intervention to help decrease unsafe wandering To prevent this from recurring on 6/3/21, the Regional Director of Reimbursement completed education to the Director of Nursing, Social Worker, Social Worker Assistant and Minimum Data Set Coordinator for care plan goals and	

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F 656	Continued From page 33 revealed Resident #43 to be disoriented, anxious, and agitated with staff with inability to redirect from emergency exit door in the hallway. Resident #43's nursing progress note dated 3/19/21 at 10:12 revealed she had been found sitting in the floor in an unidentified resident's bathroom on the 700/800 hall unit. A Quarterly MDS dated 3/31/21 indicated Resident #43 had severe cognitive impairment and supervision assistance with locomotion both on and off the unit. The MDS further indicated Resident #43 wandered daily, exhibited symptoms of verbal behaviors directed at others and other behavioral symptoms not directed at others which included physical symptoms such as rummaging, or verbal/vocal symptoms like screaming, disruptive sounds. Resident #43's nursing progress note dated 4/29/21 at 9:54 AM revealed on 4/25/21 Resident #43 had been found wandering into another resident's room (resident not identified in this note). An observation on 5/23/21 at 2:38 PM revealed Resident #43 self-propelling her wheelchair in the hallway near the conference room which included the front lobby entrance. Resident #43 was observed to be confused. A review of the comprehensive plan of care on 5/23/21 at 3:10 PM did not include a care plan for Resident #43's wandering behaviors. A nursing progress note dated 5/24/21 at 2:21 PM revealed Resident #43 was in the bathroom of room 506.	F 656	interventions for residents with wandering behaviors. Effective 6/3/2021, any new Director of Nursing, Social Worker, Social Worker Assistant or Minimum Data Set Coordinator responsible for care plan development and updates will be educated upon hire. During routine rounds the interdisciplinary staff will observe for and communicate changes in wandering behavior to ensure the residents plan of care includes this behavior and interventions to help reduce unsafe wandering To monitor and maintain ongoing compliance, beginning 6/21/2021, the facility Administrator or their designee will audit 10 residents each week for 12 weeks to ensure that care plans are reflective and accurate of any observations of wandering behavior. Beginning 6/28/21, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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An interview on 5/25/21 at 12:00 PM with NA #3 revealed she was aware Resident #43 was a known wanderer. NA #3 verified Resident #43 wanders off her unit almost daily and staff from other areas of the building must bring her back to the unit because Resident #43 gets out of the staff sight when they are busy.

An interview on 5/25/21 at 12:05 PM with Nurse #10 revealed she was a nurse who was assigned to work the 500/600 hall unit. Nurse #10 verified Resident #43 was a known wanderer and wandered off the unit daily and was often located on the other side of the facility by staff who worked those units. Nurse #10 said, it is her right to wander so I don't try to redirect her even though I am aware she had sustained injuries when she had wandered off the unit in the past.

An interview on 5/25/21 at 12:20 PM with the Social Worker (SW) revealed she had started as the Social Worker one month ago and was still acclimating to the position and was not familiar with Resident #43; however, after review of Resident #43's MDS dated 3/31/31 and her comprehensive care plan stated Resident #43 should be care planned for wandering to include interventions to monitor Resident #43's location on all shifts.

An interview on 5/25/21 at 12:26 PM with the Director of Nursing (DON) revealed she was familiar with Resident #43 and her known history of wandering and injury while unmonitored. She did not believe Resident #43 had ever eloped; however, believed her comprehensive care plan should include wandering.

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F 656	Continued From page 35 An interview on 5/27/21 at 2:48 PM with the Administrator revealed he was familiar with Resident #43's wandering expected all residents with known behaviors to include wandering to have a care plan that reflects interventions for wandering.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, roommate, and staff interview the facility failed to provide incontinent care when notified to a dependent resident for 1 of 4 (Resident #81) residents reviewed for activity of daily living. The findings included: Resident #81 was admitted to the facility on 01/06/18 with diagnoses that included Alzheimer's Disease, dementia, heart failure, chronic obstructive pulmonary disease, and others. Review of a care plan updated on 12/23/20 read in part, alteration in elimination related to being completely incontinent of bowel and bladder. The goal read, resident will be clean, dry, and odor free through the next review. The interventions included: provide incontinence care as needed, monitor for skin redness and irritation, and others. Review of the quarterly Minimum Data Set (MDS) dated 05/05/21 indicated that Resident #81 was	F 677	Incontinence care was provided for Resident #81 on 5/26/21 during the survey and the resident did not have any obvious negative outcome. The skin was clean, pink, and intact. The resident's skin condition was assessed on 5/27/2021 remained intact with no breakdown. All residents have the potential to be affected, therefore incontinence care rounds were complete on 5/27/2021, to ensure all residents have received incontinence care timely. Any resident who was identified needing incontinent care was provide care timely. To prevent this from recurring on 6/3/21, the Assistant Director of Nursing completed Incontinence Care education for licensed staff and certified nursing assistant staff on timely incontinent care for residents that are incontinent. Effective 6/3/2021, any new licensed	6/23/21

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F 677	Continued From page 36 severely cognitively impaired for daily decision making and required extensive assistance of 2 person with toileting. The MDS further indicated that Resident #81 was always incontinent of bowel and bladder. a. An interview was conducted with Resident #81's roommate on 05/24/21 at 10:01 AM. The roommate stated that on 05/22/21 she turned the call light around 1:30 PM according to the watch she wore on her wrist to alert the staff that Resident #81 needed incontinence assistance and they did not come back until 2:40 PM to provide care to her. An interview was conducted with Nurse #4 on 05/25/21 at 4:45 PM. Nurse #4 confirmed that she worked the unit where Resident #81 resided on Saturday 05/22/21. She stated she was busy with her duties and could not speak to the care that Nurse Aide (NA) #1 and NA #2 rendered to Resident #81 or the other residents. She did say that it was very busy, and they had pulled 1 NA off the unit to help on another unit and left NA #1 and NA #2 to cover the unit all day and "they were swamped." An attempt to speak to NA # 1 who cared for Resident #81 on 05/22/21 without success was made on 05/26/21 at 9:36 AM. An interview was conducted with NA #2 on 05/26/21 at 11:28 AM. NA #2 confirmed that she and NA #1 worked the unit where Resident #81 resided on 05/22/21. She stated that Resident #81 was confused and not able to communicate her needs. She explained that during lunch she was pulled to care for a another resident who was very sick so NA #1 had to handle lunch by herself	F 677	nurses or certified nursing aide staff that are hired or are agency will receive this education. During routine rounds, the interdisciplinary team will observe for and communicate any ADL care needs to the staff responsible, including incontinent care needs. To monitor and maintain ongoing compliance, beginning 6/21/2021, the facility Director of Nursing or their designee will conduct 10 resident observations per week for residents that require incontinence care, for 12 weeks to validate care was provided timely. Beginning 6/28/21, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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so we did not get to provide any care to Resident #81 until after lunch and after I had the other patient stable which was approximately after 2:00 PM. NA #2 stated that it was time for the afternoon rounds so she and NA #1 both provided incontinent care to Resident #81. NA #2 stated that Resident #81 had an incontinent episode of stool and was cleaned up and a clean dry brief applied and then they covered her with a blanket and that was the extent of the care they provided to Resident #81 that day. She added they had started the day with 3 NAs, but one got pulled so that left NA #1 and NA #2 and they did the best they could.

An interview was conducted with the Director of Nursing (DON) on 05/27/21 at 2:48 PM. The DON stated that she expected the staff to provide incontinent care immediately when notified that there was a need. She stated that it was unacceptable for Resident #81 to wait an hour or longer to have incontinence care. She further stated that the care should have been provided to Resident #81 on Saturday 05/22/21 with either a bed bath or shower, oral hygiene, personal hygiene, and routine incontinence care.

b. An observation on 5/26/21 at 11:31 AM revealed Resident #81 was dressed and siting up in her wheelchair and alone at a table in the unit's dining room.

An interview on 5/26/21 at 11:34 AM with NA # 10 and NA #11 revealed they were assigned to work the 100/200 hall unit on day shift and were familiar with Resident #81. NA #11 stated she had gotten Resident #81 out of bed around 10:00 AM that morning and placed her in her wheelchair.

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NA #11 verified Resident #81 was always incontinent of bowel and bladder, wore a brief at all times and required total care for incontinence care.

A continuous observation on 5/26/21 beginning at 3:48 PM and ending at 4:30 PM revealed Personal Care Assistant (PCA) #1 in the hallway who was unable to identify Resident #81 when the surveyor requested to observe incontinence care for this resident. PCA #1 left and went to locate a co-worker for assistance. Within minutes, PCA #1 and PCA #2 returned and identified Resident #81 who was located sitting in her wheelchair in the family room. After placing Resident #81 back to bed, both PCA #1 and PCA #2 began to undress her lower body while the door adjacent to the hall was still open when the surveyor stopped them and instructed the staff to provide the resident with privacy before continuing. After closing the door, PCA #1 and PCA #1 removed Resident #81's pants, socks, and shoes followed by her heavily saturated brief. The brief was observed to have a dark yellow color inside, a strong urine odor present, and the inside of the brief showed visible cotton shedding of the liner inside. The brief was discarded and visualization of Resident #81's buttocks and peri-area revealed a dark pink color on her buttocks and a slightly pinkish red area in her groin region. PCA #1 completed incontinence care to include PCA #1 placing a barrier cream to her peri-area and a new brief was applied.

A follow-up interview on 5/27/21 at 11:00 AM with NA #10 and NA #11 revealed they were assigned to care for Resident #81 on day shift. NA #11 verified she had gotten Resident #81 up from bed after breakfast on 5/26/21 and put her in her

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F 677	Continued From page 39 wheelchair. She verified she did not provide any incontinence care to Resident #81 the remainder of her shift. She explained when she glanced at the brief, she did not notice the blue indicators on the brief which lead her to believe Resident #81 wasn't very wet. NA #11 stated she had been taught to provide incontinence care to all incontinent residents by performing a check and change procedure, but she did not change a residents brief unless she was able to see the blue indicator marks and she did not place a resident in the bed to manually verify if they were soiled. An interview on 5/26/21 at 4:45 PM with Nurse #12 revealed she was an agency nurse assigned to work the 100/200 hall unit on day shift. She was somewhat familiar with Resident #81 and stated she used a nursing report sheet to know a resident's transfer status. Nurse #12 looked at her paper and stated Resident #81's transfer status was a 2-person physical assist, but the paper did not indicate the use of the lift was required. She also explained Resident #81 was always incontinent of bowel and bladder and required every 2-hour incontinence care to prevent skin breakdown. An interview on 05/26/21 at 5:45 PM with the Administrator indicated all staff are trained during orientation that residents are to receive incontinence care every 2 hours and he expected all incontinent residents to be cleaned and dried on rounds every 2 hours. He further indicated staff should obtain all resident transfer status from the Kardex located on the inside of the wardrobe (closet) door.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices	F 689		6/23/21

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F 689	Continued From page 40 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to identify the root causes, monitor, and implement effective interventions to a keep a wandering resident free from injury when a wandering resident sustained multiple skin tears, bruises, and had multiple falls of which one resulted in a right hip fracture for 1 of 2 residents reviewed for accidents (Resident #43). The facility also failed to keep Resident #43 from wandering into 2 other resident's rooms and going through their personal belongings and touching them for 2 of 2 residents reviewed for privacy (Resident #21 and Resident #79). Findings included: 1.Resident # 43 was admitted to the facility on 07/24/20 with diagnoses that included dementia with behavioral disturbances and a history of falling. A quarterly Minimum Data Set (MDS) dated 3/31/21 indicated Resident #43 had severe cognitive impairment and required supervision assistance with locomotion both on and off the unit and had a fall with minor injury. The MDS further indicated Resident #43 wandered daily,	F 689	F689 – Quality of Care – Free of Accident Hazards/Supervision/Devices On 5/24/21 Resident #43 was assessed as a result of her fall. No immediate injury was identified. Resident was monitored for several days. Upon change in condition of acute pain, facility physician was notified, Resident #43 was sent to the hospital and treated with surgical intervention for hip fracture. Upon return to facility on 5/27/21, resident fall care plan was reviewed and updated. On 5/28/21 the unit manager completed a review for all current residents for acute change in pain and change of condition, with no concerns identified. On 5/28/2021, a review of the last 30 days of falls was completed and care plans reviewed to ensure all current resident interventions remained appropriate and no other updates were needed based on the residents current condition. To prevent this from recurring on 6/3/21, the Director of Nursing completed	

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F 689	Continued From page 41 exhibited symptoms of verbal behaviors directed at others and other behavioral symptoms not directed at others which included physical symptoms such as rummaging, or verbal/vocal symptoms like screaming, disruptive sounds. A review of the comprehensive plan of care revealed there was not a care plan for Resident #43's wandering behaviors included. The comprehensive care plan for falls revised 3/22/21 with interventions for multiple falls to include application of a stop sign on the bathroom door to encourage Resident #43 to call for assistance before attempting to toilet herself and non-skid footwear at all times. a. Resident #43's nursing progress note dated 3/19/21 at 10:12 revealed she had been found sitting in the floor in an unidentified resident's bathroom on the 700/800 hall unit (which was not the unit she resided). Resident #43 was noted to have obtained a skin tear to the right knee at the time. A nursing progress note dated 4/21/21 at 4:35 PM indicated Resident #43 had sustained a skin tear to her right forearm measuring 18cm x 0.4 x 0.1 of an unidentified origin. The skin tear required a wrap treatment and indicated staff notified maintenance to repair a door frame of an unspecified location. Resident #43's nursing progress note dated 4/29/21 at 9:54 AM revealed on 4/25/21 Resident #43 had been found wandering into another unidentified residents room and had told staff she had hit her head, pointing to her left eyebrow region on the door when she had tried opening it; however at the time, there was no visible injury.	F 689	education to all staff on providing supervision to keep our residents safe including redirection for residents that wander into potentially unsafe areas such as other rooms or off the unit. Effective 6/3/2021, any new staff hired or agency staff will be educated on upon orientation. Assigned department staff will be provided fall care plans for review and monitoring for compliance routinely as part of ongoing practice. Beginning 6/28/21, to monitor and maintain ongoing compliance, the facility Administrator or their designee will audit 20 resident observations per week to ensure fall interventions remain in place. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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An icepack was provided, but two days later Resident #43 developed bruising in the same locations on the face she had previously identified.

An observation on 5/23/21 at 12:38 PM revealed Resident #43 self-propelling her wheelchair in the hallway near the conference room which included the front lobby entrance. Resident #43 was observed to be near the front lobby looking for her mother and opening office doors. During the observation, there were no staff attempting to assist or redirect Resident #43 back to her unit.

An observation on 05/24/21 at 2:00 PM revealed Resident #43 self-propelling herself in her wheelchair in the hallway and into other resident's room. Staff attempted to redirect Resident #43 to her room, but she quickly returned to her wandering behavior after only minutes.

A nursing progress note dated 5/24/21 at 2:21 PM revealed Resident #43 was in the bathroom of room 506 and had fallen. Resident #43 sustained a skin tear to her right elbow which required a skin treatment and bruising to her left upper back from the fall.

An interview on 5/25/21 at 12:00 PM with NA #3 revealed she was aware Resident #43 was a known wanderer and a high fall risk. NA #3 verified Resident #43 wanders off her unit almost daily and staff from other areas of the building must bring her back to the unit because Resident #43 gets out of the staff sight when they are busy.

An interview on 5/25/21 at 12:05 PM with Nurse #10 revealed she was a nurse who was assigned to work the 500/600 hall unit. Nurse #10 verified

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Resident #43 was a known wanderer and wandered off the unit daily and was often located on the other side of the facility by staff who worked those units before hall staff were aware, she had exited the unit. Nurse #10 said, it is her "right" to wander so I don't try to redirect her even though I am aware she had sustained injuries when she had wandered off the unit in the past.

An interview on 5/25/21 at 12:20 PM with the Social Worker (SW) revealed she had started as the social worker one month ago and was still acclimating to the position and was not familiar with Resident #43; however, after review of Resident #43's MDS dated 3/31/31 and her comprehensive care plan stated Resident #43 should be care planned for wandering to include interventions for all staff to monitor Resident #43's location on all shifts.

An interview on 05/25/21 at 1:00 PM with Nurse #5 revealed she frequently worked the 500/600 hall and 700/800 hall on night shift and was familiar with Resident #43. Nurse #5 elaborated to explain Resident #43 was a known wanderer and wandered off the unit during her shift before staff were aware. Nurse #5 explained Resident #43 was started on a medication for anxiety recently which has improved her frequency of wandering at night. Nurse #5 verbalized Resident #43 exits her room looking for her mother or to use the bathroom and was known to wander into Resident #21 and Resident #79's room which frightened and startled them. Nurse #5 stated if an incident occurs, the nurse on the unit would complete an incident report in the electronic medical record and obtain orders from the provider for treatment if an injury occurs.

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A nurse progress note labeled fall follow-up dated 5/27/21 at 2:21 AM revealed Resident #43 with a new onset of back pain.

A nurse progress note dated 5/27/21 at 12:00 PM revealed Resident #43 with new complaints of right hip pain which was swollen and was unable to be moved without screaming out. Resident #43 is unable to verbalize how she may have hurt her hip or when the pain originated. An order was obtained for a STAT x-ray of the right hip.

An x-ray report of the right hip dated 5/27/21 indicated Resident #43 had sustained a moderately displaced acute fracture of the right femoral neck with clinical follow-up recommended.

An interview on 5/27/21 at 2:48 PM with the Director of Nursing (DON) revealed she was familiar with Resident #43 and her known history of wandering and injury while unmonitored. She did not believe Resident #43 had ever eloped and therefore she did not have a wander guard in place; however, believed her comprehensive care plan should include wandering and interventions to keep Resident #43 from harm. In the event an incident occurs involving a resident, a nurse will complete an incident report and obtain orders for immediate aid if the resident sustains an injury. Following the incident, the incident reports are reviewed by the interdisciplinary team and an intervention will be put into place if needed and the care plan is updated to reflect the new interventions.

An interview on 5/27/21 at 2:48 PM with the Administrator revealed he was familiar with Resident #43's wandering expected all residents

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with known behaviors to include wandering to have a care plan that reflects interventions for wandering to keep Resident #43 from injury.

An interview on 06/04/21 at 3:45 PM with Nurse Practitioner (NP) revealed she is familiar with Resident #43 and her history of wandering and high fall risk. The NP indicated Resident #43 currently had a right hip fracture that she believed to be sustained after an impact from a fall or trauma. She is aware Resident #43 had a fall on 5/24/21, but recalled visualizing Resident #43 up self-propelling her wheelchair in the hallway while she had been making resident rounds on either Tuesday 5/25/21 or Wednesday 5/26/21 and was unable to determine if the fractured right hip was a late onset symptom of the fall on 5/24/21 or if there was a possibility there could have been another unidentified fall between 5/24/21 and 5/27/21. The NP felt that three days was a long time for Resident #43 to appear at her baseline to having acute excruciating pain in the right hip three days post a fall for someone who is diagnosed with an acute displaced right hip fracture. The NP also explained that according to the x-ray report the injury was not linked to an age-related condition or a spontaneous fracture. The NP elaborated she had not been to the building to evaluate Resident #43 since her return; however, she was aware the fracture required a surgical intervention and Resident #43 had an acute change of condition as a result of the fracture requiring surgical intervention.

b. Resident #21 was admitted to the facility on 7/11/21 with diagnoses that included a history of falling.

A quarterly MDS dated 2/22/21 revealed Resident

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#21 was cognitively intact and required supervision assistance with most activities of daily living (ADL's). Under a section labeled mood, the MDS revealed Resident #21 had trouble falling asleep and staying asleep and exhibited to behavioral concerns to include delusions or hallucinations.

An interview on 5/23/21 at 10:28 AM with Resident #21 revealed she had been startled and frightened on several occasions when a wandering resident, identified to be Resident #43, had entered her room. Resident #21 stated she had trouble sleeping already and had recently been woke up by Resident #43 touching her and rummaging through her personal belongings.

A follow-up interview on 5/26/21 at 10:45AM with Resident #21 revealed Resident #43 had entered her room again this week and she called for staff assistance to get Resident #43 out of her room, but Resident #43 fell in the bathroom before staff arrived. Resident #21 explained she needed to use the toilet but was delayed secondary to Resident #43's fall when she wandered into her bathroom. Resident #21 elaborated even if she (Resident #43) doesn't know what she is doing, staff should do a better job keeping her out of places she doesn't belong. Resident #21 further indicated she doesn't own much anymore but expected her belongings not to be accessed without her permission and it upset her to be woken up with Resident #43 touching her and her personal property.

c. Resident #79 was admitted to the facility on 9/25/20 with diagnoses that included dementia with behavioral disturbances chronic obstructive pulmonary disease, and dependance on

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supplemental oxygen.

A physician's order dated 9/28/20 indicated Resident #79 was to receive Oxygen via nasal cannula at 2 liters (L/NC) to keep oxygen saturations above 90%.

A significant Change MDS dated 4/27/21 had moderate cognitive impairment, was able to make her needs known, and had no hallucinations or delusions.

An interview on 05/23/21 at 10:10 AM with Resident #79 revealed she was happy with the facility other than facility staff not preventing a wandering resident (Resident #43) from entering her room. Resident #79 stated she had been awakened by Resident #43 recently when Resident #43 had been rummaging through her belongings. She stated she opened her eyes to see Resident #43 standing next to her bed and holding Resident #79's oxygen tubing in her hand after she had removed the oxygen tubing from the concentrator that was delivering supplemental oxygen to Resident #79.

d. An observation on 05/25/21 at 11:55 PM revealed Resident #43 lying in her bed without non-skid socks. Her bare feet were exposed from the end of the sheet. There was no stop sign observed on the bathroom door as indicated as interventions on the fall care plan.

An interview on 5/25/21 at 12:00 PM with NA #3 revealed she was not aware Resident #43 had an intervention to wear non-skid socks at all times, so she always removes all resident's socks before placing them to bed for a nap.

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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 689	Continued From page 48 An interview on 5/25/21 at 12:05 PM with Nurse #10 revealed she was a nurse who was assigned to work the 500/600 hall unit. Nurse #10 further revealed Resident #43 should wear non-skid footwear at all times due to her frequent falls. An interview on 05/25/21 at 1:00 PM with Nurse #5 revealed Resident #43 should wear non-skid footwear on her feet at all times. Nurse #5 stated there was occasional staff may remove her non-skid socks for short periods of time if Resident #43 had any swelling, but she had not had any recently that she was aware. An interview on 5/27/21 at 2:48 PM with the Director of Nursing (DON) revealed she expected all interventions on a resident's care plan to be followed to include non-kid socks and a stop sign on the bathroom door to deter Resident #43 from going to the bathroom unassisted. An interview on 5/27/21 at 2:48 PM with the Administrator revealed he expects staff to follow all care plan interventions to include non-skid socks and a stop sign in Resident #43's bathroom.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		6/23/21

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	345567	A. BUILDING _____ B. WING _____	C 06/04/2021

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F 695	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to ensure an oxygen tank had oxygen in it and was delivering oxygen to the resident for 1 of 4 residents (Resident #60) reviewed with oxygen. The findings included: Resident #60 was admitted to the facility on 04/15/21 and most recently readmitted on 05/21/21 with diagnoses that included dysphagia and chest pressure. Review of a Minimum Data Set (MDS) dated 04/17/21 revealed that Resident #60 was cognitively intact for daily decision making and required limited assistance with activities of daily living. The MDS further revealed that no oxygen was used during the assessment reference period. Review of Resident #60's medical record revealed no care plan for the use of oxygen. An observation and interview were conducted with Resident #60 on 05/23/21 at 11:06 AM. Resident #60 was resting in bed with his eyes open. He was alert and verbal and was observed to have an oxygen cannula in his nose that was connected to a tank of oxygen that was sitting next to his bed secured in a mobile cart. The tank of oxygen was set to deliver 2 liters of oxygen, but the dial indicated the tank was empty. Resident #60 stated that they applied the oxygen on 05/21/21 because he was short of breath. Resident #60 denied being short of breath and denied any chest pain or pressure	F 695	F695 – Quality of Care – Oxygen delivery for Respiratory Care Oxygen was provided for Resident #60 on 5/23/21. All residents on oxygen therapy have the potential to be affected, therefore Oxygen rounding was complete on 5/31/21 to ensure all residents were receiving oxygen per physician order. All other identified issues were corrected. To prevent this from recurring, beginning 6/3/2021, the DON or designee educated the licensed nursing and certified nursing aides on the requirement for completing oxygen administration per physician order. Effective 6/3/2021, any new licensed nurses or certified nursing aide staff that are hired or are agency will receive this education. During routine rounds interdisciplinary staff will monitor residents who are on oxygen to ensure that each resident has adequate oxygen supply and the oxygen is being administered per physician orders Beginning 6/21/21, to monitor and maintain ongoing compliance, the facility Administrator or their designee will conduct 10 resident oxygen observations per week for residents that require supplemental oxygen, for 12 weeks to ensure residents are receiving oxygen as ordered.	

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F 695	Continued From page 50 An observation was made of Resident #60 on 05/23/21 at 12:14 PM. Resident #60 remained in bed and was resting with his eyes closed. He was observed to have an oxygen cannula in his nose that remained connected to the tank of oxygen sitting next to his bed. The tank was set to deliver 2 liters of oxygen, but the dial indicated the tank was empty. Review of a physician order dated 05/24/21 read, oxygen at 2 liters per minute via nasal cannula. An interview was conducted with Nurse #4 on 05/25/21 at 12:03 PM. Nurse #4 confirmed that she worked 7:00 AM to 7:00 PM on 05/22/21 and 05/23/21. She stated that on Saturday she could not recall if Resident #60 was wearing oxygen or not and on Sunday she did not realize he was wearing oxygen until the Director of Nursing (DON) informed her that Resident #60's oxygen tank was empty and stated his pulse oximeter was down to 74 and needed to get him a concentrator of oxygen. Nurse #4 stated that the DON did obtain an oxygen concentrator for Resident #60 on 05/23/21. Nurse #4 stated that on 05/22/21 she was in Resident #60's room a few times taking him the phone to call his family and then again to pick the phone up but did not notice if he was wearing oxygen or not nor could she verify if the oxygen tank at his bedside was empty or not. An interview was conducted with Nurse #3 on 05/25/21 at 1:23 PM. Nurse #3 confirmed that she was working the unit where Resident #60 resided from 7:00 PM to 7:00 AM on 05/21/21 and 05/22/21 when he returned from the hospital for chest pain. She stated that Resident #60	F 695	Beginning 6/28/2021 the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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F 695	Continued From page 51	F 695		

readmitted with oxygen in place via a tank of oxygen and was set to deliver oxygen at 2 liters per minute. Nurse #3 stated that when she returned to the facility on Saturday evening it was reported that first shift had noted the tank to be empty and she stated that she went to Resident #60's room to check on him and check his pulse oximeter but could not recall what it was. Nurse #3 stated that the tanks of oxygen didn't last very long so at some point someone had to change it out, but she could not say for how long the cylinder of oxygen had been empty. She stated that she was so focused on another resident who was sick that she did not check on the oxygen until someone reported that it was empty. Nurse #3 stated she could not tell how long Resident #60's tank had been out of oxygen on 05/23/21 but stated she had checked on him at 3:30 AM and his pulse oximeter was 93% at that time but did not verify that the tank had oxygen in it.

An interview with the DON was conducted on 05/25/21 at 11:38 AM. The DON stated that when she arrived at the facility on 05/23/21 she began to round and discovered that Resident #60's oxygen tank was empty. She stated she immediately placed Resident #60 on an oxygen concentrator and checked his pulse oximeter but could not recall what it was.

A follow up interview was conducted with the DON on 05/27/21 at 2:48 PM. The DON stated that the admission nurse should have taken Resident #60 off the tank of oxygen and placed him on a concentrator and if a concentrator was unavailable should have obtained a new tank and monitored it to make sure it was not empty. The DON stated that she expected the nurses to check the oxygen at least every shift as prompted

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F 695	Continued From page 52 on the medication administrator record.	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and Nurse Practitioner interview the facility failed to administer pain medication when requested by the resident (Resident #1) for 1 of 4 residents reviewed for pain. Resident #1 experienced a right clavicle fracture and requested pain medication and subsequently waited over 2 hours for her pain medication for pain she rated on a pain scale of 7 out of 10 and described as "miserable." The findings included: Resident #1 was admitted to the facility on 05/05/21 with diagnoses that included pathological fracture of the femur, neoplasm related pain, Parkinson's disease, and others. Review of an admission assessment dated 05/05/21 stated that Resident #1 was alert and oriented times 3 (person, place, and time). Review of a physician order dated 05/05/21 read, Morphine Sulfate Extended release 60 milligrams (mg) by mouth every 12 hours for pain.	F 697	Resident #1 and Resident #133 received pain medications on 5/23/21. All residents that experience pain have the potential to be affected, therefore by 5/28/21 100% audit of current residents was complete to ensure residents received adequate pain control based on interviews. For non-alert residents, observations for pain were completed. Any identified areas of concerns were addressed promptly. To prevent this from recurring, beginning 6/3/2021, the DON or designee educated the licensed nursing staff and Medication Aides on the requirement for timely pain medication delivery per physician order and resident request. Effective 6/3/2021, any new licensed nurses or Medication Aide staff that are hired or are agency will receive this education. During routine rounds, the interdisciplinary staff will monitor and report any concerns of pain, including medications not being administered timely based concerns	6/23/21

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F 697	Continued From page 53 Review of a Minimum Data Set (MDS) dated 05/11/21 was not yet completed. Review of pain interview and evaluation dated 05/11/21 indicated that Resident #1 reported pain frequently of a 7 on a pain scale. Review of a care plan dated 05/12/21 read, Resident has pain/potential for pain. The goal read; Resident will express pain level within satisfactory time. The interventions included: administer pharmacological interventions as indicated per physician and monitor effectiveness, assess for verbal and nonverbal signs and symptoms of pain, implement non-pharmacological interventions to release the pain, and provide education to resident and family. Review of an X-ray report dated 05/21/21 read in part, right clavicle: mildly displaced fracture of the medial aspect of the right clavicle. An observation and interview were conducted with Resident #1 on 05/23/21 at 10:21 AM. Resident #1 was resting in her bed and was noted to be guarding her right arm. Resident #1 stated that she had broken her collar bone on 05/21/21 and she had requested her medication which included her scheduled morphine at 8:30 AM and had not yet received it. Resident #1 stated that she was "miserable", and her pain was a 7 on the pain scale. Resident #1 stated that she had requested her medication from Nurse #4 and looked at her phone and stated it has been almost 2 hours and she still had not gotten her medication. Resident #1 stated her pain had not gotten any worse, but it surely had not gotten any better either.	F 697	voiced by residents. All concerns will be reported to the nurse for follow up. To monitor and maintain ongoing compliance, beginning 6/21/2021, the facility Director of Nursing or their designee will conduct 20 resident reviews per week for 12 weeks, including observations and or interviews to ensure pain is medication administered timely and the residents pain is at an acceptable level. Beginning 6/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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F 697	Continued From page 54	F 697		

An interview was conducted with Medication Aide (MA) #1 on 05/23/21 at 10:45 AM. MA #1 confirmed she was working the unit where Resident #1 resided because Nurse #4 had been pulled off the medication cart to assist with other duties. MA #1 stated that no one including Resident #1 had asked her for her medications. She stated, "I will take her something now."

A follow up interview was conducted with Resident #1 on 05/23/21 at 11:15 AM. Resident #1 confirmed that MA #1 had brought her medication including her morphine at 11:00 AM. Resident #1 stated that she was still hurting and her pain was still close to a 7 but she was beginning to relax a bit.

An interview was conducted with Nurse #4 on 05/23/21 at 12:28 PM. Nurse #4 stated that she was supposed to be working the medication cart on the unit where Resident #1 resided but had been pulled from the medication cart to tend to other duties. Nurse #4 confirmed that earlier in the day approximately around 8:30 AM Resident #1 had requested her medications and she had explained to her that MA #1 would be bringing her medications soon. Nurse #4 stated that she did not report to MA #1 that Resident #1 had requested her medications because MA #1's medication cart was just a few door down from Resident #1's room and she assumed that Resident #1 would be next on the medication pass.

An interview was conducted with the Director of Nursing (DON) on 05/27/21 at 2:48 PM. The DON stated that the staff conducted a pain assessment every shift and when administering pain

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F 697	Continued From page 55 medication they were to document where the pain was located and then go back and document the effectiveness of it. The DON stated that when Resident #1 requested her medications including her pain medication that the staff should have assessed her pain immediately and then administered the medications as ordered and requested by the resident.	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews the facility failed to assess the need for side rails for 1 of 1 resident reviewed	F 700	F700 – Quality of Care – Bedrail Assessment	6/23/21

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F 700	Continued From page 56 for catheter use (Resident #241). Findings Included: Resident #241 was admitted to the facility on 05/21/21 with diagnoses that included acute respiratory failure, and pressure ulcer of the sacral region. A review of Resident #241's initial nursing assessment dated 05/21/21 revealed Resident #241 to be alert and oriented. An observation of Resident #241 on 05/23/21 at 12:49 PM revealed resident to be in bed, visiting with her family. Resident #241's bed was observed with bilateral ¼ side rails. A review of Resident #241's electronic assessments on 05/26/21 revealed no documented or completed side rail assessments. An interview with Resident #241 on 05/26/21 at 10:34 AM revealed she had side rails on her bed since her admission to the facility on 05/21/21. She reported she utilized them for bed mobility and positioning. She reported she did not remember any staff members assessing her for the use of side rails prior to her using them. An interview with Nurse #3 on 05/26/21 at 2:50PM revealed she had worked in the facility for approximately 7 days. She verified she was the admitting nurse for Resident #241. Nurse #3 reported Resident #241 was the first resident that she admitted to the facility. She stated she did receive some training on what was expected to be completed when admitted to the facility. She reported there were multiple assessments that automatically generate which she completed but stated there were others that needed to be	F 700	The bedrail assessment was complete for resident #241 on 6/1/21 but the resident no longer resides in the facility. No adverse events occurred due to a bedrail assessment not being complete. All residents have the potential to be affected, therefore an audit was complete on 6/7/21 to ensure bed rail assessments for each resident had been complete within the last 90 days. No other discrepancies were noted. To prevent this from recurring, beginning 6/3/2021, the DON or designee educated the licensed nursing staff on the requirement bed rail assessments to be complete per facility policy, on admission, quarterly and upon significant change. Effective 6/3/2021, any new licensed nurses or certified nursing aide staff that are hired or are agency will receive this education. All new admissions will be reviewed in clinical meeting to ensure admission assessments are completed including siderail assessments. Beginning 6/21/21, to monitor and maintain ongoing compliance the facility Administrator or their designee will audit all new admissions and 5 random resident charts per week for 12 weeks to validate the timely completion of bed rail assessments. Beginning 6/28/2021The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of	

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F 700	Continued From page 57 physically initiated by the admitting nurse for completion. Nurse #3 reported she would "not be surprised" if there was no side rail assessment for Resident #241 due to her being the first admission she had completed and most likely had overlooked it. Nurse #3 reported side rails were used in the facility and stated she was aware that before the use of side rails by a resident, a comprehensive side rail assessment should have been completed. During an interview on 05/27/21 at 2:51 PM with the Director of Nursing she revealed it was the responsibility of the admitting hall nurse to comprehensively assess admitting residents for the use of side rails. She reported it was her understanding that it was an assessment that prepopulated based on answers during the initial admission assessment. She further stated she expected side rail assessments be completed if a resident was going to use side rails while admitted.	F 700	auditing. Dates corrective actions will be completed: 6/23/21	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, pharmacist and staff interviews, the facility failed to maintain a medication error rate at 5% or below when a medication aide did not follow physician orders. There were 4 errors for 1 of 4 residents (Resident #72) out of 26 opportunities	F 759	F759 – Pharmacy Services – Medication Rate Resident #72 no longer resides in the facility. On 5/25/21 a medication error report was completed and the physician	6/23/21

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F 759	Continued From page 58 observed on medication pass which resulted in a 15.38% medication error rate. Findings included: Resident #72 was admitted to the facility on 04/21/21 with diagnoses that included chronic kidney disease. A physician order dated 04/22/21 revealed Resident #72 was to receive Rena-Vite, one tablet, daily. An observation on 05/24/21 at 8:02 AM revealed MA #1 preparing medications for Resident #72. The medications included Vitamin C 500mg (milligram), Folic Acid 400mg, and B-Complex, Finasteride 5mg tablet, Furosemide 40mg tablet, and Potassium Chloride Extended Release 10 MEQ (milliequivalent) tablet. MA #1 was observed to approach and administer all medications to Resident #72. MA #1 verified Resident #72 had swallowed all medications and then exited the room and returned to the medication cart. MA #1 was not observed to administer a Rena-Vite tab to Resident #72. A review of the Medication Administration Record (MAR) dated May 2021 revealed Resident #72 received Rena-Vite on 05/24/21 by Medication Aide #1 (MA #1) and did not indicate Resident #72 had orders to include Vitamin C 500mg, Folic Acid 400mg, or B-Complex. An interview on 05/25/21 at 8:30 AM with MA #1 revealed she was assigned to administer medication to residents on the 300/400 hall unit on 05/24/21 and verified she administered morning medications to Resident #72. MA #1	F 759	was notified of the error. No further orders were obtained. No adverse events occurred due to resident #72 not receiving the correct medications. All residents have the potential to be affected, therefore a Medication Administration Record to Medication Card Audit was completed on 6/3/2021 to ensure all medications were available in the building to be administered. Medications not present were ordered from the pharmacy. All concerns were addressed and medications ordered as needed To prevent this from recurring, beginning 6/3/2021, the DON or designee educated the licensed nursing staff and Medication Aides on policies and procedures of medication administration when a medication is not available to include, administering medications as order and when medications not available to notification the physician for further direction. Effective 6/3/2021, any new licensed nurses or medication aides that are hired or are agency will receive this education. During routine rounding the clinical managers will check with the nurses to ensure all medication are available, and will follow up with any concerns. Providers will be notified when medications are not available for administration as ordered. Beginning 6/21/21, to monitor and maintain ongoing compliance the facility Director of Nursing or their designee will	

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F 759	Continued From page 59 indicated she did not have any Rena-Vite located on the cart on 05/24/21 and therefore, she substituted Vitamin C, Folic Acid, and B Complex from the house stock bottles located in the top of the medication cart and was unaware the available stocked doses were not equivalent to the Rena-Vite tablet ordered and had not looked for the medication outside her unit or verified with her nurse, pharmacy, or a medical provider the doses was equivalent prior to administering the medications to Resident #72. An interview on 05/25/21 at 9:18 AM with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC #1) revealed MA #1 was assigned to administer medications for Resident #72 on 05/24/21 during the day shift. The DON indicated a medication error occurred when MA #1 failed to administer a medication as ordered and administered three medications (Vitamin C 500mg, Folic Acid 400mg, and B-Complex) without a physician's order. The DON and RNC #1 stated a physician's order must be obtained to substitute a medication of an equivalent dosage and the physician must be notified when a medication error occurs. An interview on 05/25/21 at 10:10 AM with the Pharmacy General Manager revealed Vitamin C 500mg, Folic Acid 400mg, and B Complex did not contain the vitamin supplement equivalent to Rena-Vite. The Pharmacist indicated the Rena-Vite ordered for Resident #72 should have been obtained by MA #1 from the facility's house stocked medications and would not have been dispensed from the pharmacy and individually blister packed for Resident #72. He explained this was not a significant medication error; however, exceeded the prescribed dose of	F 759	perform 10 resident Medication Administration Record to Medication Cart audits per week for 12 weeks, as well as 5 Medication administration observations to ensure medications are delivered and administered per physician order. Beginning 6/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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F 759	Continued From page 60 vitamins included in the Rena-Vite which could be of concern for Resident #72 secondary to his diagnosis of chronic kidney disease. An interview on 05/27/21 at 12:00 PM with the Administrator revealed he expects there to be a zero percent medication error rate and for any staff member who completes a medication error to notify the medical provider.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		6/23/21

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F 761	Continued From page 61 by: Based on observation, record review, and staff interview, the facility failed to ensure a controlled substance medication ordered for a resident was safely stored and secured using a double locked feature for 1 of 2 medication storage refrigerators observed (Resident #41). A controlled substance has an accepted medical use, a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. The facility also failed to remove medications placed at bedside for 1 of 1 resident were reviewed for medications left at bedside (Resident #38). Findings included: 1. Review of the facility policy titled, "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles " revised 10/28/19 read in part under the section General Storage Procedures: 3.1 Facility should store Scheduled II-V Controlled Substances, in a separate compartment within the locked medication carts and should have a different key or access device, i.e. 3.1.1 Store all drugs and biologicals in locked compartments, including the storage of Scheduled II-V medications in separately locked, permanently affixed compartments, permitting only authorized personnel to have access. Resident #41 was admitted to the facility on 7/23/19 with diagnoses that included dementia with behavioral disturbances, Alzheimer's disease and anxiety. A review of Resident #41's Medication Administration Record (MAR) dated May 2021 indicated Resident #41 received Lorazepam	F 761	F761 □ Pharmacy Services □ Remove Medications at Bedside ¿ On 5/24/21 the narcotic box was removed from the Medication Storage Room Refrigerator.¿ Medication for resident #41 was relocated to a storage box that was properly secured under a double lock feature.¿ Resident #38 received medications on 5/24/21. ¿Review of the room did not reveal any further medications at bedside. No adverse events occurred due to medications being left at the bedside.¿¿¿ ¿¿¿¿¿ All residents have the potential to be affected, therefore all medication refrigerators were checked, only the one noted during survey did not have an affixed narc lock box, however, all narcotics were secured in lock affixed boxes on 5/24/2021. ¿¿On 6/1/2021, all medication refrigerators have affixed narcotic boxes in the medication room, on each unit. On 6/18/21, A new lock box was ordered, received from pharmacy, and installed by the maintenance director.¿ On 6/22/21 Maintenance Director installed pad lock locks to all narcotic medication refrigerators. ¿¿On 5/24/21 all resident rooms were reviewed to ensure no medications were at the bedside.¿ All other findings were corrected.¿¿¿¿¿¿¿ To prevent this from recurring, beginning 6/3/2021, the DON or designee educated the Licensed Nursing Staff and	

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F 761	Continued From page 62 Intensol Concentrate 2 milligram (mg)/ milliliter (mL) three times daily for agitation/anxiety at 6:00 AM, noon, and 8:00 PM daily and had received the medication last around noon on 5/24/21 by Nurse #1. An observation on 05/24/21 at 4:10 PM with Nurse #1 revealed the medication storage room contained a small refrigerator which had an unsecured clear plastic box sitting on the shelf inside the door. The lock attached to the clear plastic box was not in the locked position and the box was not securely fastened inside the refrigerator. Upon further evaluation of the clear plastic box, it revealed its contents to be an open box of a controlled substance labeled Lorazepam concentrate 2 milligram (mg)/ milliliter (mL) and identified to be ordered for Resident #41. An interview with Nurse #1 on 5/24/21 at 4:33 PM revealed she was the nurse assigned to the 500/600 on 5/24/21. She explained she was responsible at the beginning and end of her shift to ensure all controlled substance counts were verified and secured under double lock and key by her and another nurse. Nurse #1 indicated controlled substance counts were verified in both the medication storage room and on the halls medication cart and she was aware the box located in the medications storage rooms refrigerator contained a lock that her key would not secure. Nurse #1 verified the box currently contained a controlled substance identified to be ordered for Resident #41. Nurse #1 she verified the count for this medication was accurate; however, acknowledged the medication was not safely secured as she had been educated was required. Nurse #1 verbalized she had knowledge that she did not have a key to lock the	F 761	Medication Aides on the requirement of proper medication pass techniques.¿ Effective 6/3/2021, any new licensed nurses or medication aides staff that are hired or are agency will receive this education.¿ During routine room rounds, the interdisciplinary staff will monitor for medications left at bedside, and will immediately alert the nurse for correction as needed.¿ Clinical managers will randomly validate that the medication rooms have locked affixed narcotic boxes installed in each medication room. ¿ Beginning 6/21/21, all narcotic lock boxes will be monitored once a week for 12 weeks by¿ the DON or designee, to ensure narcotics are locked under double lock and key and boxes are secured to the refrigerator. Beginning 6/21/21, to monitor and maintain ongoing compliance the facility Director of Nursing or their designee will perform 10 room observations per week for 12 weeks to ensure medications are not left at the bedside.¿¿¿¿¿¿¿ Beginning 6/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing.¿ Dates corrective actions will be completed: 6/23/21	

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box located in the 500/600 medication storage refrigerator and stated the clear plastic box located inside the refrigerator had never been secured inside. She further indicated she had not reported the concern to the Director of Nursing, the Administrator, or placed a maintenance repair request when she had noticed she was not able to lock the box to secure the controlled substances.

An interview with Regional Nurse Consultant #1 (RNC #1) and Nursing Home Administrator (NHA) on 5/24/21 at 5:22 PM revealed they were unaware the medication storage room refrigerator contained an unlocked clear plastic box which held a controlled substance identified to belong to Resident #41. The Administrator stated he was unaware the box was not secured, but acknowledged he was aware all controlled substances were always required to be secured and indicated Nurse #1 should have reported being unable to secure controlled substance immediately.

2. Resident #38 was admitted to the facility on 03/30/17 and currently had diagnoses that included malignant neoplasm of the brain.

The recent annual Minimum Data Set assessment dated 03/23/21 indicated Resident #38's cognition was severely impaired.

A review of Resident #38's medical record revealed physician orders for the following medications: Aspirin, Vitamin B 12, Keppra solution (used in the treatment of seizures), Oscal

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(calcium supplement), Vitamin D, and Tylenol. The medications were assigned to be given at the 8:00 AM medication pass.

On 05/24/21 at 9:22 AM an observation was made of Resident #38 lying in bed sleeping. A graduated medication cup of crushed medications mixed in applesauce and approximately 5 milliliters (ml) of clear liquid in a graduated medication cup setting on Resident #38's over bed table.

On 05/24/21 at 9:31 AM an observation was made of Nurse Aide (NA) #6 feeding Resident #38 and there was no medication cup in sight. When the NA was asked what happened to the crushed medication and clear medication that was on the over bed table the NA stated she gave the medications to the Staff Development Coordinator (SDC) who had just left the room.

At 10:12 AM on 05/24/21 an observation was made of Nurse #7 in Resident #38's room giving the Resident her medications.

At 10:17 AM on 05/24/21 during an interview with Nurse #7 she explained that when she went into Resident #38's room to give her the medications she was called away for another resident, so she set the medications on the Resident's over bed table with the intention of coming right back after tented to the other resident. The Nurse continued to explain that the SDC brought her Resident #38's medications then she realized she had not gone back to Resident #38's room to give her the medications. Nurse #7 stated she should have either given the medications to Resident #38 before she left the room, or she should have taken the mediations with her and not left them at

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F 761	Continued From page 65 Resident #38's bedside. An interview was conducted with the SDC on 05/24/21 at 10:22 AM. The SDC confirmed she removed the medications from Resident #38's bedside and gave them to Nurse #7. The SDC explained she was new at the facility and had not educated the staff on leaving the medications at the residents' bedside. The SDC stated Nurse #7 should have either given Resident #38 the medications or she should have taken them with her and secured them in the medication cart until she tended to the other resident. On 05/24/21 at 11:30 AM during an interview with the Director of Nursing (DON) she explained that Nurse #7 should not have left Resident #38's medications at the bedside but should have taken the medications and locked them up until the situation with the other resident was resolved. The DON indicated it was her expectation that the residents' medications not be left at bedside unless they were assessed to be able to self-medicate. An interview was conducted with the Administrator on 05/27/21 at 2:47 PM. The Administrator indicated his expectation was that staff follow the facility policy for medication delivery which includes not leaving the medications at the residents' bedside.	F 761		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special	F 800		6/23/21

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F 800	Continued From page 66 dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to serve and deliver meal trays to 2 of 3 new admissions (Resident #135 and Resident #137) reviewed. The findings included: 1. Resident #135 was admitted to the facility on 05/21/21 with diagnoses that included non-traumatic intracranial hemorrhage, heart disease and others. Review of a discharge summary dated 05/21/21 from the local hospital indicated his discharge diet was regular cardiac diet with thin liquids. Review of an admission assessment dated 05/21/21 indicated that Resident #135 was alert and oriented for person, place, and time. Review of a physician order dated 05/23/21 read, regular diet regular texture and thin consistency. An observation of Nurse Aide (NA) #8 was made on 05/23/21 at 10:10 AM. NA #8 was observed going in and out of rooms on the unit picking up breakfast trays. NA #8 entered Resident #135's room to pick up his breakfast tray and he stated, "what tray" "I never got a tray." NA #8 exited Resident #135's room and left the unit. An observation and interview were conducted with Resident #135 on 05/23/21 at 10:52 AM. Resident #135 was resting in bed and was alert and verbal. He stated that it was after 10:00 AM	F 800	Resident #135 was provided a sandwich and cereal the morning of 5/23/21.¿ A name tag was created and placed on the resident□s door.¿ No adverse events occurred due to resident not originally receiving a meal tray, and there were no other incidents of this event for resident #135. Resident #137¿no longer resides in the facility. ¿¿¿¿¿ All residents have the potential to be affected, therefore on 5/27/21 all resident were reviewed to ensure they received a meal tray and a name tag on the door.¿ No other findings were noted.¿¿¿¿¿ To prevent this from recurring, beginning 6/3/2021, the Dietary Manager or designee educated the dietary staff members on the requirement for all residents to receive a meal per physicians order.¿ Effective 6/3/2021, any new dietary staff member will staff that are hired will receive this education.¿ Dietary staff will utilize a daily census as a second check to validate all current residents receive a meal tray for each meal. To monitor ongoing compliance, beginning 6/21/2021, the Dietary Manager or designee will observe 20 resident meals per week for 12 weeks to ensure all residents receive meal tickets.¿The Dietary Manager or designee will validate 5 times weekly for 12 weeks, that the daily census reflects all meals were served to the current residents for that day. ¿¿ Beginning 6/28/2021, the results of the	

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F 800	Continued From page 67 and the staff came in his room to pick up his breakfast tray and I told them I never got a tray. Resident #135 stated that the young lady brought me a bowl of cereal and a peanut butter and jelly sandwich "if you want to call it that" the bread was stale and hard. The bowl of cereal was sitting on Resident #135's bedside table and the uneaten peanut butter sandwich laid next to it. The sandwich was hard and stiff to touch. Resident #135 stated that the only reason he ate the cereal was because he wanted to keep his strength up so he could participate with therapy that day. Resident #135 stated that he had received a meal tray for each meal on 05/22/21 without incident. An interview was conducted with NA #8 on 05/26/21 at 8:51 AM. NA #8 confirmed that she worked the unit where Resident #135 resided on 05/23/21. She stated that when she arrived for her shift she did not get to round with the previous shift because they were too tired but she did walk the unit and the door to Resident #135's room was closed and there was no name on the door so she assumed that the room was empty. NA #8 stated that when she was picking up the breakfast trays on the unit the door to Resident #135's room was open, and she walked in to get the breakfast tray and Resident #135 stated he never received a breakfast tray. NA #8 stated there was no tray ticket for Resident #135 and when she called the kitchen they stated they had already thrown the left-over food out. NA #8 stated she did make Resident #135 a peanut butter and jelly sandwich and took him a bowl of cereal. NA #8 stated that she assumed if the resident was in the facility then there was a meal ticket and dietary would plate the meal and we would deliver the tray to the resident.	F 800	audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing.¿ Dates corrective actions will be completed: 6/23/21	

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An interview was conducted with the Dietary Manager (DM) and the Administrator on 05/24/21 at 5:10 PM. The DM stated she was new to the facility and had only been there around a week. She stated that there were a couple of ways that she learned of new admissions, one way was by the new admission slip and another way was the staff would tape the diet slip to the door of the kitchen. She stated that once she was aware of the new admission the diet was entered into the system and the tray card was created for that resident. The DM stated that at the end of each day she would print the following days meal tray tickets and the dietary staff would take the meal tray tickets to the unit and prepare each residents meal tray based off the meal tray ticket which contained their diet and a list of likes and dislikes. She added on Friday afternoon before she left for the day she had printed all the tray tickets for the weekend, and she may have printed them before Resident #135 admitted to the facility. The Administrator stated that the nursing staff were expected to make an inventory of the residents on the unit to make sure that each resident received a meal tray and had adequate nutrition as backup plan in the event there was no meal tray ticket. He added that he had received a grievance on Sunday about a resident that did not receive a tray but could not recall who the resident was. The DM stated that when she had learned that Resident #135 had not received a breakfast tray she had printed meal tickets for Resident #135 and ensure he received both lunch and dinner. The Administrator stated that he fully expected each resident to receive a meal tray.

2. Resident #137 was admitted to the facility on 05/21/21 with diagnoses that included presence of artificial knee joint, osteoarthritis, diabetes, and

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others.

Review of an admission assessment dated 05/21/21 indicated Resident #137 was alert and oriented to person, place, and time.

Review of a physician order dated 05/23/21 read, regular diet thin consistency.

An observation and interview were conducted with Resident #137 on 05/24/21 at 9:44 AM. Resident #137 stated that he admitted to the facility Friday afternoon/evening and on Saturday morning he never received a breakfast tray. He stated that around 10:00 AM the staff was making rounds picking up the breakfast trays and I told the staff I never received a tray. He stated the young lady stated she would check on it and get me something. Resident #137 stated, "I got a cold waffle, sausage patty, and a cold scrambled egg" but it was well after 10:00 AM. Resident #137 stated that after breakfast on 05/22/21 he did receive at meal tray at each meal since then.

An interview was conducted with Nurse Aide (NA) #9 on 05/26/21 at 11:36 AM. NA #9 confirmed that Resident #137 did not get a breakfast meal tray from the kitchen and we did not realize it until we were picking up the meal trays. NA #9 stated that they had 3 NAs on the unit, and they pulled one of the NAs to go to another unit to work and that NA went to the kitchen and got Resident #137 a breakfast meal tray. She stated it was sometime around 10:00 AM but could not recall the exact time nor could she recall what was on the tray.

An interview was conducted with the Dietary Manager (DM) and the Administrator on 05/24/21

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F 800	Continued From page 70 at 5:10 PM. The DM stated she was new to the facility and had only been there around a week. She stated that there were a couple of ways that she learned of new admissions, one way was by the new admission slip and another way was the staff would tape the diet slip to the door of the kitchen. She stated that once she was aware of the new admission the diet was entered into the system and the tray card was created for that resident. The DM stated that at the end of each day she would print the following days meal tray tickets and the dietary staff would take the meal tray tickets to the unit and prepare each residents meal tray based off the meal tray ticket which contained their diet and a list of likes and dislikes. She added on Friday afternoon before she left for the day she had printed all the tray tickets for the weekend, and she may have printed them before Resident #137 admitted to the facility. The Administrator stated that the nursing staff were expected to make an inventory of the residents on the unit to make sure that each resident received a meal tray and had adequate nutrition as backup plan in the event there was no meal tray ticket. He added that he had received a grievance on Sunday about a resident that did not receive a tray but could not recall who the resident was. The DM stated that when she had learned that Resident #137 had not received a breakfast tray she had printed meal tickets for Resident #137 and ensure he received both lunch and dinner. The Administrator state that he fully expected each resident to receive a meal tray.	F 800		
F 806 SS=B	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides-	F 806		6/23/21

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F 806	Continued From page 71 §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to honor food preferences for 1 of 7 residents reviewed for food preferences (Resident #287). Findings included: Resident #287 was admitted to the facility on 03/17/21. An Admission Minimum Data Set (MDS) dated 03/23/21 indicated Resident #287 was cognitively intact and required setup assistance for meals. A nutrition care plan dated 03/24/21 included an intervention that indicated "respect resident's dietary choices" and "review preferences per routine and PRN" (as needed). An observation on 05/23/21 at 10:46 AM revealed a glass of milk with a lid attached on Resident #287's nightstand. An observation on 05/25/21 at 8:48 AM revealed Resident #287 lying in the bed with her meal tray sitting on her bedside table. The tray had not been setup, the lid was covering her plate and included a hard-boiled egg, a piece of toast, a bowl of cereal, a cup of coffee, and a glass of	F 806	F806 – Food – Preferences honored Resident #287 meal ticket was corrected to reflect likes and dislikes on 5/26/2021. No adverse events occurred due to discrepancy in tray ticket accuracy. All residents have the potential to be affected, therefore on 5/26/21 the Licensed Registered Dietician, reviewed all resident tray tickets to ensure tray tickets were accurate based on resident preference. All other findings were corrected. To prevent this from recurring, beginning 6/3/2021, the Dietary Manager or designee educated the dietary staff members on the requirement for all residents to have accurate tray tickets including honoring preferences of likes and dislikes. Effective 6/3/2021, any new dietary staff member hired will receive this education. Tray tickets were enhanced using color to help identify preferences, etc. Beginning on 6/21/21, the Dietary Manager or designee or designee will	

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F 806	Continued From page 72 milk. The meal ticket indicated to send cereal and no milk with a preference to receive a hard-boiled egg. The meal ticket on the meal tray further revealed a dislike to include a hard-boiled egg. An interview on 05/25/21 at 8:48 AM with Resident #287 revealed she had again received milk and demanded it be removed from her tray. Resident #287 stated, I've told staff I do not want milk brought to my room and they don't even bother to listen to me. It does as much good to "talk to that wall because they ignore everything." An interview on 05/25/21 at 8:51 AM with Nurse #2 revealed she delivered Resident #287's breakfast tray on the morning of 05/25/21. She indicated she was not assigned to deliver meal trays but had been asked to assist on that morning and admitted she had been taught to review meal tray card for diet and preferences before she delivered each tray; however, she failed to review Resident #287's meal tray card before she delivered her breakfast on 05/25/21. Nurse #2 indicated Resident #287's breakfast meal ticket on 05/25/21 indicated she did not wish to receive milk and listed a hard-boiled egg in both the request section and under the dislike portion on the meal tray ticket. An interview on 05/25/21 at 8:55 AM with the Administrator revealed he expected all staff to review each resident's meal tray card for the correct diet and honor each resident's food preferences listed on the ticket.	F 806	observe 20 meal tickets per week for 12 weeks to ensure all tickets reflect resident choices. Beginning 6/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendation. Dates corrective actions will be completed: 6/23/21	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets	F 808		6/23/21

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F 808	Continued From page 73 §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and Nurse Practitioner interview the facility failed to enter the correct physician diet order into the electronic medical record and subsequently served the incorrect diet with the incorrect consistency of liquids to a resident (Resident #60) who was supposed to receive a mechanically altered diet with honey thick liquids. This affected 1 of 3 new admissions reviewed. The findings included: Resident #60 was admitted to the facility on 04/15/21 and most recently readmitted on 05/21/21 with diagnoses that included dysphagia. Review of a Minimum Data Set (MDS) dated 04/17/21 revealed that Resident #60 was cognitively intact for daily decision making and required set up assistance with eating. The MDS further revealed that Resident #60 had coughing or choking during meals or when swallowing and had complaints of difficulty or pain when swallowing. The MDS also indicated that Resident #60 required a mechanically altered and therapeutic diet. Review of a discharge summary from the local hospital dated 05/21/21 indicated Resident #60's	F 808	F808 – Food – Serving the Correct Diet Resident #60 was assessed on 5/25/21 to ensure health and safety of the resident. The physician was notified and orders received were processes. No adverse events occurred due to the resident receiving an incorrect diet. All residents have the potential to be affected, therefore on 5/27/21 all resident meals were observed to ensure residents received meals based on physician orders. No other findings were present. To prevent this from recurring, beginning 6/3/2021, the Dietary Manager or designee educated the dietary staff members on the requirement for all residents to have accurate tray tickets including liquid consistency and diet texture. On 6/3/21 the Administrator educated Department Managers on dining room standards to ensure all residents received the appropriate meal according to the tray ticket. Effective 6/3/2021, any new dietary staff member that are hired	

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F 808	Continued From page 74 diet was mechanically altered with moderately (honey) thick liquids. Review of a physician order dated 05/22/21 read low concentrated sweets/no added salt diet with thin (regular) consistency. a. An observation and interview were conducted with Resident #60 on 05/23/21 at 11:06 AM. Resident #60 was resting in bed with his eyes open. He was alert and verbal and had a cup of thickened liquids with a straw in a cup and a cup of thin clear liquids sitting on his bedside table. Resident #60 was observed to pick up the cup of clear thin liquid and take a drink. When asked if he was supposed to have that he stated, "I am supposed to have those thick liquids, but they told me I could have this water." An interview was conducted with Nurse #3 on 05/25/21 at 1:23 PM. Nurse #3 confirmed that she was working on 05/21/21 when Resident #60 returned from the hospital. Nurse #3 stated that before Resident #60 went to the hospital he was on thin liquids, but when he returned, they were supposed to be thickened liquids. Nurse #3 stated that Nurse Aide (NA) #8 should have removed the thin liquids from his room and given him thickened liquids. An interview was conducted with NA #8 on 05/26/21 at 8:51 AM. NA #8 confirmed that she worked the unit where Resident #60 resided on 05/23/21. She stated that Resident #60 had some thin water in his room, and he had asked for fresh water, and "I got him a cup of fresh thin water." NA #8 stated that she did not know that Resident #60 was on thickened liquids or she would have removed the thin liquids from his room and given	F 808	will receive this education. Effective 6/3/21, any new administrative staff will receive education on dining room duty services. Beginning 6/21/21 to monitor ongoing compliance, the Dietary Manager or designee or designee will observe 20 residents trays per week to ensure all residents receive meals based on tray tickets details. Beginning 6/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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F 808	Continued From page 75	F 808		

him thickened liquids as ordered.

b. An observation of Resident #60 was made on 05/24/21 at 5:51 PM. Resident #60 was sitting up in bed and had his evening meal tray in front of him. Resident #60 was observed to have 3 bowls of food on his tray, one contained a bowl of slice red beets, another bowl had a shredded toss salad with dressing, and the third bowl had beef stew in it. The bowl of beef stew contained large chunks of carrots, potatoes, and meat. There was also a smaller bowl of apple cobbler and Resident #60 also had a cup of thin juice. There was handwritten tray card that contained Resident #60's room number and stated "mech soft with honey."

An interview was conducted with the Dietary Aide (DA) #1 on 05/24/21 at 5:55 PM. DA #1 stated that the mechanically altered diet for the evening meal consisted of a shredded salad, beef stew and buttered beets along with the dessert.

An interview was conducted with the Regional Registered Dietician (RD) on 05/24/21 at 6:09 PM. The RD stated that the mechanically altered diet for the evening meal consisted of beef stew and buttered beets along with the dessert of apple cobbler with crumb topping. The RD stated that Resident #60 should not have gotten the shredded salad on a mechanically altered diet.

A follow up observation was made along with the Administrator of Resident #60 on 05/24/21 at 6:10 PM. Resident #60 remained sitting up in bed and was still eating his evening meal. Resident #60 had eaten all the shredded salad and was working on the beef stew. He had drunk approximately 75% of the thin juice that was on

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F 808	Continued From page 76	F 808		

the tray as well. The Administrator stated that normally he would be in the kitchen checking behind the staff to ensure that the correct tray was served. He explained that his Dietary Manger was new, and he was the back up and had been spending a lot of time in the kitchen overseeing things to ensure things ran smoothly. The Administrator stated he would follow up and see why Resident #60 was still getting the incorrect food and liquid on his tray.

An interview was conducted with the Speech Therapist (ST) on 05/25/21 at 10:33 AM. The ST stated that she had not seen Resident #60 since his return from the hospital. She stated that before Resident #60 discharged to the hospital he was on a mechanical soft diet with thin liquids. The ST stated that when a resident discharged to the hospital the nursing staff at the facility were supposed to enter readmission orders from the discharge summary and in this case that was not done, and the order was entered incorrectly. The ST stated that the discharge summary stated a mechanically altered diet with moderately thick liquid would equate to mechanically altered diet with honey thick liquids. She added that she would do a full assessment since Resident #60 was served the wrong consistency liquids and foods.

An interview was conducted with the Director of Nursing (DON) on 05/25/21 at 11:38 AM. The DON stated when a resident was gone to the hospital for less than 72 hours, they do not take them out of the computer system. So when Resident #60 was set to return to the facility his orders were reconciled with the discharge summary and approved by the Nurse Practitioner (NP) then one of the agency nurses accidently

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F 808	Continued From page 77	F 808		

transferred Resident #60 out of the system which wiped out his orders all together. When she was notified on 05/22/21 that Resident #60's order has been wiped out, the DON stated she went in remotely and just reactivated Resident #60's previous orders and that was how Resident #60's orders did not reflect the diet change that was stated on the discharge summary. Once the error was discovered they asked the NP to assess Resident #60 and corrected the diet slip and made sure dietary was aware.

An interview was conducted with the NP on 05/26/21 at 10:23 AM. The NP stated that she expected that once she verified Resident #60's orders from the hospital that the staff followed those orders. The NP stated that she had verified Resident #60's orders on 05/21/21 before she left for the day and when she learned that Resident #60 had gotten the wrong diet and liquids she instructed the nursing staff to again go back through the orders and make sure they were correct. The NP stated that she did evaluate Resident #60 after he had received the incorrect diet and liquids and ordered a STAT (now) chest x-ray which did show pneumonia. She added that it was recurrent pneumonia and not an acute episode that he had had since April 2021 and she again placed Resident #60 on an antibiotic.

An interview was conducted with the DON and the Administrator on 05/27/21 at 2:48 PM. The Administrator stated that he expected Resident #60 to receive the correct diet and the correct liquids at each meal. The DON stated that she too expected that Resident #60 received the correct diet and liquids at each meal. She added that she believed that the breakdown occurred when she reactivated the orders that were

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F 808	Continued From page 78 accidentally deactivated because those orders where his previous orders and not his new orders and she did not realize that. The DON stated that when Resident #60 readmitted to the facility from the hospital his thin liquids should have been removed from the room and thickened liquids supplied to him as instructed on the discharge summary.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and facility staff interviews, the facility failed to ensure potentially hazardous food items were disposed of on their expiration date for 1 of 1 walk in refrigerator and failed to remove one expired container of liquid supplement from 1 of 4	F 812	F812 – Food – Outdated Items On 5/26/21 the 1 case of open outdated pasteurized eggs were discarded. No adverse events occurred due to the outdated items. All undated or outdated	6/23/21

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F 812	Continued From page 79 medications carts. Findings Included: 1. An observation made on 05/26/21 at 3:28PM of the walk-in refrigerator in the kitchen revealed 1 opened case of pasteurized eggs with a received by date of 04/15/21 and an expiration date of 05/25/21. Further review of the case revealed there were 109 raw, pasteurized eggs remaining in the case. During an interview with the Dietary Manager on 05/26/21 at 3:32PM revealed she had checked the refrigerators the previous night and "must have overlooked" the expiration date of the 109 pasteurized eggs. The Dietary Manager reported she did not believe that any of the expired eggs had been served to residents but verified had a resident in the facility requested a boiled egg or fried egg, that the expired eggs would most likely have been used to fulfill the request. An interview with the Administrator on 05/27/21 at 2:49PM revealed he had an expectation that no expired food items were to be left in the refrigerators. He also expected dietary staff to have daily checks in place to ensure no expired food was left in the refrigerators and that opened items were to be labeled and kept for the appropriate amount of time. 2. An observation made on 05/25/21 at 7:54AM of the 300/400 hall medication cart revealed a liquid supplement container with a date of 04/20/2 that was opened and partially consumed. Additional observation at this time revealed MA #1 to provide the supplement to Resident #234.	F 812	liquid supplements were disposed of immediately upon identification. No resident suffered any negative effects from the alleged deficiency. All residents have the potential to be affected, therefore on 5/26/21 all food storage areas and medication carts were checked to ensure no remaining outdated food or supplements remained in the building. All other outdated items were discarded. To prevent this from recurring, beginning 6/3/2021, the Dietary Manager or designee educated the dietary staff members on the requirement to discard outdated food. On 6/3/21 DON educated licensed nursed on the requirement to date food and supplement items when opening and use by discard date. On 6/3/21 the Administrator educated Department Managers on dining room standards to ensure all items in food storage areas are labeled and dated appropriately. Effective 6/3/2021, any new dietary staff member will staff that are hired will receive this education. Effective 6/3/21, any new administrative staff will receive education on dining room duty services. During routine rounds, the interdisciplinary staff will monitor for outdated expired items. Any item found to be not labeled or expired, will be discarded immediately. Beginning 6/21/21, to monitor ongoing compliance the Dietary Manager or designee or designee will observe and check all food storage areas during 5x	

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F 812	Continued From page 80 During an interview with MA #1 on 05/25/21 at 8:30 AM, she reported she believed the 04/20/21 date on the container was when the supplement was brought to the floor. She stated she was unsure when it was opened, and she was unsure if it was expired. An interview with the DON on 05/25/21 at 9:18 AM revealed all supplements should be labeled with the open date. She reported if the supplement had a date of 04/20/21, she would expect the nurse to discard the supplement and it should not have been used. An interview with the Dietician on 05/25/21 at 9:38 AM revealed all supplements should be labeled in black marker with the date the facility received the container. She also reported that the container should then be dated when it was opened as supplements can only be used for 4 days after opening before needing to be discarded.	F 812	weekly, to ensure all items are dated and food storage remains free from expired items. The DON or designee will monitor medication carts 5x weekly to ensure all supplements are dated and are not expired. Beginning 6/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		6/23/21

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must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 82 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and Resident interviews the facility failed to maintain accurate medical records for the administration of treatments for 1 of 5 residents reviewed for unnecessary medications (Resident #16). The findings included: 1. a. Resident #16 was admitted to the facility on 02/04/21 with diagnoses that included heart failure and lymphedema. A review of Resident #16's admission Minimum Data Set assessment dated 02/10/21 indicated she was cognitively intact. A review of Resident #16's medical record revealed a physician's order dated 03/08/21 that indicated "Apply leg compression sleeves x (for) 30 minutes every morning and at bedtime for Lymphedema. Staff to assist with donning and removal of sleeves". A review of Resident #16's Medication Administration Record (MAR) for May 2021	F 842	Resident #16 remains in the facility. Order for leg compression sleeves was discontinued due to noncompliance with physicians order. No apparent negative outcomes due to resident not receiving leg compression sleeves as ordered. The pain patch for Resident #16 was removed on 5/25/21. The physician was notified of the incident and an incident report was created. No adverse events occurred due to the patch not being removed. On 5/31/21 facility wound nurse validated that all treatments were in place per physician order. All residents with medication patch orders have the potential to be affected, therefore a skin check audit was complete for all residents with patch orders on 6/3/21 to ensure all patches were removed timely. No other discrepancies were noted. To prevent this from recurring, beginning 6/3/21, the DON or designee educated the licensed nursing staff on documentation of treatments provided to reflect an accurate medical record.	

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F 842	Continued From page 83 revealed a treatment for the compression sleeves to be applied twice a day at 5:00 AM and 6:00 PM. The MAR indicated that for the last seven days (05/18/21-05/25/21) the order for the compression sleeves had been signed off that the compression sleeves were applied 9 times out of a total of 14 times. On 05/25/21 at 9:46 AM during an interview with Resident #16 an observation was made of extreme bilateral lymphedema of her lower extremities. The Resident explained that she had compression sleeves that she used to use twice a day for 30 minutes, but her legs became too large due to the lymphedema that she was unable to apply the sleeves around her legs. The Resident continued to explain that it had been weeks since she last had the compression sleeves on. On 05/25/21 at 1:18 PM an interview was conducted with Nurse #5 who initialed that she had applied Resident #16's compression sleeves on May 18th, 22nd, 23rd and 24th at 5:00 AM. The Nurse explained that Resident #16 was alert and oriented and voiced her needs. Nurse #5 continued to explain that Resident #16 had an order for bilateral compression sleeves to be applied in the mornings but due to the extreme lymphedema in her legs Nurse #5 was unable to apply the sleeves. When the Nurse was asked why she initialed as having applied the compression sleeves 4 times in the last week she replied it was due to her not paying attention to what she was initialing. An interview was conducted with Nurse #1 on 05/25/21 at 4:42 PM. The Nurse initialed that she applied Resident #16's compression sleeves on May 20th at 6:00 PM. Nurse #1 described	F 842	Effective 5/25/2021, any new licensed staff that are hired or licensed agency staff will receive this education. Beginning 6/21/21, the facility Director of Nursing or designee will audit treatment administration records and observe what was documented was accurate according to documentation. Any deficient practice will be addressed immediately and documented. The facility Director of Nursing or their designee will audit 5 resident skin checks per week for resident that have pain patches to ensure proper application and removal based on physicians orders for 12 weeks. Beginning 6/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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Resident #16 as alert and oriented and voiced her needs. The Nurse explained that the Resident had an order for bilateral compression sleeves but had been unable to wear them for several weeks due to the extreme edema in her lower legs. When the Nurse was asked why she initialed that she had applied the compression sleeves on the 20th she stated it was a case of her not paying attention to what she was initialing and signing off everything at the end of her shift to make sure she had everything signed off.

On 05/26/21 at 3:10 PM an interview was conducted with Nurse #7 who initialed that she applied Resident #16's compression sleeves on May 22nd and 24th at 6:00 PM. The Nurse explained that she did not apply the compression sleeves because Resident #16 refused them for being too painful. When Nurse #7 was showed the MAR that indicated she had applied the compression sleeves the Nurse stated that she initialed them off before she went into the Resident's room to apply them and forgot to change it when the Resident refused the sleeves.

On 05/27/21 at 12:41 PM an interview was conducted with Nurse #8 who had initialed that she applied Resident #16's compression sleeves on May 21st at 6:00 PM. The Nurse explained that she thought the order was asking if the compression sleeves had been applied for 30 minutes by the nurse aides who she thought were responsible for applying the compression sleeves.

Several attempts were made to interview Nurse #6 who initialed she applied Resident #16's compression sleeves on May 20th at 5:00 AM but the attempts were unsuccessful.

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An interview was conducted with the Director of Nursing (DON) on 05/27/21 at 10:51 AM. The DON explained that if Resident #16's compression sleeves were not able to be applied then her expectation was that the provider should have been notified so a different course of treatment could have been sought.

During an interview with the Administrator on 05/27/21 at 2:47 PM he indicated his expectation was that the facility follows the policies and procedures for medical record accuracy and that they rendered the care ordered by the Provider.

b. Resident #16 was admitted to the facility on 02/04/21 with diagnoses that included osteoarthritis.
The Minimum Data Set assessment dated 02/10/21 revealed Resident #16 was cognitively intact.

The Care Plan initiated 02/04/21 revealed Resident #16 had altered musculoskeletal status with the goal that she would be able to demonstrate techniques and behaviors that enabled the resumption of activities. The intervention included to administer pharmacological and non-pharmacological pain relief interventions.

A review of Resident #16's medical record revealed a physician order dated 03/31/21 for "Icy Hot Patch (Menthol), apply to right upper arm one time a day for arm pain".

A review of Resident #16's Medication Administration Record (MAR) for 05/2021 revealed the order for the pain patch was initialed

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as applied on 05/23/21 by Nurse #9 and on 05/24/21 by Nurse #7.

On 05/25/21 at 9:40 AM an observation and interview with Resident #16 revealed a pain patch on her right shoulder with the date and initials of 05/23/21 TC. The Resident stated she had chronic pain in her right shoulder and received a pain patch that was applied daily for pain relief. When the Resident was asked if the pain patch was changed the day before on 05/24/21 the Resident stated she thought it was. Resident #16 denied having increased pain in her right shoulder due to the pain patch being two days old.

On 05/25/21 at 9:46 AM during the interview with Resident #16, Nurse #7 came in to apply the pain patch. The Nurse was asked what the date was that was on the current pain patch on the Resident's right shoulder and the Nurse stated the 23rd.

During an interview with Nurse #7 on 05/25/21 at 11:10 AM an observation was made of Resident #16's MAR with Nurse #7 that revealed she initialed that the pain patch was applied on 05/24/21 to Resident #16 by Nurse #7. The Nurse reported she was sure she changed the pain patch on the Resident's right shoulder on 05/24/21 and offered the explanation that Resident #16 could have moved the pain patch to her left shoulder.

A follow up observation and interview was conducted with Resident #16 on 05/25/21 at 12:01 PM during which it was noted that there was no pain patch on the Resident's left shoulder. The Resident explained that she does not have pain in her left shoulder that the pain was only in

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F 842	Continued From page 87 her right shoulder because she had a torn rotator cuff and could not raise her right arm. A follow up interview with Nurse #7 on 05/26/21 at 3:10 PM was conducted. Nurse #7 stated after she thought about it, she remembered she went to apply the patch on 05/24/21 and could not apply the patch because Resident #16 was otherwise detained. The Nurse explained that she had initialed the order for the pain patch off before she went into apply the patch and she forgot to go back and apply the pain patch. The Nurse stated she should not have initialed the order off before she applied the pain patch. Several attempts were made to interview Nurse #9, but the attempts were unsuccessful. An interview was conducted with the Director of Nursing (DON) on 05/27/21 at 10:51 AM. The DON explained that if Resident #16's pain patch was not applied then the Nurse should have notified the Provider for further orders. The DON also indicated her expectation was that the nurses initial the medication and treatment records after they have been given. On 05/27/21 at 2:47 PM during an interview with the Administrator he stated that it was his expectation that the facility follows the policy for medical record accuracy and the medication and treatment orders given by the Providers.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		6/23/21

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

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

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 89 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement enhanced droplet precautions for Resident #60 who readmitted to the facility and was unvaccinated against COVID-19 and failed to implement enhanced droplet precautions for Resident #135 who was newly admitted to the facility and was unvaccinated against COVID-19 as directed by their policy and recommended by the Center for Disease Control and Prevention (CDC). This affected 2 of 3 new admissions reviewed. These failures occurred during a global pandemic. The findings included:	F 880	F880 – Infection Control – 2 Admissions on Precautions Resident #60 and Resident #135 were put on Enhanced Droplet Precautions on 5/23/21. Resident #60 and resident #135 are no longer on isolation precautions, but did not have any negative outcome as a result in the delay of placing on isolation precautions. Both residents remain free from Covid 19 virus infection. All residents have the potential to be affected, therefore on 5/23/21 all resident that admitted or readmitted within the	

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F 880	Continued From page 90 Review of a facility policy titled, "Guidance for Removal of Transmission Based Precautions for COVID-19 patients dated February 16, 2021 read in part, New Admissions: should remain isolated in the facility's observation unit and in a private room for 14 days after admission or patients who have been fully vaccinated and at least 14 days have passed since the final vaccination may go to the green unit if they have supporting documentation/evidence of vaccination status. Review of CDC guidance titled, "Infection Control for Nursing Homes" summary of recent changes dated March 29, 2021 read in part, "all other new admissions and readmissions should be placed in a 14 day quarantine even if they have a negative test upon admission. Exceptions include residents within 3 months of a SARS-CoV-2 infection and fully vaccinated residents. 1. Resident #60 was admitted to the facility on 04/15/21 and most recently readmitted on 05/21/21 with diagnoses that included dysphagia and chest pressure. Review of a comprehensive Minimum Data Set (MDS) dated 04/17/21 revealed that Resident #60 was cognitively intact for daily decision making and required limited assistance with activities of daily living. Review of a physician order dated 05/22/21 read, droplet/contact precautions not to be discontinued until negative test and/or met the criteria for isolation discontinuation per CDC guidelines. Review of a Nurse Practitioner (NP) progress note dated 05/26/21 at 5:11 PM The note	F 880	previous 14 days were reviewed to ensure they were on proper isolation. No other findings were noted. To prevent this from recurring, beginning 6/3/2021, the DON or designee educated the licensed nursing staff on the requirement of contact isolation procedures. Effective 6/3/2021, any new licensed nurses or certified nursing aide staff that are hired or are agency will receive this education. The facility administrator educated the interdisciplinary staff on ensuring that all admissions were reviewed and placed on proper precautions based on CDC CMS guidance and facility policy. The admissions staff will set up new admission rooms with appropriate isolation equipment as necessary. Beginning 6/21/21, to monitor ongoing compliance the director of nursing or designee will observe all new admissions and readmissions over the next 12 weeks to ensure proper isolation procedures are followed. Beginning 6/28/2021, the results of the audits will be forwarded to the facility QAPI committee for further review and recommendations during the duration of auditing. Dates corrective actions will be completed: 6/23/21	

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indicated that Resident #60 had a COVID-19 February 16, 2021. The progress note was signed the NP.

An observation and interview were conducted with Resident #60 on 05/23/21 at 11:06 AM. Upon arriving to Resident #60's room the door was open and there was no sign indicating any precautions or sign indicating any Personal Protective Equipment (PPE) was needed to enter the room. Resident #60 was resting in bed with his eyes open and was alert and verbal. Resident #60 stated he readmitted to the facility from the hospital on 05/21/21. Resident #60 stated that he has not had the COVID-19 vaccination but added that he had COVID-19 back in February 2021 from what he could recall.

Review of Resident #60's medical record revealed no record of COVID-19 vaccination status.

An observation of Resident #60's door was made on 05/24/21 at 9:30 AM. The door to Resident #60's room was closed and there was a sign on the door that read, Enhanced Droplet Precautions, before entering this room follow the instructions below. Perform hand hygiene, eye protection when entering the room, gown and gloves when entering room, universal masking: N95 (if available) if not, surgical mask acceptable and must fully cover nose, mouth, and chin.

An interview was conducted with Nurse #3 on 05/25/21 at 1:23 PM. Nurse #3 confirmed she was working on 05/21/21 when Resident #60 readmitted to the facility. She stated that another nurse that was working, but she could not recall who it was, had told her that she had completed

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everything for Resident #60's admission and all she needed to do was complete a nurse note. Nurse #3 stated that when she went into the computer system all of Resident #60's orders were discontinued. She added that the DON had reactivated Resident #60's orders but she was very busy with another resident who was very sick she did not pay attention to whether or not Resident #60 was on transmission-based precautions or not. Nurse #3 confirmed that she had been in and out of Resident #60's room several times between 05/21/21 and 05/22/21 and did not apply any PPE because there was not a sign on the door. Nurse #3 stated that she was "old school and not very familiar" with how things ran in the facility. Nurse #3 explained she did not realize that Resident #60 needed to be placed under quarantine when he readmitted to the facility. She stated she used to have a nurse that helped with her with things like that, but that nurse was no longer employed by the facility.

An interview was conducted with Nurse Aide (NA) #8 on 05/26/21 at 8:51 AM. NA #8 confirmed that she had worked the unit where Resident #60 resided on 05/23/21 and provided care to Resident #60. NA #8 stated that Resident #60 was not on any precautions and she did not have to apply any PPE when she entered his room. NA #8 added that if she needed to apply PPE there would be a sign on the door indicating which PPE she needed to wear but again stated that Resident #60 did not have a sign on his door indicating any PPE was required to enter the room.

An interview was conducted with the Director of Nursing (DON) on 05/24/21 at 11:36 AM. The DON confirmed that she was also in charge of

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infection control in the facility. The DON stated that if new or readmission resident returned from the hospital and were unvaccinated, they must go on a 14-day quarantine on the observation unit. She added that the facility would test the new/readmission resident on day 7 and again on day 14 and if they remained negative and asymptomatic, they could be moved off the observation hall. The DON stated that when she came to the facility on 05/23/21 and began rounding on the unit she noticed that Resident #60 was not on isolation and she spoke with the nurses and when she returned to the building on 05/24/21 Resident #60 was on isolation with a sign on his door. The DON stated that the admission nurse should have placed the appropriate sign on the door and placed a PPE cart outside of Resident #60's door on 05/21/21 upon admission. The DON stated that she expected the staff to follow the CDC guidelines as well as their company policy and Resident #60 who to her knowledge was not vaccinated should have been placed under quarantine when he readmitted on 05/21/21. She further expected the staff to apply the correct PPE as directed by the sign on the door.

A follow up interview was conducted with the DON and the Administrator on 05/27/21 at 2:48 AM. The Administrator stated that he expected the staff to follow their company's policy as well as the CDC guidelines for new/readmissions.

2. Resident #135 was admitted to the facility on 05/21/21 with diagnoses that included: non traumatic intracranial hemorrhage, heart disease, history of falls, and others.

Review of an admission assessment dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(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 94	F 880		

05/21/21 indicated Resident #135 was alert and oriented to person, place, and time.

Review of a physician order dated 05/21/21 read, droplet/contact precautions not to be discontinued until negative test and/or met the criteria for isolation discontinuation per CDC guidelines.

Review of Resident #135's medical record revealed no record of COVID-19 vaccination status.

An observation of Nurse Aide (NA) #8 was made on 05/23/21 at 10:10 AM. NA #8 was observed going in and out of rooms on the unit picking up breakfast trays. NA #8 entered Resident #135's room to pick up his breakfast tray without applying any PPE.

An observation and interview were conducted with Resident #135 on 05/23/21 at 10:55 AM. Upon arriving at Resident #135's room on the observation unit the door of the room was open and there was no sign on the door that indicated Resident #135 required transmission based precautions and no sign that indicated any Personal Protective Equipment (PPE) was required when entering the room. Resident #135 was sitting in bed and was alert and verbal. Resident #135 stated that he had not had COVID-19 vaccination, and indicated he was scheduled to get one and the vaccine was pulled from use and had rescheduled but had a stroke and ended up in the hospital and he had not had the opportunity to get the vaccine since then.

An observation of Resident #135's door was made on 05/24/21 at 9:30 AM. The door to Resident #135's room on the observation unit

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F 880	Continued From page 95	F 880		

was closed and there was a sign on the door that read, Enhanced Droplet Precautions, before entering this room follow the instructions below. Perform hand hygiene, eye protection when entering the room, gown and gloves when entering room, universal masking: N95 (if available) if not, surgical mask acceptable and must fully cover nose, mouth, and chin.

An interview was conducted with Nurse #3 on 05/25/21 at 1:23 PM. Nurse #3 confirmed she was working on 05/21/21 when Resident #135 admitted to the facility. Nurse #3 confirmed that she had been in and out of Resident #135's room several times between 05/21/21 and 05/22/21 and did not apply any PPE because there was not a sign on the door. Nurse #3 stated that she was "old school and not very familiar" with how things ran in the facility. She stated she used to have a nurse that helped with her with things like that, but that nurse was no longer employed by the facility and she did not realize that Resident #135 required transmission-based precautions.

An interview was conducted with NA #8 on 05/26/21 at 8:51 AM. NA #8 confirmed that she had worked the unit where Resident #135 resided on 05/23/21 and provided care to Resident #135. NA #8 stated that Resident #135 was not on any precautions and she did not have to apply any PPE when she entered his room. NA #8 added that if she needed to apply PPE there would be a sign on the door indicating which PPE she needed to wear but again stated that Resident #135 did not have a sign on his door indicating any PPE was required to enter the room.

An interview was conducted with the Director of Nursing (DON) on 05/24/21 at 11:36 AM. The

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	345567	A. BUILDING _____ B. WING _____	C 06/04/2021

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F 880	Continued From page 96	F 880		

DON confirmed that she was also in charge of infection control in the facility. The DON stated that if new or readmission resident returned from the hospital and were unvaccinated, they must go on a 14-day quarantine on the observation unit. She added that the facility would test the new/readmission resident on day 7 and again on day 14 and if they remained negative and asymptomatic, they could be moved off the observation hall. The DON stated that when she came to the facility on 05/23/21 and began rounding on the unit she noticed that Resident #135 was not on isolation and she spoke with the nurses and when she returned to the building on 05/24/21 Resident #135 was on isolation with a sign on his door. The DON stated that the admission nurse should have placed the appropriate sign on the door and placed a PPE cart outside of Resident #135's door. The DON stated that she expected the staff to follow the CDC guidelines as well as their company policy and Resident #135 who to her knowledge was not vaccinated should have been placed under quarantine when he admitted on 05/21/21. She further expected the staff to apply the correct PPE as directed by the sign on the door.

A follow up interview was conducted with the DON and the Administrator on 05/27/21 at 2:48 AM. The Administrator stated that he expected the staff to follow their company's policy as well as the CDC guidelines for new/readmissions.