STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 07/30/2021

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LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(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 The survey team entered the facility on 07/26/21 to conduct a Recertification and Complaint Investigation survey. The survey team was onsite 07/26-07/29/21. Additional information was obtained offsite on 07/30/21. Therefore, the exit date was 07/30/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# KN0011.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 07/26/21-07/29/21 to conduct an unannounced Recertification and Complaint Investigation. Additional information was obtained offsite on 07/30/21. Therefore, the exit date was 07/30/21. 2 of the 30 complaint allegations were substantiated. Event ID# KN0011.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow the prescribed physician ' s order and administered an as needed opioid pain medication before it was due 4 out of 20 times for 1 of 1 residents (Resident #59) observed. Findings included: Resident #59 was admitted to the facility on 04/28/21 and discharged to the hospital on	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged	8/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/20/2021

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F 658	Continued From page 1 05/06/21. Diagnoses included, in part, displaced fracture of the lateral end of the left clavicle, multiple fracture of left ribs, superior rim of left pubis, fifth lumbar, sacrum, contusion of lung (unilateral), idiopathic (unknown reason) aseptic necrosis of right and left femur, and osteoarthritis. The Minimum Data Set 5-day assessment dated 05/05/21 revealed Resident #59 was mildly cognitively impaired and received a scheduled and as needed pain medication regimen with complaints of frequent pain on a scale of 5 out of 10. The narcotic count sheet (NCS) dated 04/27/21 for Oxycodone (opioid pain medication) 5 milligrams (mg) tablet indicated to give 0.5 (1/2) tab or 1 tablet every 6 hours as needed for pain. A physician ' s order was written on 04/28/21 for Oxycodone 5 mg give 0.5 (1/2) tablet by mouth every 6 hours as needed for mild to moderate pain. A physician ' s order was written on 04/28/21 for Oxycodone 5 mg give 1 tablet by mouth every 6 hours as needed for severe pain. The NCS on 05/01/21 revealed Nurse #9 removed two ½ tablets of Oxycodone 5 mg at 4:45 PM. On 05/01/21 Nurse #12 removed one ½ tablet at 9:25 PM. The NSC revealed Nurse #12 removed the medication 4 hours and 45 minutes after 4:45 PM. Based on the physician ' s order, the medication was not due until on or after 10:45 PM which would have been 6 hours. On 05/02/21 Nurse #12 removed two ½ tablets of Oxycodone 5 mg at 1:25 AM. The NCS revealed	F 658	deficiencies cited have been or will be corrected by the date or dates indicated. F 658 (Services Provided Meet Professional Standards) Corrective Action for Affected Residents Resident # 59. No longer resides at the facility, was transferred on 5/6/2021. Nurse #9 and Nurse #12 failed to follow the prescribed physician's order and administered an as needed opioid pain medication before it was due. The Director of Nursing and the RN manager educated Nurse #9 and Nurse #12 on 8/20/2021 to administer medication as prescribed by the physician. Corrective Action for Potentially Affected Residents All residents that have PRN narcotic pain medications have the potential to be affected by this alleged deficient practice. On 8/19/2021, the DON, RN Manager and LPN Support Nurse audited all residents that have PRN narcotic pain medications. PRN narcotic pain medications sheets were audited for correct administration times. In addition, Licensed Nurses and Med Aides identified from the audit were in serviced to follow physician orders as written and to notify the physician if existing order does not meet the need of the resident. This was completed on 8/20/2021. Systemic Changes On 8/19/2021 the DON and RN Nurse Manager began in-servicing all Licensed Nurses, LPN Support Nurse. This in-service included the following topics: - Policy and Procedure for	

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F 658	Continued From page 2 Nurse #12 last removed the medication at 9:25 PM on the evening shift on 05/01/21. The NCS revealed the medication was removed 4 hours after the previous dose. Based on the physician ' s order, the medication was not due until on or after 3:25 AM which would have been 6 hours. On 05/02/21 at 5:10 PM Nurse #9 removed two ½ tablets of Oxycodone 5 mg at 5:10 PM. On 05/02/21 Nurse #12 removed one ½ tablet of Oxycodone 5 mg at 8:00 PM. The NCS revealed the medication was removed 3 hours after the previous dose. The medication was administered (one ½ tablet) for mild to moderate pain and, based on the physician ' s order, was not due to be administered until on or after 11:00 PM which would have been 6 hours. A physician ' s order written on 05/02/21 for Oxycodone 5 mg give 1 tablet (two ½ tablets) every 4 hours as needed for severe pain. On the same evening of 05/02/21, the NCS revealed Nurse #12 removed two ½ tablets for severe pain of Oxycodone 5 mg at 10:25 PM. The NCS revealed the medication was removed 2.25 hours after the previous dose. Based on the physician ' s order, the medication was not due until on or after 12:00 AM which would have been 4 hours. An interview was conducted with Nurse #12 on 07/30/21 via phone at 5:34 PM. Nurse #12 stated Resident #59 was having a lot of pain and she believed the physician had given orders that the nurses could give her extra medicine. Nurse #12 did not recall obtaining any one-time orders for breakthrough pain and added nurses can only give additional medication if they have a physician	F 658	administering medications. - Licensed Nurses and Medication aides are to follow prescribed physician order which include PRN pain medication. - Licensed Nurses were also in-serviced to assess and follow the physicians order as written, then to notify the physician to get a one-time order or change existing order to meet the need of the resident if their pain was not controlled. The Director of Nursing and RN Nurse Manager will ensure that any Active Full time, Part time, agency and PRN Nurses who have not received this training by 8/23/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all newly hired nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The DON and RN Nurse Manager and Support Nurse will monitor this issue using the Survey Quality Assurance Tool for Monitoring pain management and administration time. The monitoring will include reviewing the medication administration for 3 residents with prn pain medication for day shift, and 3 residents with PRN narcotic pain medication for night shift. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and	

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F 658	Continued From page 3 order. Nurse #12 stated there would have to have been a reason that she would have given the oxycodone too soon on those 4 occasions, but she does not know. Nurse #12 stated if she had taken it out of the narcotic box to be given to the resident then she gave it to the resident. Nurse #12 stated she did not recall notifying the physician she administered the medication too soon. An interview was conducted with the Director of Nursing (DON) via phone on 7/30/21. The DON stated she expected her nurses to follow the physician ' s order as written and if there were any concerns or questions they should call the physician to get a one-time order or change the existing order to meet the needs of the resident if the pain was not controlled.	F 658	corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker, Therapy Director, Housekeeping Supervisor. Date of compliance: 8/23/2021.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, Nurse Practitioner interview, resident interview and record review, the facility failed to utilize a mechanical lift to transfer a non-ambulatory resident from her wheelchair to the bed which resulted in the resident falling three times and experiencing pain and soreness from the falls. In	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of	8/23/21

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F 689	Continued From page 4 addition, the facility failed to have the resident assessed by a licensed medical professional before staff moved the resident after she fell, and failed to assess and monitor the resident for 72 hours after the falls as directed on the resident's care plan for 1 of 4 residents reviewed for accidents, (Resident #46). Findings included: Resident #46 was admitted to the facility on 08/31/19 with diagnoses that included Type 2 Diabetes Mellitus with diabetic neuropathy, primary osteoarthritis, chronic pain syndrome, deconditioning, weakness and seizures. Review of a quarterly Minimum Data Set (MDS) assessment completed on 06/08/21 revealed Resident #46 had intact cognition. She required extensive assistance for bed mobility, transfers, locomotion and dressing. She was dependent for toilet use. She was not steady when transferring and was only able to stabilize with staff assistance. She used a wheelchair for locomotion. She had received scheduled pain medications during the assessment look back period. She was 63 inches tall and weighed 238 pounds. Review of the care plan for Resident #46 dated 06/14/21 revealed the resident was at increased risk of falling related to de-conditioning, psychoactive and diuretic drug use, and weakness. The goal was for the resident to have minimized falls x 90 days. Included in the interventions was for nurses to monitor and document for 72 hours post fall for the following signs and symptoms: pain, bruising, mental status change, confusion, sleepiness, inability to	F 689	correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 689 (Free of Accident Hazards/Supervision/Devices) Corrective Action for Affected Residents On 7/3/21, Resident #46 – NA's #4 and #5 failed to utilize a mechanical lift to transfer a non-ambulatory resident from her wheelchair to the bed which resulted in a fall. NA's #4 and #5 failed to have resident assessed by a licensed medical professional before they moved the resident. Resident was assessed for pain and injury on 7/5/2021 by the Nurse Practitioner. Resident was also assessed on 7/7/2021 by Director of Nursing no injuries or pain, no bruising found, nor were any other skin injuries present. Vital signs were stable. Corrective Action for Potentially Affected Residents All residents requiring a lift for transfers have the potential to be affected by this alleged deficient practice. On 7/30/2021 the Director of Nursing and RN Manager assessed all current residents using a lift for pain by placing extremities through ROM and observing for complaints of pain and to observe for facial grimacing as well as any swelling or bruising, 100% of remaining residents was not affected by this practice. The Maintenance Director audited all six lifts, batteries, charging stations, and 100% of lifts and charging stations were	

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F 689	Continued From page 5 maintain posture, and agitation. If any of the symptoms were present the nurse was to report to the physician. Review of fall assessments documented for Resident #46 revealed no assessments were completed or documented until 07/07/21 when the Director of Nursing (DON) learned of the falls that had occurred on 07/03/21. No nursing progress notes or assessments were documented on 07/03/21 for Resident #46. Review of a progress note written by the facility Nurse Practitioner on 07/05/21 revealed the following: "Seen today for routine assessment for low acuity plan of care and follow up to a fall. (Resident #46) does not have any concerns or complaints today other than the episode with the fall over the weekend. She stated that staff attempted to lift her in the bed and allowed her to fall to the floor a couple of times. She complained of being sore under the arms and legs. No acute injury noted on examination. She endorsed that the pain is getting better. Will continue to treat with prn pain regimen...She denies any pain at this time just some remaining soreness under arms from staff attempting to get her off the floor." During an interview with the facility Nurse Practitioner on 07/27/21 at 3:20 PM she stated she remembered when she returned to work she learned that Resident #46 had fallen over the weekend and she assessed the resident. She recalled the resident was not injured but had felt sore after being dropped a couple of times by the staff. During an interview conducted with DON on	F 689	found to be in working order. Also, all lifts batteries were audited and 100% of batteries were charged and in working order, this was completed on 7/30/2021. Education completed for all Nursing staff regarding not moving resident after a fall until the resident is assessed by a licensed medical professional. This will be completed on 8/23/2021. Education completed for nursing staff to determine what type of lift is needed for resident and how to place batteries on charging station at the end of the AM and PM shifts. This will be completed on 8/23/2021. Systemic Changes On 07/30/21 the DON and RN Nurse Manager began in-servicing all current Nursing staff. This in-service included the following topics: - Not moving resident after a fall until the resident is assessed by a licensed medical professional. Initial Fall UDA must be completed and monitored for 72 hours post fall. - The importance of and how to place batteries on charging station at the end of the AM and PM shifts. The Director of Nursing and RN Nurse manager will ensure that any nursing staff who has not received this training by 08/23/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all RN, LPN, and C NA's and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance	

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F 689	Continued From page 6 07/27/21 at 3:32 PM she stated she visited Resident #46 daily. She investigated the incident on 07/07/21 when she returned to work after the holiday but was unable to produce the paperwork because her office had been flooded and the paperwork was lost. She learned during her investigation two agency NA's (#4 and #5) had tried to use a lift machine but the battery was dead so they decided to transfer the resident themselves. They couldn't do it and lowered the resident to the floor. She stated NA #6 came to the room and helped the other two aides get the resident into bed. She reported the resident had been assessed by the Nurse Practitioner two days after the fall and found no reason to get an x-ray. It was her understanding the resident had been dropped three times during the same shift during the same attempt to transfer her into her bed. She presented documentation showing NA's #4 and #5 were trained to use the sit to stand lift on 06/25/21. During an interview conducted with Resident #46 on 07/28/21 at 9:30 AM she stated two agency aides (NA's #4 & #5) came into her room with a lift (sit to stand). She recalled the aides only buckled one strap around her waist and when she told them there were 2 straps that went around the waist they disagreed with her. She did not think they were trained to use the lift equipment. She stated the lift did not work and the aides decided to lift her themselves from the wheelchair to the bed. She remembered each one grabbed her under an arm and tried to lift her but she fell. She stated they then tried to lift her off the floor and dropped her again. She said at that point they called NA #6 into the room to help lift her onto the bed and dropped her a third time. She recalled NA #6 told them to lower the bed	F 689	The Director or Nursing and RN Nurse Manager will monitor this issue using the Survey Quality Assurance Tool for Monitoring transfer safety and staff knowledge on what to do after a fall. The monitoring will include reviewing lift procedures and safety techniques as well as interviewing staff on initial action to be taken immediately after a resident fall. This will be done for 4 residents with lifts for day shift and 3 residents with lift for night shift. And 4 staff on day shift and 3 staff on night shift. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker, Therapy Director, Housekeeping Supervisor. Date of compliance: 08/23/21.	

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F 689	Continued From page 7	F 689		

because it was too high. Nurse Aides #4 and #5 grabbed her under her arms and Nurse Aide #6 grabbed her ankles and she was able to use her right leg to roll onto the bed face first. She concluded she was not injured but she was sore afterward.

During an interview conducted by phone with NA #6 on 07/28/21 at 10:51 AM she stated she had been called into the resident's room because the lift equipment was not working. She told the other aides the battery was dead and left the room to look for another battery. She recalled when she was gone the other aides tried to lift the resident into bed but put her to the floor because she was too heavy. She helped them put the resident in bed when she returned. She recalled the resident said to her she was not injured or sore. She stated she told Nurse #8 that Resident #46 fell. She replaced the battery on the lift. She concluded herself and the other two aides made a decision to lift the resident into bed since there were 3 of them and had not thought of using a different lift.

An observation of Resident #46 being transferred using a sit to stand mechanical lift was made on 07/28/21 at 2:10 PM. Care was provided by Nurse Aides (NA's) #1 and #2. The Nursing Supervisor was also present. The resident was sitting in her wheelchair. The sit to stand lift was rolled in front of the resident. One strap was buckled around the resident's shins and 2 straps were buckled around the resident's waist. Another strap was placed around the residents back and brought forward under each arm. All straps were attached to the lift machine after application to the resident. The resident was raised without incident to a standing position and

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F 689	Continued From page 8	F 689		

lowered back into her wheelchair after she received incontinent care. Throughout care the resident was talkative and displayed no sign of pain or discomfort. Correct use of the sit to stand lift was demonstrated.

During an interview with NA #4 on 07/28/21 at 4:00 PM she stated she worked at the facility through an agency usually 2 days a week. She was familiar with Resident #46. She was assisting NA #5 the night Resident #46 fell. She recalled the battery on the sit to stand lift was dead. She stated the bed was lowered and the resident was transitioned to the bed. She was halfway on the bed but she slipped off and scooted down to the floor. She stated 3 of them, (herself, NA #5 and NA #6) , picked her up off the floor and put her into bed. She stated she did not tell the nurse the resident had fallen. She had assumed NA #6 was the nurse, she didn't know she was a NA/Med Tech.

During an interview with NA #5 on 07/28/21 at 4:10 PM she stated she worked at the facility 4 to 5 days a week through an agency. She confirmed she was familiar with Resident #6 and was taking care of her the night she fell. She remembered she had volunteered to stay over and work a double shift because another staff member had called out. She stated the lift machine on the hall was brought to the room but it was not working properly so herself and NA #4 tried to do a stand and pivot with the resident but she was half asleep and slid off the edge of the bed onto the floor. She recalled NA #6 came into the room and helped lift the resident into bed by doing a "one-two-three". She stated that was the only time the resident fell that night. She commented she had not told anyone else the

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F 689	Continued From page 9 resident had fallen because she thought NA #6 would make the report. During an interview with Nurse #8 on 07/28/21 at 4:59 PM she stated she was not working the night Resident #46 fell. She produced the working schedule for 07/03/21 and she was not on the schedule. During an additional interview conducted with the DON on 07/29/21 at 2:50 PM she stated she expected all staff to use mechanical lifts when transferring a resident. She reported the facility had a "no lift" policy that meant staff were not to physically lift resident's themselves. She expected all residents who had fallen to be assessed by a nurse before the resident is moved and for nursing to continue to assess the resident for 72 hours after the fall. She reported an in-service had been conducted on 07/08/21 instructing staff not to physically lift residents. She explained she had verbally reviewed the in-service with NA's #4 and #5 but that they had not signed the attendance sheet for the in-service.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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	F 726		8/19/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 10 accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to demonstrate a working knowledge of the IV (Intravenous) pump equipment to enable antibiotic IV medication to be administered for 1 of 1 resident's reviewed for IV medication administration, (Resident #160). Findings included: Resident #160 was admitted to the facility on 07/21/21 with diagnoses that included bacteremia and Klebsiella pneumonia. Physician orders for July 2021 related to IV medication administration for Resident #160 included: Piperacillin Sod-tazobactam Solution Reconstituted 3-0.375 Grams (GM)-Use 3.375	F 726	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 726 (Competent Nursing Staff) Corrective Action for Affected Residents For resident # 160. Nurse #6 did not have knowledge of how to operate the IV pump	

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	345373	A. BUILDING _____ B. WING _____	C 07/30/2021

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F 726	Continued From page 11 GM intravenously every 6 hours for septic shock for 7 days, end date 07/28/21. Review of a Medicare 5 Day MDS (Minimum Data Set) assessment for Resident #160 revealed the resident had intact cognition. No further information was available as the assessment was in progress at the time of the survey. Review of the care plan for Resident #160 revealed the following focus areas: I am on antibiotic therapy with risk for adverse side effects related to Klebsiella and possible enterococcal bacteremia and I am receiving IV medications via PICC (peripherally inserted central catheter) line with risk for complications such as infection and infiltration. Goals included: I will be free of any discomfort or adverse side effects of antibiotic therapy through the review date and my risk for complications related to use of the (PICC line, Central line, Port a Catheter) will be minimized through current interventions x 90 days. Interventions included, in part: Administer medication as ordered, flush according to physician order, and inspect site for redness inflammation, bruising, or change in location and report to physician if noted. An observation of PICC line medication administration was made on 07/28/21 at 2:25 PM. Nurse #6 could not demonstrate the use of the IV pump to administer the antibiotic medication. She stated she did not know how the IV pump operated or how to work it. She commented she did not know how she was going to administer the medication through the PICC line and would have to call her supervisor. She explained she did not know what to do regarding the medication that was scheduled for 12:00 noon and was now 3	F 726	to administer the antibiotic medication. Nurse #6 was immediately educated by the RN Manager on 7/28/2021 on how to use the IV Pump and to set the rate of infusion, she was able to verbalized how to use the IV Pump. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 7/29/2021, the RN Manager audited 100% of the remaining residents' orders for IV medication however there was no other resident with IV medication. Systemic Changes On 7/28/2021 the Director of Nursing/RN Manager/ Designee began in-servicing all current Nurses on the use of the IV Pump to administer antibiotic medication. This in-service included the following topics: - Policies and procedure for administering IV medication - How to use the IV Pump to administer IV medications as ordered by the physician. The Director of Nursing or RN Manager will ensure that any Nurse who has not received this training by 8/19/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The DON/Nurse manager/designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Licensed Nurses knowledge of the use of	

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F 726	Continued From page 12 hours late. She stated she thought she would ask the night shift to give the next dose due at 6:00 PM three hours late. The Director of Nursing (DON) was present and instructed Nurse #6 to call the physician for instruction because the medication was very late. An observation of medication administration through a PICC line for Resident #160 was made on 07/28/21 at 5:15 PM. Staff present included the Nursing Supervisor, the DON and Nurse #6. The Nursing Supervisor demonstrated to Nurse #6 and the DON how to use the IV Pump to administer the medication and set the rate of infusion. Nurse #6 explained she had never had to give IV medication at the facility on the unit she normally worked and that was why she did not know how to administer the IV medication through the PICC line using an IV pump. The Nursing Supervisor administered the 6:00 PM dose of IV antibiotic through the PICC line at the time of the observation. During an interview with the DON on 07/28/21 at 5:25 PM she stated she expected all nursing staff to know how to use the IV pumps provided by the pharmacy and to administer IV medications as ordered by the physician. She commented the facility would start an in-service to ensure all the nurses knew how to use the IV pumps used by the facility.	F 726	IV pump to administer IV medication as ordered by a physician. The monitoring will include interviewing Licensed Nurses to ensure verbalization of how to use the IV Pump to administer medication as per physician order. 3 Licensed Nurses will be interviewed on day shift and two nurses will be interviewed on night shift. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager, and Social Worker, Therapy Director, Housekeeping Supervisor. Date of compliance: 8/19/2021	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760		8/19/21

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F 760	Continued From page 13 by: Based on observation, staff interviews and record review, the facility failed to administer intravenous (IV) medication as ordered by the physician for 1 of 1 resident's reviewed for IV medication administration, (Resident #160). Findings included: Resident #160 was admitted to the facility on 07/21/21 with diagnoses that included bacteremia and Klebsiella pneumonia. Physician orders for July 2021 related to IV medication administration for Resident #160 included: Piperacillin Sod-tazobactam Solution Reconstituted 3-0.375 Grams (GM)-Use 3.375 GM intravenously every 6 hours for septic shock for 7 days, end date 07/28/21. Dose administration times on the medication administration record were 6:00 AM, 12:00 Noon, 6:00 PM and 12:00 Midnight. Review of a Medicare 5 Day MDS (Minimum Data Set) assessment for Resident #160 revealed the resident had intact cognition. No further information was available as the assessment was in progress at the time of the survey. Review of the care plan for Resident #160 revealed the following focus areas: I am on antibiotic therapy with risk for adverse side effects related to Klebsiella and possible enterococcal bacteremia and I am receiving IV medications via PICC (peripherally inserted central catheter) line with risk for complications such as infection and infiltration. Goals included: I will be free of any discomfort or adverse side effects of antibiotic therapy through the review date and my risk for	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 760 (Resident are Free of Significant Med Errors) Corrective Action for Affected Residents For resident #160, On 7/28/21 Nurse #6 failed to administer IV medication as ordered by the physician. Nurse #6 was immediately educated by the Director of Nursing on 7/28/2021 on how to use the IV Pump and to set the rate of infusion, she was able to verbalized how to use the IV Pump. She was also immediately educated to administer IV medication as ordered by the physician. RN Manager immediately notify physician that the IV medication was not administered as ordered by the physician. An order was received by the physician to hold the IV medication that was due at 12 noon. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 7/29/2021, the RN Manager audited 100% of the remaining residents' physician orders for IV medication however there was no other residents	

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F 760	Continued From page 14 complications related to use of the (PICC line, Central line, Port a Catheter) will be minimized through current interventions x 90 days. Interventions included, in part: Administer medication as ordered, flush according to physician order, and inspect site for redness inflammation, bruising, or change in location and report to physician if noted. An observation of PICC line medication administration was made on 07/28/21 at 2:25 PM. Nurse #6 stated she could not administer the medication because she did not know how to operate the IV pump. She explained the dose was also three hours late because at the time the dose was due (12:00 noon) she was busy assisting another resident with a discharge. She stated she thought she would ask the next shift to give the 6:00 PM dose three hours late to compensate for the lateness of the 12:00 PM dose. The Director of Nursing (DON) was present and instructed Nurse #6 to call the physician for instruction because the medication was very late. The Nursing Supervisor was also present and stated she would call the physician to explain the situation and ask for instruction regarding the administration of the 12:00 noon missed dose of IV antibiotic. At 3:45 PM the Nursing Supervisor reported the physician had returned her call and instructed her to hold the medication that was due at 12:00 noon. Record review revealed the following order written on 07/28/21 at 4:38 PM: Ok to hold 12 PM dose of Piperacillin Sod-Tazobactam Solution Reconstituted 3-0.375 GM one time only for septic shock. An observation of medication administration	F 760	identified on IV medication. Systemic Changes On 7/28/2021 the Director of Nursing and RN Nurse Manager began in-servicing all Licensed Nurses. This in-service included the following topics: The use of IV Pump, Policies and Procedures for IV therapy and Medication Administration. The Director of Nursing will ensure that any Licensed Nurse whom has not received this training by 8/19/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Nurse and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing/RN nurse manager will monitor this issue using the Survey Quality Assurance Tool for Monitoring Tool for Monitoring the use of IV pump to administer IV medication as ordered by a physician. This will also include verbalizing the process of IV medication administration for 3 residents for day shift, and 3 residents with IV medication for night shift. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life/QA Committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support	

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F 760	Continued From page 15 through a PICC line for Resident #160 was made on 07/28/21 at 5:15 PM. The Nursing Supervisor administered the 6:00 PM dose of IV antibiotic through the PICC line at the time of the observation. During an interview with the DON on 07/28/21 at 5:25 PM she stated she expected all nursing staff to administer IV medications as ordered by the physician.	F 760	Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker, Therapy Director, Housekeeping Supervisor. Date of compliance: 8/19/2021	
F 842 SS=E	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 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	F 842		8/23/21

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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.

§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.

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F 842	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately document the time and date on the Medication Administration Record (MAR) 11 out of 20 times when prescribed as needed pain medication was removed from the narcotic dispensing card for 1 of 1 residents (Resident #59) reviewed for pain management. Finding included: Resident #59 was admitted to the facility on 04/28/21 and discharged to the hospital on 05/06/21. Diagnoses included, in part, displaced fracture of the lateral end of the left clavicle, multiple fracture of left ribs, superior rim of left pubis, fifth lumbar, sacrum, contusion of lung (unilateral), idiopathic aseptic necrosis of right and left femur, and osteoarthritis. The Minimum Data Set 5-day assessment dated 05/05/21 revealed Resident #59 was mildly cognitively impaired and received a scheduled and as needed pain medication regimen with complaints of frequent pain on a scale of 5 out of 10. The narcotic count sheet (NCS) dated 04/27/21 for Oxycodone 5 mg tablet indicated to give 0.5 (1/2) tab or 1 tablet every 6 hours as needed for pain. The NCS stated forty ½ tablets were dispensed and available in the medication dispensing card. A physician ' s order was written on 04/28/21 for Oxycodone (opioid pain medication) 5 milligrams (mg) give 0.5 (1/2) tablet by mouth every 6 hours as needed for mild to moderate pain.	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 842 (Resident Records – Identifiable Information) Corrective Action for Affected Residents Resident # 59 No longer resides at the facility, transferred on 5/6/2021, Nurse #11 and Nurse #12 failed to accurately document the time and date on the medication administration record (MAR). The Director of Nursing (DON) and the RN manager educated Nurse #11 and Nurse #12 to document on the Medication Administration Record whenever a prescribed medication is administered on 8/20/2021. Corrective Action for Potentially Affected Residents All residents that have PRN narcotic pain medications have the potential to be affected by this alleged deficient practice. On 8/20/2021, the DON, RN manager, LPN Support nurse audited all residents with a prn narcotic pain medication count sheet for supported documentation on MAR. This was completed on 8/20/2021.	

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F 842	Continued From page 18 A physician ' s order was written on 04/28/21 for Oxycodone 5 mg give 1 tablet by mouth every 6 hours as needed for severe pain. The narcotic count sheet (NCS) for Oxycodone 5 mg tablet indicated to give 0.5 (1/2) tab or 1 tablet every 6 hours as needed for pain. On 04/29/21 at 8:00 AM and 3:00 PM, Nurse #11 removed two ½ tablets from the medication dispensing card. A review of the April MAR revealed on 04/29/21 there was no documentation to support Oxycodone 5 mg was administered to Resident #59 at 8:00 AM or at 3:00 PM by Nurse #11. An interview was conducted with Nurse #11 via phone on 07/30/21 at 10:10 AM. Nurse #11 reported she should have documented on the MAR that she gave the prescribed pain medication to Resident #59, and added, that she did not know why she did not record the medication as given and stated that it was policy to document all medications that were administered on the MAR. Nurse #11 stated the MAR should match the narcotic count sheet. The narcotic count sheet (NCS) for Oxycodone 5 mg tablet indicated to give 0.5 (1/2) tab or 1 tablet every 6 hours as needed for pain. On 05/02/21 at 10:45 PM, Nurse #12 removed two ½ tablets from the medication dispensing card. The May MAR revealed there was no documentation to support Oxycodone 5 mg was given to Resident #59 by Nurse #12 on 05/02/21 at 10:45 PM. An interview was conducted with Nurse #12 via	F 842	In addition, licensed nurses and med aids identified from the audit were in-serviced to document all medication administered to resident on the MAR Systemic Changes On 8/20/2021 the Director of Nursing/ RN manager and designee began in-servicing all Licensed Nurses and Med Aides. This in-service included the following topics: - Policies and Procedure of Medication Administration - When Administering a Medication, the supporting documentation must be placed on Electronic MAR immediately after giving to a resident. The Director of Nursing, RN Nurse Manager and LPN Support Nurse will ensure that any Licensed Nurse or Medication Aide who has not received this training by 8/23/2021 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurses and Medication Aide. Quality Assurance The DON or RN Manager will monitor this issue using the Survey Quality Assurance Tool for Monitoring documentation of medication administered on MAR. The monitoring will include reviewing the narcotic count sheet for supported documentation on MAR of four residents on day shift, and three residents on night shift. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated	

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F 842	Continued From page 19	F 842		

phone on 07/30/21 at 5:34 PM. Nurse #12 reported she did not know why she did not document on the MAR that the medication was given to Resident #59. Nurse #12 stated she may have gotten distracted, and added, if she had taken it out of the narcotic box to be given to the resident then she gave it to the resident, but she just forgot to document the administration on the MAR.

The narcotic count sheet (NCS) for Oxycodone 5 mg tablet indicated to give 0.5 (1/2) tab or 1 tablet every 6 hours as needed for pain. On 05/04/21 Nurse #11 removed two ½ tablets from the medication dispensing card at 9:15 AM, 2:00 PM, and 6:30 PM, and on 05/05/21 Nurse #11 removed two ½ tablets from the medication dispensing card at 8:00 AM and 2:00 PM.

The May MAR revealed there was no documentation to support Oxycodone 5 mg was given to Resident #59 by Nurse #11 on 05/04/21 at 9:15 AM, 2:00 PM or 6:30 PM. There was no documentation to support Oxycodone 5 mg was given to Resident #59 by Nurse #11 on 05/05/21 at 8:00 AM or 2:00 PM.

An interview was conducted with Nurse #11 via phone on 07/30/21 at 10:10 AM. Nurse #11 reported she should have documented on the MAR that she gave the prescribed pain medication to Resident #59, and added, that she did not know why she did not record the medication as given and stated that it was policy to document all medications that were administered on the MAR. Nurse #11 stated the MAR should match the narcotic count sheet.

An interview was conducted with the Director of

as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker, Housekeeping Supervisor, Therapy Director.

Date of compliance: 8/23/2021

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F 842	Continued From page 20 Nursing (DON) via phone on 7/30/21 at 4:30 PM. The DON stated her expectation of the nurses was to document on the MAR whenever they administered prescribed medications. The DON stated it was important to have accurate documentation to prevent medication errors and it was also important to document when PRN (as needed) medications were given in order to prevent double dosing or giving the medication too soon. The DON stated the Medication Administration Record should reflect what was removed from the narcotic count sheet.	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 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		8/23/21

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	345373	A. BUILDING _____ B. WING _____	C 07/30/2021

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F 880	Continued From page 21 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 22 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement the Centers for Medicare and Medicaid Services (CMS) guidelines and the facility's COVID-19 Program Infection Control Policy to a) ensure staff were screened upon entering the facility when a staff member was observed entering through a back door upon arriving for her shift and failed to be screened by a trained staff member before entering the resident care area (Nurse Aide #11), and two staff members were observed entering through the back door without screening and walked through the facility to the front entrance to be screened prior to starting their shift (Nurse Aide #4, #5). b) ensure staff were screened by a nurse or trained staff member prior to entering the facility when a staff member was observed screening herself upon entering the facility through a back door for 4 of 4 staff members. These failures occurred during the COVID-19 pandemic. Findings included: A review of the facility policy titled; COVID-19 Program, revised July 2021, read in part, all employees are screened as they arrive at the beginning of the shift and upon returning after leaving the facility. Employee screenings are conducted by a nurse and consist of a temperature, sign and symptom review, along with screening questions. An observation conducted on 07/28/21 beginning at 2:50 PM revealed Nurse aide #11entering	F 880	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F tag-880-Infection Prevention & Control On 7/28/2021 The facility□s COVID-19 screening policy and procedure was not implemented when NA #11, who had not been screened for COVID-19, entered the facility and proceeded to her assignment. NA #11 was immediately removed from her assignment and re-educated immediately by Administrator on 7/28/2021. On 7/28/2021 NA #4, NA #5, and NA#10 were also re-educated by the Administrator. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 7/28/2021 the Administrator audited all remaining staff including Department Heads, Nursing, Dietary, Therapy, Housekeeping, and Laundry. All remaining staff were found to have followed the Covid 19 screening process. How the facility will identify other residents	

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F 880	Continued From page 23 through the back door of the facility without completing the electronic screening assessment tool that was stationed at the back door that did not have a trained staff member in place to conduct the screening. She was observed going to her assigned hall without being screened. An observation conducted on 07/28/21 beginning at 2:50 PM revealed Nurse aide #4 and Nurse aide #5 entering through the back door without screening and walked through the facility to the front entrance where they were both screened prior to starting their shift. An interview was conducted with Nurse aide #11 on 07/28/21 at 3:15 PM. She stated she did not get screened when she arrived for her shift. She stated she was not aware the facility was screening again, and stated it was an error on her part and she should have completed the screening when she entered the building. An interview was conducted on 07/28/21 at 3:30 PM with Nurse aide #4 along with Nurse aide #5. They both reported they entered through the back door and did not complete the screening upon entrance because there was not a staff member there to complete the screening, so they walked through the building to the front entrance and were screened by a staff member. b) An observation conducted on 07/28/21 at 3:00 PM revealed Nurse aide #10 entering through the back door of the facility and screening herself using an electronic screening assessment tool then going to her assigned hall. An interview was conducted on 07/28/21 at 03:10 PM with Nurse Aide #10. She stated she was an	F 880	having the potential to be affected by the same deficient practice: All employees must enter using the designated front entrance only. Each employee will be screened by a trained screener prior to the start of their shift and before going into any other area of the facility. On 7/28/2021 all door entry codes were changed by Maintenance Director on all entrance doors and staff are to enter only through the designated front entrance to be screened. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 7/28/2021 the Director of Nursing and the Administrator initiated education on the COVID 19 policy version 25 based on CDC and NCDHHS guidance on the screening process for all full-time, part-time, and PRN personnel. All education will be completed prior to an employee working their next shift, this education will be completed by the Administrator, Director of Nursing, or Charge Nurse on duty. All education will be completed on or before 8/23/2021, however, no employee will work prior to receiving the education. Beginning 7/28/2021 all new employees will receive this same education on day 1 of orientation by the Director of Staff Development and/or the Director of Nursing. In addition to this, any agency employee utilized by the facility will receive this in-service education prior to their shift. Indicate how the facility plans to monitor	

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F 880	Continued From page 24 agency aide and she screened herself in at the back door. She reported there was usually a person at the back door to complete the screening but there wasn't one that day, so she screened herself and checked her temperature. She indicated she was aware that a nurse or trained staff member should have conducted the screening but stated she was in a hurry. An interview was conducted on 07/28/21 at 4:45 PM with the Director of Nursing (DON). She stated employees were required to enter the facility through the front entrance and they allowed entrance through the back door prior to this week. She stated the facility was in outbreak status due to a staff member testing positive over the weekend, so staff were only allowed entrance through the front door beginning 07/26/21. She reported there wasn't always a designated screener posted at the back door and staff were supposed to have a nurse check their temperature and conduct screening, and stated staff were not allowed to check their own temperature. She stated her expectation was for all staff to enter through the front door when they arrived for their shift and be screened immediately by a trained staff member or nurse upon entering the building. A follow up interview was conducted 07/29/21 3:39 PM with the Administrator along with the DON. The Administrator stated a process was in place for screening employees upon arrival for their shift however the staff members just failed to implement it. The DON stated all staff were trained on the screening process, and education was underway again for all staff regarding the screening process. She stated staff were educated to enter only through the designated	F 880	its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Administrator, Director of Nursing or designee will audit by observing 3-day shifts, 3 evening shifts and 2-night shift staff 3 x a week with at least one of the observations to occur on a Saturday or Sunday to assure that all employees are entering only through the designated facility entrance for screening prior to the start of their shift. This audit will be completed weekly x4 weeks then monthly x 3 months. QA Reports will be presented in the weekly QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Minimum Data Set Nurse, Social Services Director, Dietary Manager, Health information Manager, Activities Director, Maintenance Director, Therapy Director, and Housekeeping Supervisor. Date of compliance will be 8/23/2021 Please see attached RCA and Attestation Statement. 9/1/2021	

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F 880	Continued From page 25 front entrance and they were required to be screened prior to the start of their shift by a nurse or trained staff member.	F 880		