STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 07/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

(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 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		8/20/21

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

Electronically Signed | 08/09/2021

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E 037	Continued From page 1 (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037		

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arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.

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E 037	Continued From page 3	E 037		

(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency

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E 037	Continued From page 4 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide and maintain documentation of annual staff training on the facility's Emergency Preparedness Plan. Findings included: A review of the facility's Emergency Preparedness Plan (EP) occurred on 7-15-21 at 3:30pm with the Administrator. During the review it was discovered there was not documentation of the annual training for staff on the EP plan. The Administrator was interviewed on 7-15-21 at 4:15pm. The Administrator stated she could not find any annual training or documentation of annual training for the staff in regard to the EP plan. The Administrator explained she was new to the building and did not know how EP training was scheduled or why the training had not occurred in the past year.	E 037	E037 EPP Training Program 1. Administrator/designee to validate all staff complete emergency preparedness training on or before 8/20/2021. 2. Administrator/designee will audit new hire training records weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 3. The results of audits will be reviewed by the Quality Assurance Performance Improvement committee for continued monitoring. The Administrator will be responsible for the implementation of this plan with a compliance date of 8/20/2021.	
F 000	INITIAL COMMENTS The survey team entered the facility on 7-12-21 to conduct a recertification survey and complaint investigation. The survey team was onsite 7-12-21 through 7-15-21. Additional information	F 000		

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F 000	Continued From page 5 was obtained offsite on 7-16-21 and 7-19-21. Therefore, the exit date was 7-19-21. Event ID# DF7C11. _23_ of the _50_ complaint allegations were substantiated.	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 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	F 550		8/20/21

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F 550	Continued From page 6 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 observation and staff and resident interview, the facility failed to cover the resident's left groin and hip with the bed sheet while the resident's room door was opened to obtain additional incontinence supplies and failed to provide the correct size undergarment which resulted in stool in the bed (Resident #415) for 1 of 6 residents reviewed for dignity. Findings included: A review of the resident ' s 5-day Minimum Data Set dated 7/3/2021 documented the resident had an intact cognition. The resident required extensive assist of 1 staff for bathing and personal care. His diagnosis was osteoarthritis. The resident was incontinent of bowel and bladder. The resident ' s care plan dated 7/11/21 documented he required assistance for activities of daily living (ADL) care for incontinence and dressing. On 07/12/21 at 11:10 am an observation was done of Resident #415 ' s incontinence care. NA #1 provided incontinence care for stool. A family member was visiting and waited in the hall because the stool had gotten in the bed and complained that "it stank in there." The resident '	F 550	F550 Resident Rights 1. Resident #415 is currently wearing the correct size brief and receiving care with dignity. 2. The Director of Nursing provided 1:1 education for employee NA#1 regarding providing dignity with providing care. Social Services interviewed current alert and oriented residents regarding dignity with care. 3.. Director of Nursing/designee to educate nursing staff on appropriate sizing for resident briefs and providing for resident’s dignity while providing care on or before 8/20/2021. 4. Director of Nursing/designee will conduct random 5 audits of care to ensure compliance with providing dignity and appropriate resident brief sizing weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 5. The results of audits will be reviewed by the Quality Assurance Performance Improvement committee for continued monitoring. The Director of Nursing will be responsible for the implementation of this plan with a compliance date of 8/20/2021.	

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s undergarment did not cover the resident ' s buttocks and stool was mostly in the bed. When asked, the NA commented that the undergarment was a size large and too small for the resident. The NA completed incontinence care and placed the same size undergarment that was too small. The NA left the room to obtain extra-large undergarments from storage. The NA did not fully cover the residents front private parts with the sheet and opened the door and left it open while she obtained the larger size undergarment. The resident's left groin area, pubic hair, left leg and hip were still visible.

On 7/12/21 at 11:20 an interview was conducted with Resident #415. The resident commented that he would like to be covered with the sheet when the door was opened and have a better fitting under garment.

An interview was conducted on 7/12/2021 at 11:30 with NA # 1. The NA stated she was assigned to the resident and that the size large undergarment was too small for the resident. There were no extra-large undergarments in the room, NA would have had to obtain some from storage which could take some time. The NA stated (agreed) that the resident's undergarment was too small, and the stool would wind up in the bed again. The NA commented that the size large undergarment was the type that were being used by staff each day (were too small).

An interview was conducted on 7/12/2021 at 2:40 pm with NA # 1. The NA stated she would be more careful to cover a resident ' s private parts before opening the resident ' s room door to provide privacy.

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F 550	Continued From page 8 An interview was conducted on 7/15/2021 at 12:15 pm with the Director of Nursing (DON). The DON stated (agreed) that a resident should have had a correctly fitting undergarment and covered for privacy before the resident ' s room door was opened.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		8/20/21

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F 584	Continued From page 9 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to (1) maintain walls, ceilings, wall vents and lighting in good repair for 8 of 23 resident rooms (Rooms 103, 102, 104, 105, 107, 111, 113 and 131), (2) maintain a clean living environment for 2 of 23 resident rooms (Rooms 103 and 105) and the facility failed to (3) provide clean bed linens for 1 of 23 residents (Resident #156) observed for environment. Findings included: 1.Observation of hall 100 revealed the facility failed to maintain walls, ceilings, wall vents and lighting in good repair for the following resident rooms: a. Observation of rooms 103 and 104 occurred on 7-12-21 at 11:10am. The observation revealed both rooms had the paint and dry wall peeling off the wall by their windows exposing the sheet rock under neath. The areas measured approximately 4 feet long and 6 inches wide. A second observation was conducted on 7-15-21 at 2:30 with the Maintenance Director, Environmental Manager and Administrator. The	F 584	F584 Safe and Clean Environment 1. Identified walls, ceilings, wall vents and lighting in rooms 102, 103, 104, 105, 107 , 111, 113 and 131 will be repaired/replaced by the Maintenance Director or designated contractor on or before 8/20/21. Upon identification, the noted bed linens were changed by the nursing staff. 2. Administrator and Maintenance completed facility wide tour to identify any other areas of concern related to walls, ceilings, vents, and lighting in rooms. All identified areas corrected as indicated. The Director of Nursing completed an audit of current residents with G-tubes to ensure clean bed linens. 3. Administrator/designee to educate all staff on the use of the work order system to place maintenance needs/issues in for repair/replacement on or before 8/20/21. Director of Nursing/designee to educate staff on ensuring that bed sheets are changed routinely and upon soiling on or before 8/20/21. 4. Maintenance/designee will conduct 5 random audits of resident rooms to	

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F 584	Continued From page 10 second observation revealed paint and dry wall peeling off the wall by their windows exposing the sheet rock underneath. The Maintenance Director was interviewed on 7-15-21 at 2:33pm. The Maintenance Director acknowledged he was responsible for repairing the walls but stated the issue had not been brought to his attention. He explained staff could place a work order through the computer and he would receive the order by computer or on his phone. b. Room 102 was observed on 7-12-21 at 11:12am and revealed a crack in the wall above the sink approximately a foot long and the base board by the bathroom was peeling away from the wall. A second observation was conducted on 7-15-21 at 2:34 with the Maintenance Director, Environmental Manager and Administrator. The second observation revealed a crack in the wall above the sink approximately a foot long and the base board by the bathroom was peeling away from the wall. The Maintenance Director was interviewed on 7-15-21 at 2:35pm. The Maintenance Director acknowledged he was responsible for repairing the wall and repairing the base boards but stated the issue had not been brought to his attention. c. An observation of room 105 occurred on 7-12-21 at 11:14am. The observation revealed the resident bathroom light had a bulb burned out causing the lighting in the bathroom to be dim. A second observation was conducted on 7-15-21	F 584	ensure compliance with the walls, ceilings, wall vents and lighting are in good repair and condition weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 5. Housekeeping Director/designee will conduct 5 random audits of resident rooms to ensure cleanliness of resident rooms weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 6. Director of Nursing/designee will conduct 5 random audits of resident rooms to ensure cleanliness of bed linens weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 7. The results of audits will be reviewed by the Quality Assurance Performance Improvement committee for continued monitoring. The Administrator will be responsible for the implementation of this plan with a compliance date of 8/20/2021.	

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F 584	Continued From page 11	F 584		

at 2:36pm with the Maintenance Director, Environmental Manager and Administrator. The second observation revealed the resident bathroom light had a bulb burned out causing the lighting in the bathroom to be dim.

The Maintenance Director was interviewed on 7-15-21 at 2:37pm. The Maintenance Director acknowledged he was responsible for replacing light bulbs when they were burned out but stated the issue had not been brought to his attention.

d. Rooms 107 and 131 were observed on 7-12-21 at 11:18am. Both rooms were observed to have brown circular marks on their ceilings measuring approximately 2 feet in diameter.

During a second observation with the Maintenance Director, Environmental Manager and Administrator on 7-15-21 at 2:38pm, the observation revealed both rooms had brown circular marks on their ceilings measuring approximately 2 feet in diameter.

The Maintenance Director was interviewed on 7-15-21 at 2:40pm. The Maintenance Director stated he was responsible for replacing ceiling tiles if they had become damaged or stained but stated the issue had not been brought to his attention.

e. An observation of room 111 occurred on 7-12-21 at 11:20am. The observation revealed a hole in the resident's wall by the door measuring approximately 4 feet by 3 feet exposing the gap between the resident's wall and the wall in the hallway.

A second observation was conducted on 7-15-21

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F 584	Continued From page 12	F 584		

at 2:42pm with the Maintenance Director, Environmental Manager and Administrator. The second observation revealed a hole in the resident's wall by the door measuring approximately 4 feet by 3 feet exposing the gap between the resident's wall and the wall in the hallway.

During an interview with the Maintenance Director on 7-15-21 at 2:43pm, the Maintenance Director said he had not been informed of the hole but would have it repaired.

f. Observation of room 113 occurred on 7-12-21 at 11:22am. The observation revealed the resident's wall heating and air vent had the front of the vent broken causing sharp plastic ends to be exposed.

During a second observation with the Maintenance Director, Environmental Manager and Administrator on 7-15-21 at 2:45pm, the observation revealed the resident's wall heating and air vent had the front of the vent broken causing sharp plastic ends to be exposed.

The Maintenance Director was interviewed on 7-15-21 at 2:47pm. The Maintenance Director stated he was responsible for the wall heating and air vents but said he was not aware of the issue.

2. Observation of hall 100 revealed the facility failed to maintain a clean-living environment for the following resident rooms:

a. An observation of rooms 103 and 105 occurred on 7-12-21 at 11:10am. The observation revealed the resident's bathroom vents contained dust.

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A second observation was conducted on 7-15-21 at 2:30pm with the Maintenance Director, Environmental Manager and Administrator. The second observation revealed the resident's bathroom vents contained dust.

The Environmental Manager was interviewed on 7-15-21 at 2:33pm. The Environmental Manager stated the housekeeping staff were to check and clean the bathroom vents daily. She explained rounds were conducted every hour to monitor the housekeepers and there were 3-4 different rooms per housekeeper that were checked daily.

3. Resident #156 was admitted to the facility on 3-27-21 with multiple diagnoses that included chronic respiratory failure, tracheostomy and moderate protein calorie malnutrition.

Resident #156's care plan dated 4-18-21 had a goal the residents Activities of Daily Living (ADL's) care would be anticipated and met.

The quarterly Minimum Data Set (MDS) dated 6-17-21 revealed Resident #156 had memory problems and was severely cognitively impaired. The MDS also revealed Resident #156 required extensive assistance with one person for bed mobility and dressing, total assistance with one person for toileting and personal hygiene.

During an interview with a family member on 7-12-21 at 11:12am, the family member stated she visited most mornings and would find Resident #156 laying in the bed with dirty bed linens. She described the bed linens as having a light brown colored area and a foul smell.

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Observation of care with nursing assistant (NA) #2 occurred on 7-15-21 at 7:40am. When NA #2 removed Resident #156's sheet from the lower half of her body, the bottom sheet was observed to have a large light brown area that extended onto the left side of the residents brief and skin. The area appeared dry. The tube for Resident #156's feeding was observed to be intact with no active leakage.

NA #2 was interviewed on 7-15-21 at 7:50am. NA #2 stated the observed large light brown area was feeding that had leaked from the tubing and he confirmed the area was dry. The NA explained Resident #156's tubing often leaked due to the movement of the resident, but he stated since the area was dry, the tubing had leaked sometime during the night.

A telephone interview occurred with NA #5 on 7-15-21 at 8:23am. The NA confirmed he had worked the night shift with Resident #156. He explained Resident #156's tube feeding had leaked around 3:30am and that he had informed the nurse. The NA said once the nurse re-attached the tube, he had changed the residents bed linens and gown. He stated he saw the resident again about 5:30am to place Resident #156's legs back in the bed but he had not checked her linens, so he was not aware if her bed linens were soiled.

During a telephone interview with Nurse #7 on 7-15-21 at 9:34am, the nurse confirmed she had worked the night shift with Resident #156. She stated when she provided medication to Resident #156 around 12:30am, she had noticed the residents tube feeding had leaked. She explained she re-attached the tubing and requested the NA

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F 584	Continued From page 15 change the residents bed linens. Nurse #7 stated she had not been informed of the feeding tube leaking around 3:30am and she had not re-attached the tube at 3:30am. She stated she provided medication to Resident #156 between 5:00am and 6:00am and said the resident's tube feeding was not leaking at that time. She acknowledged she did not pull the sheet back to see if there was feeding on the resident's sheet or skin. Nurse #4 was interviewed on 7-15-21 at 10:30am. The nurse confirmed she was the nurse for Resident #156. She stated she was not informed by the NA's at the start of shift (7:00am) of Resident #156's feeding tube leaking. The nurse explained if the feeding was dry on the bed linens, then the feeding tube had to have leaked during the night. The Administrator was interviewed on 7-15-21 at 2:50pm. The Administrator discussed developing a walk around tool for the staff to identify any issues within the resident rooms and reporting the issues to maintenance or housekeeping. She also stated she had expected staff to maintain a clean and safe environment for the residents.	F 584		
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 that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655		8/20/21

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F 655	Continued From page 16 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: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission for Resident #1 that	F 655	F655 Baseline Care Plan 1.Resident #1 discharged from the facility prior to survey .	

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F 655	Continued From page 17 included therapy services, activities of daily living (ADL) assistance, diet, and tracheostomy care for 1 of 1 resident reviewed for baseline care plans. Findings included: Resident #1 was admitted to the facility on 4/23/21 for diagnoses that included acute and chronic embolism and thrombosis of unspecified deep veins of left distal lower extremity, peripheral vascular disease, congestive heart failure, malnutrition, hepatitis C, pulmonary hypertension, hypoxia, and non-Hodgkin lymphoma. Review of the Resident #1's care plan dated 4/28/21 revealed the 48-hour baseline care plan was not completed within 48 hours of admission. An interview on 7/16/21 at 12:13 PM with the Social Worker (SW) revealed she was aware that the baseline care plan was completed on 4/28/21 and stated the reason was because there was a meeting with the family on 4/26/21 and the resident's discharge plans were undecided at that time. The SW indicated the normal process for baseline care plans is to have them completed within 48 hours of a resident's admission. An interview on 7/15/21 at 3:50 PM with the Director of Nursing (DON) revealed she was aware that the baseline care plan was not completed within 48 hours of Resident #1's admission. The DON was not employed at the time of Resident #1's stay at the facility, but she provided documentation that baseline care plan was completed on 4/28/21 by the SW.	F 655	2. Director of Nursing/Designee completed an audit of all new admissions within the last 30 days to ensure an accurate baseline care plan was completed within 48 hours of admission. 3. Director of Nursing/designee to educate nursing and social services staff on ensuring that a baseline care plan with the required components is completed within 48 hours of admission on or before 8/20/21. 4. Director of Nursing/designee will conduct 5 random audits of admissions to ensure a base line care plan with the required components is completed within 48 hours of admission weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 5. The results of audits will be reviewed by the Quality Assurance Performance Improvement committee for continued monitoring. The Director of Nursing will be responsible for the implementation of this plan with a compliance date of 8/20/2021.	
F 677 SS=E	ADL Care Provided for Dependent Residents	F 677		8/20/21

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F 677	Continued From page 18 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 record review, observations, and staff, resident and family member interview, the facility failed to provide care for dependent residents for nail care, hair wash, and bathing/showers (Residents #48, 118, and 415), and for incontinence care (Residents #65 and 415) for 4 of 9 residents reviewed for activities of daily living (ADL). Findings included: 1. Resident #48 was admitted to the facility on 2/2/21 with the diagnoses of cellulitis of both lower limbs. The resident ' s quarterly Minimum Data Set (MDS) dated 4/26/21 documented the resident ' s assessment that he had clear speech and understood/understands with an intact cognition. The resident required 2 staff and was total dependence for ADLs. The resident ' s care plan dated 5/17/21 documented that he required assistance for ADL care in bathing, grooming, personal hygiene, and dressing. A review of the resident ' s June 2021 shower/bathing sheets documented he received a bath on 6/3/21, 6/14/21, 6/16/21, 6/17/21, 6/24/21, and 6/29/21. There was no documentation of hair washing or facial shave. The resident was not hospitalized and there was	F 677	F677 ADL Care 1. Residents #48, 118, 415 received showers, hair wash and nail care by nursing staff. Residents #65 and and #415 have been receiving incontinence care more frequently since the survey. 2. Director of Nursing, ADON and Unit Managers to complete 100% audit of current residents for ADL needs such as showers, hair and nail care and incontinence care. All areas identified to be addressed as indicated. 3. Director of Nursing/designee to educate nursing staff on the center shower, shaving, nail care and hair washing, and incontinence care procedure on or before 8/20/21. 4 Director of Nursing/designee will conduct 5 random audits of dependent residents to ensure personal grooming is appropriate and residents are shaven, clean and recent nail care has been provided weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 5. The results of audits will be reviewed by the Quality Assurance Performance Improvement committee for continued monitoring. The Director of Nursing will be responsible for the implementation of this	

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F 677	Continued From page 19 no documentation of refusal or care plan for refusal. The resident was scheduled for bathing twice a week (bathing by choice). An observation of the resident was done on 7/12/2021 at 11:45 am. The resident was lying in his bed with hair that appeared greasy, long-dirty nails, and long facial hair (visible hair that could be gathered) The resident was interviewed during the observation on 7/12/2021 at 11:45 am. The resident stated that he had not had his hair washed, face shaved, or his nails cut in a while. The resident also stated that he asked staff to shave him (a female NA but could not remember her name) and "the nursing assistant (NA) did not return to shave me." The resident replied that he received bed baths, but not always twice a week. An observation of the resident was done on 7/13/2021 at 3:30 pm. The resident ' s hygiene remained unchanged from the day before, long nails and facial hair, and dirty nails and hair. On 7/13/2021 at 11:40 am an interview was conducted with Nurse #3. She stated NAs were responsible to review the tablet for the NA care plan of each assigned resident before care was provided. Showers/baths were provided twice a week. All care provided by the NA was required to be documented for each individual resident in the tablet. On 7/14/2021 at 2:30 am the resident was observed to have had received a bed bath and shave, but his nails were still long and dirty. Hair had not been washed (still appeared greasy and strands separated).	F 677	plan with a compliance date of 8/20/2021.	

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On 7/16/2021 at 12:15 pm an interview was conducted with NA #2. The NA stated that shaving was not scheduled but some residents asked and were shaved. During COVID shaving and female resident hair washing became the responsibility of the NA to keep up with. During some shifts there was too much to complete, and shaving was not done and only hair combing was done for that week. Women (residents) could have a hair wash in the bed with a pan, but it took a long time to accomplish. Resident ' s nails were assessed for wash and cut, and some residents asked for nail cut. When the shift was short staffed, the NA could not return to cut nails after incontinence care because there was not enough time. NA stated that he noticed many residents had long nails and I tried to return when I could. NAs were required to document the care they provided in the tablet. Each NA had a tablet to use during the shift. Hair wash was not always documented but was supposed to be completed with the bath or shower. Care was not always accomplished because of the shift being short staffed from COVID. Showers and bathing were scheduled 2 times a week. Incontinence care was scheduled for every 2 hours and as needed. If the shift was short staffed, answering the call light was delayed.

7/16/2021 at 12:15 pm an interview was conducted with NA #3. The NA stated on some shifts there was too much to complete. NAs were required to document the care they provided in the tablet. Each NA had a tablet to use during the shift. Care was not always accomplished because of the shift being short staffed from COVID. Incontinence care was scheduled for every 2 hours and as needed. If the shift was

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short staffed, answering the call light was delayed.

On 7/16/2021 at 12:40 pm an interview was conducted with NA #4. The NA stated recently the shift had been very short staffed. Staffing was slowly getting better. The NA was required to document care in the tablet. Agency NAs had not always followed protocol.

On 7/16/2021 at 12:51 pm an interview was conducted with NA #5. The NA stated if the shift was not fully staffed, it could be difficult to complete all tasks. There were more tasks on certain days than there was time and care had to be prioritized. The resident ' s care plan was documented in the tablet. Charting of care was completed in the tablet and was easily accessible.

2. Resident #118 was admitted to the facility on 1/29/2021 with the diagnosis of ESRD.

The resident had a MDS significant change assessment dated 5/27/21 which revealed clear speech and understood/understands, and his cognition was moderately impaired. The resident was dependent for all ADLs.

The resident ' s care plan dated 6/3/21 documented that he required assistance for all ADL care related to recent illness.

On 7/12/201 at 11:30 am an observation was attempted but the resident was out of the facility.

On 07/13/21 at 1:19 pm an observation was done of the resident sitting in his wheelchair in his room. The resident ' s facial hair was noticeably long, and fingernails were long and dirty.

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Concurrent interview with the resident was conducted. The resident stated that the "staff were sometimes busy" and "they got to me when they could" (provided care). "The staff were sometimes in a rush or had a bad day" (resident ' s observation).

On 7/13/2021 at 11:40 am an interview was conducted with Nurse #3. She stated NAs were responsible to review the tablet for the NA care plan of each assigned resident before care was provided. Showers/baths were provided twice a week. All care provided by the NA was required to be documented for each individual resident in the tablet.

On 7/14/2021 at 2:40 pm the resident was observed to have received a facial shave and nail trim.

On 7/16/2021 at 12:15 pm an interview was conducted with NA #2. The NA stated that shaving was not scheduled but some residents asked and were shaved. During COVID shaving and female resident hair washing became the responsibility of the NA to keep up with. During some shifts there was too much to complete, and shaving was not done and only hair combing was done for that week. Women (residents) could have a hair wash in the bed with a pan, but it took a long time to accomplish. Resident ' s nails were assessed for wash and cut, and some residents asked for nail cut. When the shift was short staffed, the NA could not return to cut nails after incontinence care because there was not enough time. NA stated that he noticed many residents had long nails and I tried to return when I could. NAs were required to document the care they provided in the tablet. Each NA had a tablet

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to use during the shift. Hair wash was not always documented but was supposed to be completed with the bath or shower. Care was not always accomplished because of the shift being short staffed from COVID. Showers and bathing were scheduled 2 times a week. Incontinence care was scheduled for every 2 hours and as needed. If the shift was short staffed, answering the call light was delayed.

7/16/2021 at 12:15 pm an interview was conducted with NA #3. The NA stated on some shifts there was too much to complete. NAs were required to document the care they provided in the tablet. Each NA had a tablet to use during the shift. Care was not always accomplished because of the shift being short staffed from COVID. Incontinence care was scheduled for every 2 hours and as needed. If the shift was short staffed, answering the call light was delayed.

On 7/16/2021 at 12:40 pm an interview was conducted with NA #4. The NA stated recently the shift had been very short staffed. Staffing was slowly getting better. The NA was required to document care in the tablet. Agency NAs had not always followed protocol.

On 7/16/2021 at 12:51 pm an interview was conducted with NA #5. The NA stated if the shift was not fully staffed, it could be difficult to complete all tasks. There were more tasks on certain days than there was time and care had to be prioritized. The resident ' s care plan was documented in the tablet. Charting of care was completed in the tablet and was easily accessible.

3. Resident #415 was admitted to the facility on

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6/28/2021 with the diagnoses of osteoarthritis.

A review of the resident ' s documented bathing for 6/28/2021 to 7/13/2021 revealed bathing was provided on 6/30/2021, 7/2/2021, 7/6/2021, and 7/10/2021. The resident had 4 baths since admission documented. No hospitalizations and no refusal were documented in the nurses notes or care plan since admission.

A review of the resident ' s 5-day MDS dated 7/3/2021 documented the resident had an intact cognition. The resident required extensive assistance of 1 staff for bathing and personal care. The resident was incontinent of bowel and bladder.

The resident ' s care plan dated 7/11/21 documented he required assistance for ADL care for bathing, grooming, personal hygiene, and dressing.

On 07/12/21 at 11:10 am an observation was done of the resident who received incontinence care by NA #1. The resident had long facial hair and long, dirty fingernails.

An interview was conducted with the resident after incontinence care on 7/12/21 at 11:25 am and stated he asked NA #1 for a shave and would like to have his nails cut. No one had shaved him, washed his hair, or cut his nails since admission (13 days) and he had not always received a bath as scheduled. The resident also stated an NA had come to answer the call light, shut the light off, and stated she would return. The NA had not returned, and my family member went to the nurses ' station to get help (for incontinence care).

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A review of the resident ' s record from 6/28/2021 to 7/13/2021 documented no hospitalizations and no refusals in the nurses ' notes or care plan since admission.

On 07/12/21 11:15 am an observation was done, and the resident's family member complained that the NA was summoned by call light and said she would return. Thirty minutes later the NA had not returned (NA #1 was not observed to be available on the hall), and the family member went up to the nurses' station to seek help. Family member stated the resident had an odorous bowel movement and was uncomfortable. An interview was permitted of the family member by the resident. The family member stated that the resident was not changed (incontinence care) in a timely manner. The NA did not return as promised, and he could not tolerate the stool odor and had to step out of the resident's room (interfered with the visit).

On 7/12/21 at 11:30 am an interview was conducted of NA #1. She stated that she was assisting other residents and was not aware Resident #415 had a bowel movement until the nurse informed her (was providing incontinence care to another resident). NA #1 commented she was not the staff who turned off the call light and would return. NA #1 stated that she was agency staffing and usually scheduled on another unit and was not familiar with this resident (#415). She noted he had facial hair and was on quarantine, but at present had no plan for a bath and shave (providing incontinence care to her assigned residents before lunch).

On 7/13/2021 at 11:40 am an interview was

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conducted with Nurse #3. She stated NAs were responsible to review the tablet for the NA care plan of each assigned resident before care was provided. Showers/baths were provided twice a week. All care provided by the NA was required to be documented for each individual resident in the tablet.

On 7/14/2021 at 2:30 am the resident was observed to have had received a bed bath and shave, but his nails were remained long and dirty. Hair had not been washed (appeared greasy and strands separated).

On 7/16/2021 at 12:15 pm an interview was conducted with NA #2. The NA stated that shaving was not scheduled but some residents asked and were shaved. During COVID shaving and female resident hair washing became the responsibility of the NA to keep up with. During some shifts there was too much to complete, and shaving was not done and only hair combing was done for that week. Women (residents) could have a hair wash in the bed with a pan, but it took a long time to accomplish. Resident ' s nails were assessed for wash and cut, and some residents asked for nail cut. When the shift was short staffed, the NA could not return to cut nails after incontinence care because there was not enough time. NA stated that he noticed many residents had long nails and I tried to return when I could. NAs were required to document the care they provided in the tablet. Each NA had a tablet to use during the shift. Hair wash was not always documented but was supposed to be completed with the bath or shower. Care was not always accomplished because of the shift being short staffed from COVID. Showers and bathing were scheduled 2 times a week. Incontinence care

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was scheduled for every 2 hours and as needed. If the shift was short staffed, answering the call light was delayed.

7/16/2021 at 12:15 pm an interview was conducted with NA #3. The NA stated on some shifts there was too much to complete. NAs were required to document the care they provided in the tablet. Each NA had a tablet to use during the shift. Care was not always accomplished because of the shift being short staffed from COVID. Incontinence care was scheduled for every 2 hours and as needed. If the shift was short staffed, answering the call light was delayed.

On 7/16/2021 at 12:40 pm an interview was conducted with NA #4. The NA stated recently the shift had been very short staffed. Staffing was slowly getting better. The NA was required to document care in the tablet. Agency NAs had not always followed protocol.

On 7/16/2021 at 12:51 pm an interview was conducted with NA #5. The NA stated if the shift was not fully staffed, it could be difficult to complete all tasks. There were more tasks on certain days than there was time and care had to be prioritized. The resident ' s care plan was documented in the tablet. Charting of care was completed in the tablet and was easily accessible.

4. Resident #65 was admitted to the facility on 12/17/2019 with the diagnoses of lower back pain and osteoarthritis.

The resident ' s quarterly MDS dated 5/5/21 documented an intact cognition. The resident required total assist of 2 staff for all ADLs. The

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resident was incontinent of bowel and bladder. The active diagnoses were debility and anemia.

The resident ' s care plan updated on 5/19/21 documented he required assistance for all ADLs and mobility.

The resident was interviewed on 7/13/2021 at 4:30 pm. The resident remembered the incident a while ago (12/14/20) when he had not received incontinence care from the NA for hours and he reported his concern to the nurse. A grievance was filed and followed up.

A review of the facility reported incident dated 12/14/20 documented that the resident filed a grievance because he had not received incontinence care for a couple of hours (NA did not return) and the allegation was substantiated. The NA was terminated, and the grievance was resolved to the resident ' s satisfaction.

On 7/16/2021 at 12:15 pm an interview was conducted with NA #2. The NA stated that shaving was not scheduled but some residents asked and were shaved. NAs were required to document the care they provided in the tablet. Each NA had a tablet to use during the shift. Hair wash was not always documented but was supposed to be completed with the bath or shower. Care was not always accomplished because of the shift being short staffed from COVID. Showers and bathing were scheduled 2 times a week. Incontinence care was scheduled for every 2 hours and as needed. If the shift was short staffed, answering the call light was delayed.

7/16/2021 at 12:15 pm an interview was

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F 677	Continued From page 29 conducted with NA #3. The NA stated on some shifts there was too much to complete. NAs were required to document the care they provided in the tablet. Each NA had a tablet to use during the shift. Care was not always accomplished because of the shift being short staffed from COVID. Incontinence care was scheduled for every 2 hours and as needed. If the shift was short staffed, answering the call light was delayed. On 7/16/2021 at 12:40 pm an interview was conducted with NA #4. The NA stated recently the shift had been very short staffed. Staffing was slowly getting better. The NA was required to document care in the tablet. Agency NAs had not always followed protocol. On 7/16/2021 at 12:51 pm an interview was conducted with NA #5. The NA stated if the shift was not fully staffed, it could be difficult to complete all tasks. There were more tasks on certain days than there was time and care had to be prioritized. The resident ' s care plan was documented in the tablet. Charting of care was completed in the tablet and was easily accessible. An interview was conducted on 7/15/2021 at 12:15 pm with the Director of Nursing (DON). The DON stated (agreed) that ADL dependent residents were required to have assistance provided as expected and as requested.	F 677		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 693		8/20/21

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F 693	Continued From page 30 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and physician interview the facility failed to (1)store a tube feeding syringe with the plunger separated from the syringe, which created the potential for bacteria growth, for 1 of 1 residents (Resident #36) and (2) administer enteral feeding as ordered. This occurred for 1 of 3 residents (Resident #156) observed for tube feeding. Findings included: 1.Resident #36 admitted to the facility on 1/19/2021 with diagnoses of liver disease, kidney disease and stroke. A Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date	F 693	F693 Tube Feed Management 1. Resident #36□s syringe was removed and the tube feed run rate was decreased to the ordered rate. Medical Director was notified of concerns with no additional orders given. Both the run rate and syringe were corrected on 715/21 by Director of Nursing. 2. Director of Nursing/designee to audit current residents who receive tube feed to verify order accuracy with run rate and ensure that G-tube syringes are not stored with plungers engaged are not witnessed on or before 8/6/2021. 3. Director of Nursing/designee to educate nursing staff the proper storage of syringes for tube feeding residents and the verification of the tube feeding run rate	

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F 693	Continued From page 31 (ARD) of 4/23/2021 indicated Resident #36 required tube feedings for 25 to 50 percent of her calorie intake and required a mechanically altered, therapeutic diet. Review of the facility's Enteral Feeding Administration by Pump policy, with a revision dated of 6/1/2021, revealed the tube feeding syringe should be rinsed after use and stored with the syringe and barrel separated prior to storage in a labeled and dated plastic bag. Review of Resident #36's Physician's Orders revealed she had an order dated 7/11/2021 for 400-milliliter water flushes twice daily. A review of the Medication Administration Record for 7/2021 indicated Resident #36 received a 400- milliliter flush through her gastrostomy tube at 8:00 am on 7/15/2021. During an observation on 7/12/2021 at 3:18 pm a 60-milliliter syringe was observed with the plunger inserted in the syringe in a clear plastic bag hanging on the tube feeding pump stand at Resident #36's bedside. There was clear liquid in the tip of the syringe. An observation on 7/14/2021 at 1:35 pm revealed the tube feeding syringe (a 60-milliliter syringe) was in a clear plastic bag hanging from the tube feeding pump stand at Resident #36's bedside. The syringe was stored with the plunger inserted and there was clear liquid in the tip of the syringe. A tube feeding syringe with the plunger inserted in the syringe was observed on 7/15/2021 at 12:10 pm stored a clear plastic bag hanging from the tube feeding pump stand at Resident #36's	F 693	matches the resident□s tube feeding order on or before 8/20/21. 4. Director of Nursing/designee will conduct 5 random audits of residents receiving tube feed to ensure appropriate syringe storage and the tube feed run rate matches the orders weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 5. Director of Nursing/designee to educate new hire nursing staff the proper storage of syringes for tube feeding residents and the verification of the tube feeding run rate matches the residents tube feeding order beginning 8/9/21. 6. The results of audits will be reviewed by the Quality Assurance Performance Improvement committee for continued monitoring. The Director of Nursing will be responsible for the implementation of this plan with a compliance date of 8/20/2021.	

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bedside. There was clear liquid observed in the tip of the syringe.

Nurse #1 was interviewed on 7/15/2021 at 12:12 pm and she stated the 11:00 pm to 7:00 am shift places a new tube feeding syringe in a storage bag on the tube feeding pump stand each morning and the plunger is sometimes in the syringe. She stated if the syringe has been used it should be stored separately to prevent bacteria growth. Nurse #1 also stated Resident #36 had received a 400 milliliter flush to her gastrostomy tube at 8:00 am.

During an interview with the Director of Nursing on 7/15/2021 at 2:48 pm she stated the tube feeding plunger should be stored separately from the syringe since it is an infection control issue. The Director of Nursing stated the facility would certainly work on this issue.

An interview was conducted with the Administrator on 7/15/2021 on 3:04 pm and she stated the nursing staff should follow the policies of the facility and infection control procedures when caring for the residents.

2. Resident #156 was admitted to the facility on 3-27-21 with multiple diagnosis that included chronic respiratory failure and moderate protein calorie malnutrition.

Resident #156's care plan dated 4-18-21 had a goal that she would not develop any tube related complications. The interventions for the goal were in part; aspiration precautions, check for patency and placement of tube daily, feedings at room

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temperature, head of the bed elevated 30-45 degrees and monitor for nausea, vomiting, diarrhea, cramping and weakness.

The quarterly Minimum Data Set (MDS) dated 6-17-21 revealed Resident #156 was severely cognitively impaired. The MDS also revealed Resident #156 was coded for a feeding tube.

Review of the physician order dated 3-27-21 revealed an order that read: "Osmolite 1.5Cal, administer continuous by pump at 55ml (Milliliters) per hour."

The initial observation of Resident #156 occurred on 7-12-21 at 11:12am. The observation revealed the resident's feeding pump was set for 60ml per hour.

An observation of Resident #156 occurred on 7-14-21 at 10:00am. The observation revealed the resident's feeding pump was set for 60ml per hour.

Resident #156 was observed on 7-15-21 at 7:40am. The observation revealed the resident's feeding pump was set for 60ml per hour.

During an interview with the Unit Coordinator on 7-15-21 at 12:50pm, The Unit Coordinator verified Resident #156's tube feeding should be set at a rate of 55ml per hour. She acknowledged the feeding pump was set for 60ml per hour and she stated the nursing staff should be checking the rate of the feeding pump every shift with the physician orders. The Unit Coordinator said she had not checked the rate of the feeding pump today (7-15-21) and she did not know how the pump rate was changed to 60ml per hour.

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F 693	Continued From page 34 Nurse #5 was interviewed on 7-15-21 at 1:00pm. The nurse explained she had worked with Resident #156 during the week of 7-12-21 and she would check the feeding pump to make sure it was running correctly, and she would look at the rate but stated she had not compared the rate on the feeding pump to the physician orders. Nurse #5 stated she had assumed the rate on the feeding pump was correct. The facility's Medical Director was interviewed on 7-15-21 at 3:13pm. The Medical Director confirmed Resident #156's feeding pump should be set at 55ml per hour. He stated he did not feel there was a clinical significance if the feeding pump was set at 60ml per hour but said he did expect staff to follow the orders as they are written. During an interview with the Administrator on 7-15-21 at 4:15pm, the Administrator stated she had expected the staff to follow physician orders.	F 693		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		8/20/21

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F 725	Continued From page 35 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, resident, and resident ' s family member interview, the facility failed to have sufficient nurse staffing to ensure activities of daily living dependent residents received showers/bathing, fingernail care, shaving, hair wash, and incontinence care for 4 of 9 sampled dependent residents (Residents #48, 65, 118, and 415). Findings included: Cross referenced to tag: Based on record review, observations, and staff, resident and family member interview, the facility failed to provide care for dependent residents for nail care, hair wash, and bathing/showers (Residents #48, 118, and 415), and for incontinence care (Residents #65 and 415) for 4 of 9 residents reviewed for activities of daily living (ADL). A review of the May and June 2021 staffing documentation revealed on day shift that the five	F 725	F725 Sufficient Staff 1. Residents #48, 118, 415 received showers, hair wash and nail care by nursing staff. Residents #65 and and #415 have been receiving incontinence care more frequently since the survey. 2. Director of Nursing, ADON and Unit Managers to complete 100% audit of current residents for ADL needs such as showers, hair and nail care and incontinence care. All areas identified to be addressed as indicated. 3. Administrator to provide education to the Nursing Leadership team and the center scheduler regarding maintaining staffing at or above the minimum hppd and alerting the Administrator in advance of and deviations from this so that action can be taken to address and meet staffing needs to ensure residents□ ADLs are met on or before 8/9/2021. 4. Administrator/designee to audit the	

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F 725	Continued From page 36 resident units had varying assigned amounts of nursing assistants, between 0 and 5 scheduled. On 5/1/21 there was an average of 2 nursing assistants assigned for each unit. On 5/5/21 and 5/6/21 there was one unit that had 4 nursing assistants scheduled and on 5/7/21 2 nursing assistants were scheduled for that same unit. On 5/8/2021 the same unit had 5 nursing assistants assigned. On 7/15/2021 at 12:15 pm interview was conducted with the Director of Nursing (DON) regarding staffing and concerns voiced by residents and staff regarding staffing which had impacted dependent resident ' s showers/bathing, fingernail care, facial shaving, hair wash, and incontinence care. The DON stated (was made aware) that nursing assistant staffing was being actively addressed by the Administrator.	F 725	nursing schedule to verify there are appropriate staff per unit to complete ADL care and that Center is running at or above the minimum hppd 5 times weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 5. Director of Nursing/designee will conduct 5 random audits of dependent residents to ensure personal grooming is appropriate and residents are shaven, clean and recent nail care has been provided weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 6. Center established a nursing on call system on 8/1/21 to assist with staffing needs to ensure satisfactory ADL care. 6. The results of audits will be reviewed by the Quality Assurance Performance Improvement committee for continued monitoring. The Director of Nursing will be responsible for the implementation of this plan with a compliance date of 8/20/2021.	
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	F 761		8/20/21

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F 761	Continued From page 37 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store medications in accordance with the manufacturer's storage instructions in 1 of 5 medication carts observed (2 south Hall Cart) and failed to date insulin when opened for use in 1 of 5 medication carts (1 North Hall Cart). The findings included: 1. In the presence of Nurse #6, an observation was made on 7/14/21 at 12:53 PM of the 2 South Hall Medication Cart that revealed a plastic bag containing forty-six tubes of ABH compound gel (Ativan, Benadryl, Haldol) for Resident #30 stored on the medication cart. The plastic bag containing all forty-six of the ABH gel tubes were labeled with large lettering which read, "Refrigerate." An interview conducted on 7/14/21 at 12:55 PM with Nurse #6 revealed she did not know how long the medication had been in the cart, she	F 761	F761 Medication Storage 1. Upon identification of medication not being stored based on manufacturers guidelines, the items were removed and appropriately disposed of. There was no ill effect of the resident and the MD was notified of the concern. 2. Director of Nursing, ADON and Unit Managers completed an audit of all med carts and medication rooms for appropriate storage and labeling of medications on 8/9/2021. 3 Director of Nursing/designee to educate nurses staff the proper storage of medications with regard to refrigeration and the assurance that medications were also dated when opened including insulin vials identified during the survey on or before 8/20/21. 4. Director of Nursing/designee will conduct 5 random audits of medication carts and medication rooms to ensure	

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	345172	A. BUILDING _____ B. WING _____	C 07/19/2021

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F 761	Continued From page 38 reported, "it was in the cart when I came in this morning." Nurse #6 indicated she arrived to work at 7:00 AM. A review of Resident #30 ' s physician orders revealed the resident had a current order for ABH- Ativan-Benadryl-Haldol *Controlled Drug*, Apply to skin topically every 6 hours(hrs.) as needed (prn) for agitation apply 1 milliliter to non-hairy area of skin every 6 hrs. prn agitation secondary to psychosis x 14 days. An interview was conducted on 7/14/21 at 4:30 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility's storage of medications were discussed. The DON reported the ABH compound gel arrived on 7/6/2021 and she had contacted the facility ' s pharmacy, after Nurse #6 had informed her of the findings, and was informed they would have to contact the pharmacy that dispensed the ABH to see what the stability of the medication was at room temperature due to it being a compound medication. A follow-up interview was conducted with the DON on 7/15/21 at 1:00 PM and she stated she was informed by the Pharmacy that dispensed the ABH compound gel to the facility the medication should have been refrigerated. She reported the medication was sent back to the dispensing pharmacy and would be replaced. 2. In the presence of Nurse #3, an observation made on 7/15/21 at 1:15 PM of the 1 North Medication Cart revealed two insulin vials (Lantus, Admelog) were opened without being labeled with the date they were opened.	F 761	appropriate storage and medication dating storage and the tube feed run rate matches the orders weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 5. The results of audits will be reviewed by the Quality Assurance Performance Improvement committee for continued monitoring. The Director of Nursing will be responsible for the implementation of this plan with a compliance date of 8/20/2021.	

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F 761	Continued From page 39 An interview was conducted on 7/15/21 at 1:20 PM with Nurse #3. When asked if she would expect the insulins to be labeled with a date once opened, she stated, "Yes they are supposed to be dated when opened." An interview was conducted on 7/20/21 at 2:02 PM with the facility's Administrator. During the interview, concerns regarding the facility's storage of medications were discussed. The Administrator reported she expected the medications to be labeled and dated when opened.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §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 and staff and resident interview, the facility failed to provide the resident her eggs in a form she preferred (fried). The preference was printed on her dietary meal ticket (fried eggs) but not provided on her meal tray (scrambled eggs) for 1 of 6 halls observed during dining (Resident #109). Findings included.	F 806	F806 Preferences 1. Resident #109 is currently receiving fried eggs per her preference. 2. Dining Services to update current residents preferences and ensure tray cards are accurate to reflect these preferences. 3. Dining Director/designee to educate dining staff on ensuring that the food	8/20/21

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F 806	Continued From page 40 On 7/13/2021 at 10:00 am an observation was done of Resident #109's breakfast tray and meal ticket. There were scrambled eggs on the plate and the meal ticket documented fried eggs were provided. On 7/13/2021 at 10:10 am an interview was conducted with the resident. The resident stated that "this keeps happening" (requested fried eggs and received scrambled eggs). The resident stated that she completed a meal form for her preference. The "meal ticket says fried eggs, but they (dietary staff) keep sending me scrambled." On 7/14/21 at 1:40 pm an interview was conducted with the Dietary Manager (DM). The DM stated he was not aware that the resident had received scrambled eggs when fried was requested and on her meal ticket. DM stated he would correct the preference.	F 806	references and requests are honored when serving meals on or before 8/20/21. 4. The Dining Director/designee will conduct 5 random audits of meal trays to verify preferences and meal accuracy weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 5. The results of audits will be reviewed by the Quality Assurance Performance Improvement committee for continued monitoring. The Administrator will be responsible for the implementation of this plan with a compliance date of 8/20/2021.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		8/20/21

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F 880	Continued From page 41	F 880		

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

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

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F 880	Continued From page 42 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff, resident, and resident ' s family member interview, the facility allowed a visitor to enter/visit a resident on new admission quarantine (Resident #415) for 1 of 2 visitors observed. Findings included: Resident #415 was admitted to the facility on 6/28/21. The resident had a physician order dated 6/28/21, admit to the facility. On 7/12/21 at 10:50 am an observation was done of Resident #415 ' s room. A visitor was observed to exit the resident ' s room only wearing a mask walk to the nurses ' station and re-enter the resident ' s room. The door was open, and the visitor remained in the resident ' s room wearing a face mask. On 07/12/21 at 11:10 am an observation was done of the resident in his room. There was signage posted on his door for droplet and contact precautions (mask, gown, and gloves) and PPE supplies outside the room door. The resident was a new admit on quarantine. Nursing	F 880	F880 Infection Control 1. All visitors for Resident #415 are appropriately wearing PPE, no negative outcome resulted from this deficient practice. 2. Infection Control Nurse/designee to educate all staff on appropriate PPE for staff, visitors and residents on or before 8/20/21. 3. Director of Nursing/designee will educate all staff using the “Keep Covid-19 Out” education series on or before 8/20/21. 3. The CNE in conjunction with the QAPI committee will conduct a RCA analysis of the infection control practices with regards to visitor and staff PPE usage on or before 8/20/21. 4. Infection Control Nurse/designee will conduct 5 random audits of staff and visitor PPE usage to ensure compliance weekly for 4 weeks, twice month for 2 months and monthly for two months for compliance. 5. The results of audits will be reviewed by the Quality Assurance Performance Improvement committee for continued	

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F 880	Continued From page 43 Assistant (NA) #1 was observed to don PPE (mask, gown, and gloves) before entry. The same visitor entered the resident ' s room only wearing a mask (NA #1 did not inform the visitor of PPE requirement). On 7/12/2021 11:20 am an interview was conducted with the resident. He stated that he was newly admitted, and all staff were wearing masks, gowns, and gloves in his room and was not aware that visitors needed to do the same (new admission, 14-day quarantine). The resident stated he had not received the COVID vaccine. On 7/12/2021 11:30 am an interview was conducted with NA #1. She stated that she was not aware visitors were required to wear PPE when visiting a resident on quarantine (posted signage). She also stated that the facility did not inform her of this requirement. On 7/12/2021 at 11:40 am an interview was conducted with the resident ' s visitor. He stated that no one had informed him he should wear a gown and gloves as well as his mask when he entered the resident ' s room (precautions signage on the door). An interview was conducted on 7/15/2021 at 12:15 pm with the Director of Nursing (DON). The DON stated (agreed) that all visitors were required to wear PPE before entry into a resident ' s quarantine room (first 14 days of admission or readmission) and that there would be follow up. On 7/16/2021 at 12:15 pm an interview was conducted with NA #2. The NA stated that visitors were scheduled by the front office and if	F 880	monitoring. The Director of Nursing will be responsible for the implementation of this plan with a compliance date of 8/20/2021.	

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F 880	Continued From page 44 the resident was on quarantine, the front office had informed the visitors what PPE was required before entering the resident ' s room while on quarantine. On 7/16/2021 at 12:40 pm an interview was conducted with NA #3. The NA stated visitors were screened and informed which residents required PPE before entering the resident ' s room. On 7/16/2021 at 12:51 pm an interview was conducted with NA #4. The NA stated visitors were screened upon entry and were not entering quarantine rooms.	F 880		