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	345183	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint survey were conducted on 7/12/21 through 7/15/21. The facility was found in complaince with requirement CFR 483.73, Emergency Preparedness. Event ID # QBPN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey were conducted from 7/12/21 through 7/15/21. Event ID #QBPN11. 9 of the 31 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or	F 551		8/12/21

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

Electronically Signed | 08/08/2021

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F 551	Continued From page 1	F 551		

delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.
(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.
(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.
This REQUIREMENT is not met as evidenced by:

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F 551	Continued From page 2 Based on record review, guardian and staff interviews, the facility failed to notify in writing the guardian of a discharge from the facility for 1 of 2 residents reviewed for discharge. (Resident #31) Findings Included: Resident #31 was admitted to the facility on 10/30/20 with diagnoses which included spinal stenosis and malignant neoplasm unspecified. Resident #31's face sheet listed Resident #31's family member as the medical representative. A review of guardianship papers revealed that Resident #31's family member became guardian on 3/31/21 and listed Resident #31 as an incompetent person. A phone call was placed on 7/15/21 at 12:30 PM to Resident #31's guardian who stated that she was involved in a care plan meeting with the Social Worker (SW) and Resident #31 on April 14th, 2021 and there was discussion about moving Resident #31 to an assisted living facility and Resident #31 wanted to leave. The family member stated that she called the facility on 5/18/21 and did not remember who she had spoken with but was told Resident #31 had discharged out of the facility on 5/11/21 and no had let her know Resident #31 had left the facility. An interview was completed with the Social Worker (SW) on 7/15/21 at 2:20 PM who stated that she could not remember if she called Resident #31's guardian about the resident's discharge on 5/11/21 and thought Resident #31 called his guardian. The SW then stated that she did not talk with the guardian as she would not	F 551	F551 This plan of correction constitutes as written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. Facility failed to notify in writing the guardian of a discharge from the facility for Resident #31. Resident did not return to the facility. 2. An audit was conducted on 8/11/2021 by the Social Worker of discharges from the last 30 days (7/12/21-8/10/21) to ensure that the guardian was included in the discharge process. 3. Social Worker and Nurse Managers were educated by the Administrator on 8/5/2021 on knowing the rights of the guardian and involvement in the discharge process. Discharging residents will be discussed in morning Stand up (Monday-Friday) with the Interdisciplinary Team (Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy Leadership, Social Worker, and Dietary) to ensure appropriate planning and	

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F 551	Continued From page 3 answer the phone. Resident #31's discharge Minimum Data Set (MDS) dated 5/11/21 coded the resident's cognition as being cognitively intact and discharged to the community. A nursing progress note dated 5/11/21 revealed Resident #31 discharged home on 5/11/21 in good condition. A record review revealed no written or verbal communication was completed to Resident #31's guardian regarding his discharge out of the facility on 5/11/21. On 7/15/21 at 4:24 PM and interview was completed with the administrator who stated that the discharge process should go through the SW and be a team effort with the interdisciplinary team and the SW should call the guardian of the discharge notice.	F 551	notifications are completed prior to discharge. The Administrator or designee will conduct audits of all discharges to ensure that guardians/Responsible Parties are involved in the discharge process weekly x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		8/12/21

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F 561	Continued From page 4 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident interview, and staff interviews, the facility failed to permit a resident who was assessed as a safe smoker to smoke when on quarantine for 1 of 5 residents reviewed for choices (Resident #49). Findings included: Resident #49 was admitted to the facility 4/27/2021 and readmitted 7/10/2021. Diagnoses for Resident #49 included lung disease, heart disease, and kidney disease. The most recent admission Minimum Data Set assessment dated 5/18/2021 assessed Resident #49 to be cognitively intact. A nursing note dated 6/14/2021 documented that Resident #49 was unhappy about not being allowed to go outside to smoke. A care plan dated 6/17/2021 addressed Resident	F 561	F561 1. The facility failed to permit a resident who was assessed as a safe smoker to smoke when on quarantine for Resident #49. Facility arranged for Resident #49 to smoke. 2. Social Worker conducted an audit on 8/11/21 of all residents on quarantine that were assessed as a safe smoker to ensure they can smoke if desired. No additional safe smokers on quarantine were identified and no further issues identified. 3. All nursing staff are to be educated by the Administrator and Director of Nursing regarding residents that are assessed as a safe smoker to be allowed to smoke when on quarantine if they deny the nicotine patch, accommodations to smoke will be made. All newly hired employees	

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F 561	Continued From page 5 #49 ' s smoking status and included interventions to encourage Resident #49 to smoke only in the designated smoking areas and to store her smoking materials at the nursing station. A smoking assessment dated 7/11/2021 assessed Resident #49 to be a safe and independent smoker. Resident #49 was interviewed on 7/12/2021 at 4:03 PM. Resident #49 reported she had been hospitalized and readmitted to the facility on 7/10/2021. Resident #49 reported she was in quarantine for 2 weeks and she had been told she was not allowed to go out to smoke during the quarantine. Resident #49 reported the facility offered her a nicotine patch, but she did not want it. Resident #49 reported it upset her to not be able to smoke while on quarantine. Nurse #3 was interviewed on 7/14/2021 at 4:02 PM. Nurse #3 reported Resident #49 had asked her multiple times to go out and smoke. Nurse #3 reported Resident #49 was very upset she was restricted from smoking while on quarantine after her hospitalization. Nurse #3 reported that none of the residents could go out and smoke when they were on quarantine. Nursing assistant (NA) #2 was interviewed on 7/15/2021 at 10:21 AM. NA #2 reported that Resident #49 had expressed she was very frustrated she was not allowed to go outside to smoke. An interview was conducted with Nurse #4 on 7/15/2021 at 10:41 AM. Nurse #4 reported Resident #49 had complained to him she was not allowed to go out to smoke when she was quarantined, and this was upsetting to her. Nurse	F 561	will receive the education in new hire orientation. No employee will be allowed to work without the education. Education to be completed by 8/11/2021. An audit will be conducted weekly by the Social Worker to ensure that residents that are assessed as safe smokers and on quarantine are able to smoke if desired. This audit will be conducted weekly x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Social Worker and Administrator	

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F 561	Continued From page 6 #4 reported Resident #49 had refused to wear the nicotine patch. The Administrator was interviewed on 7/15/2021 at 3:59 PM. The Administrator reported the facility had prevented residents from going outside to smoke during their quarantine after hospitalization and no residents had complained about the process. The Administrator reported he expected the facility to honor residents wishes and make accommodations for their choices.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every	F 565		8/12/21

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F 565	Continued From page 7 request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident interviews, and staff interviews, the facility failed to protect resident ' s property from loss for 5 of 6 residents reviewed for missing clothing (Resident # 50, Resident # 61, Resident #59, Resident #69, Resident #79). Findings included: 1. The resident council meeting minutes dated 1/26/2021 noted residents reported missing clothing from laundry. The resident council meeting minutes dated 2/23/2021 noted residents reported not getting clothing back from the laundry in a timely manner. The grievance response form indicated the laundry staff reported some clothing were without resident names, or the names/initials were unreadable. The grievance form indicated the laundry manager would check the laundry twice per day to make certain personal items were going out to residents. The resident council meeting minutes dated 3/30/2021 noted residents reported missing clothing from the laundry. Resident #50 was	F 565	F565 1. The facility failed to protect resident□s property from loss (Resident #50, #61, #59, #69 and #79) when reviewed for missing clothing. Resident #50, #79, and #59 clothes has been returned or are no longer missing. Residents #61 and #69 are still missing clothes. Administrator has informed Resident and/or Responsible Party that facility will reimburse for missing clothing. 2. An audit was conducted by Social Worker and Housekeeping Manager to ensure that current residents were not missing any clothing. This audit will be completed by 8/6/2021. 3. Administrator educated Social Worker, Housekeeping Manager, receptionist, ambassadors, and admissions coordinator on 9/10/2021 regarding the need to follow up with all residents to ensure they are not missing any clothing and returning clean clothing timely. Upon admission when new residents enter the facility, the receptionist	

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noted to report he had sent clothing to the laundry in a bag with his name on the bag and the clothing had not been returned to him.

The resident council meeting minutes dated 4/27/2021 noted residents reported laundry was being misplaced or lost. The grievance response form documented clothing that was lost had no names on the clothing. The laundry manager noted a bin of clothing was used for all clothing without names.

A. A grievance/concern form dated 3/31/2021 was reviewed. The grievance form was completed for Resident #50 and reported he was missing clothing. The grievance form reported Resident #50 ' s clothing was not found.

Resident #50 was admitted to the facility on 11/13/2017 with diagnoses to include heart failure and stroke. The most recent quarterly Minimum Data Set assessment dated 4/15/2021 assessed Resident #50 to be cognitively intact.

The resident council was interviewed on 7/13/2021 at 1:43 PM. Resident #50 was in attendance. Resident #50 reported he was missing clothing and it had not been replaced by the facility.

The Activities Director was interviewed on 7/13/2021 at 2:38 PM. The AD reported missing laundry had been an ongoing issue for residents. The AD reported she completed grievances for the resident council and gave to the Social Worker, who would then give the grievance to the department manager.

An interview was conducted with Laundry Aide

will complete an inventory log, if facility does their laundry the residents clothes will be taken by the receptionist to be labeled in the collar of the clothing with black magic marker. Upon admission the admissions coordinator will ensure residents closet in room will be labeled with their name, what bed they re in, and whether the facility or family does their laundry. The ambassadors will complete an audit of their assigned rooms to ensure resident name tags on closets has their name, bed number, and whether the facility or the family does their laundry. If the resident s laundry is not labeled the ambassadors will label them with a sharpie, this is to be completed by 9/10/21.
An audit will be conducted by Social Worker to ensure that residents are not missing any clothing and that they are being returned timely. This audit will consist of 20 residents per week x 4 weeks, 15 residents per week x 4 weeks and 10 residents per week x 4 weeks. The Administrator will review the results of the weekly audits to ensure the new process s effectiveness.

4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance improvement by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

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(LA) #1 and LA #2 on 7/14/2021 at 9:16 AM. LA #1 and LA #2 reported clothing came to the laundry frequently without a resident name in the clothing. LA #1 and LA #2 reported the clothing without a resident name was stored in the clean linen room on a rack. LA #1 and LA #2 reported they received 1-2 complaints per week related to missing laundry.

The Laundry manager (LM) was interviewed on 7/14/2021 at 9:45 AM. The LM reported she received frequent complaints related to missing clothing. The LM reported there was a section in the clean linen room where clothing without names was stored and staff were encouraged to look for missing clothing.

A follow-up interview was conducted on 7/15/2021 at 10:29 AM with the LM. The LM reported a label maker was ordered and she would use the label maker to identify resident clothing to prevent missing clothing.

The Housekeeping Department Corporate Consultant (HD) was interviewed on 7/15/2021 at 2:04 PM. The HD reported she had not worked at the facility for several months, but she was aware there was an issue with missing clothing. The HD reported there was no clothing in the clean linen room that was unlabeled at this time.

The Administrator was interviewed on 7/15/2021 at 3:54 PM. The Administrator reported missing clothing had been an ongoing issue for the laundry. The Administrator reported the resident clothing had not been labeled correctly and the facility was planning to purchase a labeling machine. The Administrator reported he expected the laundry staff to identify clothing that

5. Person Responsible: Administrator

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was not labeled and return all clothing to residents.

B. Resident #61 was admitted to the facility 2/14/2018 with diagnoses to of hypertension and vascular disease. The most recent quarterly MDS assessed Resident #61 to be cognitively intact.

The resident council was interviewed on 7/13/2021 at 1:43 PM. Resident #61 was in attendance. Resident #61 reported he was missing multiple pairs of shorts and shirts and no one could find the clothing.

The Activities Director was interviewed on 7/13/2021 at 2:38 PM. The AD reported missing laundry had been an ongoing issue for residents. The AD reported the dryer in the laundry room had been broken and this set back the return of laundry for residents.

An interview was conducted with Laundry Aide (LA) #1 and LA #2 on 7/14/2021 at 9:16 AM. LA #1 and LA #2 reported clothing came to the laundry frequently without a resident name in the clothing. LA #1 and LA #2 reported the clothing without a resident name was stored in the clean linen room on a rack. LA #1 and LA #2 reported they received 1-2 complaints per week related to missing laundry.

The Laundry manager (LM) was interviewed on 7/14/2021 at 9:45 AM. The LM reported she received frequent complaints related to missing clothing. The LM reported there was a section in the clean linen room where clothing without names was stored and staff were encouraged to look for missing clothing.

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A follow-up interview was conducted on 7/15/2021 at 10:29 AM with the LM. The LM reported a label maker was ordered and she would use the label maker to identify resident clothing to prevent missing clothing.

The Housekeeping Department Corporate Consultant (HD) was interviewed on 7/15/2021 at 2:04 PM. The HD reported she had not worked at the facility for several months, but she was aware there was an issue with missing clothing. The HD reported there was no clothing in the clean linen room that was unlabeled at this time.

The Administrator was interviewed on 7/15/2021 at 3:54 PM. The Administrator reported missing clothing had been an ongoing issue for the laundry. The Administrator reported the resident clothing had not been labeled correctly and the facility was planning to purchase a labeling machine. The Administrator reported he expected the laundry staff to identify clothing that was not labeled and return all clothing to residents.

c. Resident #59 was admitted to the facility on 03/27/19.

The most recent quarterly Minimum Data Set assessment dated 05/13/21 indicated Resident #59 was moderately cognitively impaired.

An interview was conducted with Resident #59 on 07/12/21 at 12:30 PM regarding her laundry. She stated when she had dirty laundry, it took forever to get her clothes back. Resident #59 said she had also complained of clothes missing to the staff.

Review of the Resident Council minutes

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indicated laundry was a concern on 01/26/21, 02/21/21, 03/30/21, 04/27/21, 05/12/21 and 06/04/21. Resident #79 was present at the 5/21/21 meeting.

Review of the January-April grievance logs for missing clothes and laundry concerns indicated there was 1 grievance for January, 2 for February, 5 for March and 3 for April.

An observation was done on 07/14/21 at 09:16 AM of the closet across from laundry with a long rack of unmarked or faded name clothes.

An interview was conducted on 07/13/21 at 10:25 AM with a family member of a discharged resident #192 .The family stated she had spoken with the current administrator regarding missing shoes, a comforter, 3 outfits and clothing items that still had tags on, all being missing from the resident's belongings. She said that the items had been professionally labeled. She had given the facility a list of missing items after discharge and never heard back. They were told the facility was not responsible for lost items. She was told by a staff member that other residents were wearing clothes with the resident's name.

An interview was conducted with the Unit Manager #2 on 7/13/21 at 03:46 PM regarding laundry concerns. She stated she had heard complaints about missing clothes, and she had encouraged residents to submit grievances. She thought moving rooms contributed to this. The Unit Manager said the Administrator was aware of the concerns. They had each resident look through the clothes to see if they could locate them. She was asked if she had heard about new clothes with tags on being taken and she

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stated she had not heard that. She acknowledged it was an ongoing issue.

The Activity Director was interviewed on 07/14/21 at 03:57 PM about missing clothing. She stated she heard something almost every day about missing items or that "so and so has my clothes on." She would also be asked if she would take their clothes to the laundry and bag them to prevent loss. She noted when the clothes were bagged there was better turn around and less loss. She noted she helped with Resident Council for six months and complaints had been going on every day and in every monthly meeting.

An interview was conducted on 07/14/21 at 09:16 AM with Laundry Aide #1 and Laundry Aide #2 regarding missing clothes. Laundry Aide #1 stated that new residents don't have clothes and they wanted clothes. Laundry Aide #2 stated 9 out of 10 clothing items were not marked. The Laundry Aides were asked about Resident #69's family member's complaint of missing clothes and they stated the family member had not spoken with them. They both stated missing clothes was a common complaint and that they heard it 1-2 times per week. Laundry Aide #1 said there were many no name clothes on a long rack in a designated closet across the hall from laundry. They both noted these clothes are available for residents with no clothes. The NAs obtained clothes from the closet for residents that don't have any clothes on admission. They said that they had heard complaints from residents also that other residents were wearing their clothes.

An interview was done on 07/14/21 at 09:45 AM with the Laundry Manager regarding missing clothing. She said she heard a lot of complaints

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about missing or lost clothes. She noted when a resident came to the facility, often they don't have any clothes. The manager stated if she heard complaints, she placed the concern on the top of her list, and she would ask for a description and tried to find them. She noted if clothes were not returned often, due to no name, or faded names. She said they had a no name rack in a closet she would look through. She was asked about the residents with no clothes on admission and she said the NAs came back and used the clothes on the no name rack for them. The Laundry Manager noted that some NAs would say, "I know these clothes belong to this person" and would take them to them but said, with COVID there were no families in to check for names in clothing and the family could not take the laundry out for several months. She said if someone's clothes were recognized by her laundry staff, they would mark them. She was asked about complaints of other residents wearing their clothes and she stated this was because of clothes taken from the no name rack. She was asked about solutions for this and stated she wanted to have a label maker and have a process to label clothes. The Manager said she wanted them to pass clothes for new admissions to her, so she could ensure they were labeled correctly. They were hoping to send a letter out to the Responsible Party and get together a resident and family event with the Activity Coordinator and help to label clothing with the residents.

The Housekeeping Department Corporate Consultant (HD) responsible for Laundry was interviewed on 7/15/2021 at 2:04 PM. The reported she had not worked at the facility for several months, but she was aware there was an issue with missing clothing. The HD reported

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there was no clothing in the laundry that was unlabeled.

The Administrator was interviewed on 7/15/2021 at 3:54 PM. The Administrator reported missing clothing had been an ongoing issue for the laundry. The Administrator reported the resident clothing had not been labeled correctly and the facility was planning to purchase a labeling machine. The Administrator reported he expected the laundry staff to identify clothing that was not labeled and return all clothing to residents.

d. Resident #69 was admitted to the facility on 04/30/19.

The most recent quarterly Minimum Data Set assessment dated 06/08/21 noted Resident #69 to be severely cognitively impaired.

An interview was conducted on 07/12/21 at 1:05 PM with a family member visiting at the facility. The family member stated that Resident #69 was missing several items of clothing from his closet that were there when they visited before COVID. It was stated that he was missing half of his clothes. The family member stated she had not filed a grievance.

Review of the Resident Council minutes indicated laundry was a concern on 01/26/21, 02/21/21, 03/30/21, 04/27/21, 05/12/21 and 06/04/21. Resident #79 was present at the 5/21/21 meeting.

Review of the January-April grievance logs for missing clothes and laundry concerns indicated there was 1 grievance for January, 2 for February, 5 for March and 3 for April.

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An observation was done on 07/14/21 at 09:16 AM of the closet across from laundry with a long rack of unmarked or faded name clothes.

An interview was conducted on 07/13/21 at 10:25 AM with a family member of a discharged resident #192 .The family stated she had spoken with the current administrator regarding missing shoes, a comforter, 3 outfits and clothing items that still had tags on, all being missing from the resident's belongings. She said that the items had been professionally labeled. She had given the facility a list of missing items after discharge and never heard back. They were told the facility was not responsible for lost items. She was told by a staff member that other residents were wearing clothes with the resident's name.

An interview was conducted with the Unit Manager #2 on 7/13/21 at 03:46 PM regarding laundry concerns. She stated she had heard complaints about missing clothes, and she had encouraged residents to submit grievances. She thought moving rooms contributed to this. The Unit Manager said the Administrator was aware of the concerns. They had each resident look through the clothes to see if they could locate them. She was asked if she had heard about new clothes with tags on being taken and she stated she had not heard that. She acknowledged it was an ongoing issue.

The Activity Director was interviewed on 07/14/21 at 03:57 PM about missing clothing. She stated she heard something almost every day about missing items or that "so and so has my clothes on." She would also be asked if she would take their clothes to the laundry and bag them to

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prevent loss. She noted when the clothes were bagged there was better turn around and less loss. She noted she helped with Resident Council for six months and complaints had been going on every day and in every monthly meeting.

An interview was conducted on 07/14/21 at 09:16 AM with Laundry Aide #1 and Laundry Aide #2 regarding missing clothes. Laundry Aide #1 stated that new residents don't have clothes and they wanted clothes. Laundry Aide #2 stated 9 out of 10 clothing items were not marked. The Laundry Aides were asked about Resident #69's family member's complaint of missing clothes and they stated the family member had not spoken with them. They both stated missing clothes was a common complaint and that they heard it 1-2 times per week. Laundry Aide #1 said there were many no name clothes on a long rack in a designated closet across the hall from laundry. They both noted these clothes are available for residents with no clothes. The NAs obtained clothes from the closet for residents that don't have any clothes on admission. They said that they had heard complaints from residents also that other residents were wearing their clothes.

An interview was done on 07/14/21 at 09:45 AM with the Laundry Manager regarding missing clothing. She said she heard a lot of complaints about missing or lost clothes. She noted when a resident came to the facility, often they don't have any clothes. The manager stated if she heard complaints, she placed the concern on the top of her list, and she would ask for a description and tried to find them. She noted if clothes were not returned often, due to no name, or faded names. She said they had a no name rack in a closet she would look through. She was asked about the

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residents with no clothes on admission and she said the NAs came back and used the clothes on the no name rack for them. The Laundry Manager noted that some NAs would say, "I know these clothes belong to this person" and would take them to them but said, with COVID there were no families in to check for names in clothing and the family could not take the laundry out for several months. She said if someone's clothes were recognized by her laundry staff, they would mark them. She was asked about complaints of other residents wearing their clothes and she stated this was because of clothes taken from the no name rack. She was asked about solutions for this and stated she wanted to have a label maker and have a process to label clothes. The Manager said she wanted them to pass clothes for new admissions to her, so she could ensure they were labeled correctly. They were hoping to send a letter out to the Responsible Party and get together a resident and family event with the Activity Coordinator and help to label clothing with the residents.

The Housekeeping Department Corporate Consultant (HD) responsible for Laundry was interviewed on 7/15/2021 at 2:04 PM. The reported she had not worked at the facility for several months, but she was aware there was an issue with missing clothing. The HD reported there was no clothing in the laundry that was unlabeled.

The Administrator was interviewed on 7/15/2021 at 3:54 PM. The Administrator reported missing clothing had been an ongoing issue for the laundry. The Administrator reported the resident clothing had not been labeled correctly and the facility was planning to purchase a labeling

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machine. The Administrator reported he expected the laundry staff to identify clothing that was not labeled and return all clothing to residents.

e. Resident #79 was admitted to the facility on 10/12/18.

The most recent quarterly Minimum Data Set assessment dated 05/27/21 indicated Resident #79 was cognitively intact.

An interview was conducted on 07/12/21 with Resident #79 at 03:02 PM. He stated the for last couple months he took his laundry out when he visited a friend and his friend did it there as he had complained multiple times in Resident Council meetings and was tired of nothing being done. He stated the facility would not keep up with the laundry and he was missing several items.

Review of the Resident Council minutes indicated laundry was a concern on 01/26/21, 02/21/21, 03/30/21, 04/27/21, 05/12/21 and 06/04/21. Resident #79 was present at the 5/21/21 meeting.

Review of the January-April grievance logs for missing clothes and laundry concerns indicated there was 1 grievance for January, 2 for February, 5 for March and 3 for April.

An observation was done on 07/14/21 at 09:16 AM of the closet across from laundry with a long rack of unmarked or faded name clothes.

An interview was conducted on 07/13/21 at 10:25 AM with a family member of a discharged resident #192 .The family stated she had spoken

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with the current administrator regarding missing shoes, a comforter, 3 outfits and clothing items that still had tags on, all being missing from the resident's belongings. She said that the items had been professionally labeled. She had given the facility a list of missing items after discharge and never heard back. They were told the facility was not responsible for lost items. She was told by a staff member that other residents were wearing clothes with the resident's name.

An interview was conducted with the Unit Manager #2 on 7/13/21 at 03:46 PM regarding laundry concerns. She stated she had heard complaints about missing clothes, and she had encouraged residents to submit grievances. She thought moving rooms contributed to this. The Unit Manager said the Administrator was aware of the concerns. They had each resident look through the clothes to see if they could locate them. She was asked if she had heard about new clothes with tags on being taken and she stated she had not heard that. She acknowledged it was an ongoing issue.

The Activity Director was interviewed on 07/14/21 at 03:57 PM about missing clothing. She stated she heard something almost every day about missing items or that "so and so has my clothes on." She would also be asked if she would take their clothes to the laundry and bag them to prevent loss. She noted when the clothes were bagged there was better turn around and less loss. She noted she helped with Resident Council for six months and complaints had been going on every day and in every monthly meeting.

An interview was conducted on 07/14/21 at 09:16 AM with Laundry Aide #1 and Laundry Aide #2

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regarding missing clothes. Laundry Aide #1 stated that new residents don't have clothes and they wanted clothes. Laundry Aide #2 stated 9 out of 10 clothing items were not marked. The Laundry Aides were asked about Resident #69's family member's complaint of missing clothes and they stated the family member had not spoken with them. They both stated missing clothes was a common complaint and that they heard it 1-2 times per week. Laundry Aide #1 said there were many no name clothes on a long rack in a designated closet across the hall from laundry. They both noted these clothes are available for residents with no clothes. The NAs obtained clothes from the closet for residents that don't have any clothes on admission. They said that they had heard complaints from residents also that other residents were wearing their clothes.

An interview was done on 07/14/21 at 09:45 AM with the Laundry Manager regarding missing clothing. She said she heard a lot of complaints about missing or lost clothes. She noted when a resident came to the facility, often they don't have any clothes. The manager stated if she heard complaints, she placed the concern on the top of her list, and she would ask for a description and tried to find them. She noted if clothes were not returned often, due to no name, or faded names. She said they had a no name rack in a closet she would look through. She was asked about the residents with no clothes on admission and she said the NAs came back and used the clothes on the no name rack for them. The Laundry Manager noted that some NAs would say, "I know these clothes belong to this person" and would take them to them but said, with COVID there were no families in to check for names in clothing and the family could not take the laundry out for

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F 565	Continued From page 22 several months. She said if someone's clothes were recognized by her laundry staff, they would mark them. She was asked about complaints of other residents wearing their clothes and she stated this was because of clothes taken from the no name rack. She was asked about solutions for this and stated she wanted to have a label maker and have a process to label clothes. The Manager said she wanted them to pass clothes for new admissions to her, so she could ensure they were labeled correctly. They were hoping to send a letter out to the Responsible Party and get together a resident and family event with the Activity Coordinator and help to label clothing with the residents. The Housekeeping Department Corporate Consultant (HD) responsible for Laundry was interviewed on 7/15/2021 at 2:04 PM. The reported she had not worked at the facility for several months, but she was aware there was an issue with missing clothing. The HD reported there was no clothing in the laundry that was unlabeled. The Administrator was interviewed on 7/15/2021 at 3:54 PM. The Administrator reported missing clothing had been an ongoing issue for the laundry. The Administrator reported the resident clothing had not been labeled correctly and the facility was planning to purchase a labeling machine. The Administrator reported he expected the laundry staff to identify clothing that was not labeled and return all clothing to residents.	F 565		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		8/12/21

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§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);

§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

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F 584	Continued From page 24 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to clean and keep furniture in good repair for 2 of 2 chairs in the front lobby, 1 of 2 overbed tables in the lobby, 8 of 8 dining room chairs, 3 of 3 cabinet drawers in the dining room, 3 of 5 chairs in the game room and 1 of 1 vinyl chair in the 100-Unit nursing station. Findings included: An observation was done on 07/12/21 at 9:15 AM of the 2 chairs and 2 overbed tables directly outside of the dietary door in the front lobby. 1 of 2 overbed tabletops sloped downward and both chairs had multiple shades of stains on the seat cushion. The game room chairs were observed on 07/12/21 at 12:15 PM and it was noted that 3 of 5 chairs had multiple dried stains in the fabric on the seat cushions. On 07/13/21 at 8:45 AM an observation was completed of 2 chairs located in the front lobby. Both chairs had the same multiple shades of stains on the seat cushion that were seen on 07/12/21. An observation was completed of the game room chairs on 07/13/21 at 08:45 AM and noted that 3 of 5 fabric chairs still had multiple dried stains on the seat cushions. An observation was done on 07/14/21 at 9:00 AM of the 2 chairs located in the front lobby. Both chairs had the same multiple shades of stains on	F 584	F584 1. The facility failed to clean and keep furniture in good repair for 2 of 2 chairs in the front lobby, 1 of 2 overbed tables in the lobby, 8 of 8 dining room chairs, 3 of 3 cabinet drawers in the dining room and 1 of 1 vinyl chair in the 100-unit nursing station. All stained and broken furniture were removed from the facility. 2. Maintenance Director and Housekeeping Manager audited facility to ensure that furniture was clean and in good repair. This audit was conducted on 8/6/2021. 3. Administrator educated Maintenance Director and Housekeeping Manager on ensuring that the facility furniture is clean and in good repair on 8/6/2021. All stained chairs were removed 7/21/21 Cabinet drawers in dining room were repaired on 7/21/21 New chairs were purchased by the facility on 8/11/21 Maintenance Director and Housekeeping Manager will conduct weekly audits x 12 weeks to ensure that facility furniture is clean and in good repair. Any stained furniture will be attempted to be cleaned	

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F 584	Continued From page 25 the seat cushion that were seen on 07/12/21. An observation was completed on 07/14/21 09:35 AM of a gray vinyl chair at the outer wall of the 100 Unit nursing station for residents to sit in. The chair had multiple areas of dried matter scattered throughout, both armrests had dried areas of white and brown stains, and dried brown areas was present along the seams of the chair. On 07/14/21 at 10:21 AM a resident was observed sitting in the gray chair at the nursing station and the chair had not been cleaned. Activity Assistant #1 was interviewed on 07/14/21 at 09:38 and stated the chair was used by residents to sit near the nursing station. An observation was conducted on 07/14/21 at 09:43 AM of the dining room chairs and 8 of 8 chairs observed had multiple large and small stains on the seat cushions, and 2 chairs had dark reddish brown spots on the seat cushion. The 3 drawer wooden cabinet built around the sink in the dining room was noted to have the top 2 of the 3 drawers sticking out and crooked. The handle was also missing from the middle drawer. An interview was completed on 07/14/21 at 01:12 PM with Resident #71 in the dining room. He said the dining room chairs were nasty and he would not sit in them. Resident #71 stated if he had a guest come see him, he asked them to put a towel down on the chairs. An interview was done on 07/14/21 at 09:45 AM with the Housekeeping Manager and the Corporate Training Manager about the stained and damaged furniture. They were asked	F 584	by housekeeping, if not able to be cleaned it will be discarded. 4. Data obtained during the audit process will be analyzed for effectiveness and reported to Quality Assurance and Performance Improvement by the maintenance director x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Responsible Person: Administrator	

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F 584	Continued From page 26	F 584		

about the stained chairs in the front lobby, the resident's dining room and the vinyl chair for residents at the 100 Unit nursing station. It was noted that they were aware they all had multiple stains, and the Housekeeping Manager stated the new administrator indicated he was working on replacing them. She said she was going to try a disinfectant cleaner and brushes to clean these areas but had not previously. They stated the stained furniture was not conducive with a homelike environment. The Corporate Training Manager said the gray chair at the nursing station should have been cleaned by housekeeping. The Housekeeping Manager stated they had not noticed the chair at the nursing station as being an issue and the furniture was supposed to be wiped down. Both Managers stated they had not noticed the stains in the lobby chairs.

An interview was conducted with the Infection Control (IC) nurse on 07/14/21 at 10:11 AM regarding the dirty gray chair at the 100 hall nursing station for residents. She stated she had not noticed the gray vinyl chair. She said she had voiced concerns with several other staff about the dirty chairs, and stated she would expect to have clean furniture, and this was for the dining area, the front lobby, resident rooms and in the game room area. The IC nurse was asked about the broken table. She said it would not be used for residents but was used for dirty trays, and usually it was in the front lobby outside the dietary door, as the dining room was locked after hours. She was asked about residents that were out in the lobby, and the risk for falling trays from the slanted table and she nodded head that it would be a risk. She noted that the facility was ordering a few new tables each month to replace the broken ones.

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F 584	Continued From page 27 An interview was conducted with the Director of Nursing (DON) on 07/15/21 at 11:45 AM regarding the concerns for maintaining a homelike environment. She was asked about the furniture in the dining room, the front lobby, the game room and the nursing unit that had multiple stains and discoloration and the broken bedside tables and cabinets in the dining room. She said they had been asking for new furniture and was not sure why it was an issue this year with the survey, as the furniture had been stained for years. She was asked about the red and brown spots on the dining room chairs and she stated she would expect the furniture to be clean, and if a resident urinated on the chair that they would throw it away. An interview was done on 07/15/21 at 09:49 AM with the Administrator. He stated he had been at the facility for 1 month. The Administrator said he wanted residents to have a homelike environment and feel comfortable here. He noted he had not heard direct complaints about the game room, lobby or dining room furniture but he did not like to look at it or sit on the furniture. He acknowledged he had spoke with the Regional Manager and he was hoping to get furniture from another facility. He was asked about the broken cabinet drawers in the dining room and missing handles. He stated the drawer tracks were broken and if maintenance was unable to repair it, he would see about removal.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		8/12/21

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F 641	Continued From page 28 resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, resident interviews and observations the facility failed to correctly code Minimum Data Set (MDS) assessments in the areas of bowel and bladder and (Resident #76), and range of motion (Resident #88) for 2 of 30 residents reviewed for MDS accuracy. Findings included: 1. Resident #76 was admitted to the facility on 02/08/21 with diagnoses that included cerebrovascular accident, incomplete paraplegia, pressure ulcer, pain, congestive heart failure, hypertension and coronary artery disease. The care plan for Resident #76 initiated on 02/22/21 indicated interventions for an indwelling urinary catheter. A record review of the Physician's orders for Resident #76 indicated the urinary catheter had been discontinued on 03/08/21. Resident #76's quarterly MDS assessment dated 04/05/21 coded the resident as being cognitively intact. The 04/05/21 MDS for Resident #76 was marked as having an indwelling catheter. An observation of Resident #76 was conducted on 07/12/21 at 01:15 PM. He was resting in bed and no urinary catheter was observed. An interview with Resident #76 was conducted on 07/12/21 at 01:16 PM. He stated he was receiving good care, his wounds had healed, and	F 641	F641 1. The facility failed to correctly code MDS assessments in the areas of bowel and bladder for Resident #76 and range of motion Resident #88 for 2 of 30 residents reviewed for MDS accuracy. The MDS for resident #76 was modified on 8/9/2021. The MDS for resident #88 was modified on 8/9/2021. 2. MDS will review residents that currently have an indwelling urinary catheter(foley) and residents that have splints to ensure MDS are accurate. If discrepancies are found MDS are to modify assessments. This review will be completed by 8/11/2021. 3. Regional MDS Consultant will educate MDS nurses on completing MDS assessments accurately when the resident has an indwelling urinary catheter(foley) and residents that have splints. This education will be completed by 8/11/2021. Director of Nursing will audit 5 MDS to ensure assessment accuracy when a resident has an indwelling urinary catheter(foley) and residents that have splints. This audit will be conducted weekly x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance	

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F 641	Continued From page 29 the catheter was removed several months ago. An interview was conducted with Nurse #1 on 07/15/21 at 03:29 PM regarding Resident #76. He stated Resident #75 had the urinary catheter removed a long time ago and was doing well without it. He noted he had worked consistently with him for a long time. The Corporate MDS Nurse was interviewed on 07/15/21 at 4:45 PM regarding the MDS for Resident #76. She said the MDS nurse had made a mistake when the indwelling urinary catheter was coded for Resident #76. An interview was done with the Director of Nursing (DON) on 07/15/21 at 11:45 AM regarding the accuracy of the MDS. She said she would expect the MDS to be accurate. 2). Resident #88 was admitted to the facility on 2/15/20 with a diagnosis of Non-Alzheimer's Dementia, spinal stenosis, and contracture to left and right elbows. The annual MDS assessment dated 4/23/21 indicated Resident #88 had severe cognitive impairment, required extensive to total assistance with all Activities of Daily Living (ADLs) and had functional limitation in range of motion in one upper extremity. An Activities of Daily Living (ADL) care plan dated 2/27/20 read in part; Resident #88 required extensive to total staff assistance with all ADL's related to left sided weakness and contractures in bilateral elbows. A review of an Occupational Therapy Evaluation dated 4/12/21 recorded Resident #88 as having	F 641	and Performance Improvement by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Responsible Person: Administrator.	

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F 641	Continued From page 30 contractures in both elbows and poor tolerance to minimal range of motion. An observation was completed on 7/13/21 at 4:43 PM revealed Resident #88 had both elbows contracted and was wearing hand splints. An interview was completed on 7/15/21 at 3:28 PM with the MDS coordinator who stated that she did not complete this MDS but according to the last Physical Therapy note that Resident #88 did have contractures in both elbows. An interview was completed on 7/15/21 at 3:40 PM with the Rehabilitation Director who stated that Resident #88 had contractures in both elbows. On 7/15/21 at 4:24 PM an interview was completed with the Administrator who stated that MDS assessments need to be accurate.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		8/12/21

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F 657	Continued From page 31 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and observations the facility failed to revise a urinary catheter care plan for 1 of 2 residents reviewed for urinary catheters. (Resident #76) Findings included: Resident #76 was admitted to the facility on 02/08/21 with diagnoses that included cerebrovascular accident. The care plan for Resident #76 initiated on 02/22/21 with a focus area for indwelling urinary catheter included interventions of securing the catheter, assessment for tubing kinks, infection and catheter removal, and catheter care each shift. No further care plan updates were noted. A record review of the Physician's orders for Resident #76 indicated the urinary catheter had been discontinued on 03/08/21. Resident #76's Quarterly MDS assessment dated 04/05/21 indicated the resident was cognitively	F 657	F657 1. Facility failed to revise a urinary catheter care plan for Resident #76 reviewed for urinary catheters. Care plan revised on 8/9/2021. 2. An audit was conducted for current facility residents to ensure care plans were accurate for residents with urinary catheters. This audit will be completed by 8/10/2021. 3. MDS Coordinator and interdisciplinary team will be educated by the Regional MDS Consultant regarding ensure care plans are accurate for residents with urinary catheters. This education will be completed by 9/10/2021. Regional MDS Consultant will audit 5 residents per week to ensure that care plans are accurate for residents with urinary catheters x 12 weeks. Administrator will review the results of the	

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F 657	Continued From page 32 intact. The 04/05/21 MDS assessment indicated Resident #76 had a urinary catheter. An observation of Resident #76 was conducted on 07/12/21 at 01:15 PM. He was resting in bed and no urinary catheter was observed. An interview was conducted with Nurse #1 on 07/15/21 at 03:29 PM regarding Resident #76. He stated Resident #75 had the urinary catheter removed a long time ago and was doing well without it. The facility's MDS Nurse was interviewed on 07/14/21 at 03:50 PM regarding care plan updates. She noted in the daily morning meetings if there were changes such as healed wounds or urinary catheter removal, she tried to update the care plan. She stated she would also update care plans after other meetings or quarterly reviews. The Corporate MDS Nurse was interviewed on 07/15/21 at 4:45 PM regarding the care plan for Resident #76. She said she would have expected the MDS nurse or nursing to have updated his care plan. An interview was done with the Director of Nursing (DON) on 07/15/21 at 11:45 AM regarding the revisions of care plans. She said she would expect the MDS to be accurate and the care plans to be updated.	F 657	weekly audit to ensure that care plan meetings are conducted within the required timeframes. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. Quality Assurance and Performance Improvement by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		8/12/21

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F 684	Continued From page 33 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to apply a wound vac on arrival to the facility and failed to contact Infectious Diseases physician for intravenous (IV) antimicrobial orders for 1 of 1 resident reviewed for quality of care (Resident #398). Findings included: Resident #398 was admitted to the facility on 6/18/2021 and discharged to the hospital 6/19/2021. Diagnoses for Resident #398 included hypertension and abdominal wall abscess. A. Hospital wound care documentation note dated 6/16/2021 was reviewed and the wound bed was pink, viable edges without granulation, and no tunneling was noted. A review of the hospital discharge orders dated 6/17/2021 revealed instructions for the mid-lower abdominal wound vac (a device used to assist in healing large, open wounds) to be replaced upon arrival to facility. Additionally, the admission orders for Resident #398 included an order dated 6/17/2021 to cleanse the midline abdominal wound with wound cleanser, apply black foam and white foam to the wound bed, drape to peri-wound and attach to wound vac at 125	F 684	F684 1. Facility failed to apply a wound vac on arrival to the facility and failed to contact infectious diseases physician for IV antimicrobial orders for Resident #398. Resident #398 was discharged to the hospital on 6/19/2021 and did not return to the facility. 2. An Audit was conducted by the Nurse Leadership team (Director of Nursing, Assistant Director of Nursing and Unit Managers) of the prior 30 days admission to ensure accuracy of order and supplies. This audit was completed on 8/11/2021. 3. Licensed Nurses will be re-educated on inputting admission orders and having a second nurse perform 2nd check of discharge /summary and orders by the Assistant Director of Nursing. Education included to ensure that Administrator or Nursing Leadership was notified of any supplies needed at that of admission. If supplies cannot be obtained by time resident admits to the facility, then Medical Director should be notified for alternate order. This education will be completed by 8/11/2021. Central supply will be re-educated to	

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F 684	Continued From page 34 mmHG (millimeters of mercury) suction on Monday, Wednesday, and Friday. A review of the treatment administration record for Resident #398 revealed the wound vac had not been reapplied at her admission to the facility. A nursing note dated 6/19/2021 documented Resident #398 was transferred to the hospital on 6/19/2021 by the request of the family because the wound vac had not been applied by the facility. The emergency room admission notes dated 6/19/2021 were reviewed. The note documented the mid-lower abdominal wound had tunneling (wound extended under the surface of the skin) that was not noted on the previous exam (no date). The wound care (WC) nurse was interviewed on 7/14/2021 at 11:26 AM. The WC nurse reported when Resident #398 arrived at the facility, they did not have white wound vac foam in stock, and it had to be ordered. The WC Nurse explained she could not apply the wound vac without the white foam. The WC nurse reported the Central Supply staff member ordered supplies needed for new admissions, including wound vac supplies. The WC nurse reported the Central Supply staff member told her that she had missed the order for white foam on the admission orders for Resident #398 and the white foam would be ordered on 6/18/2021. The WC nurse stated she was not working on 6/19/2021 and the wound vac was not applied to Resident #398. The WC nurse indicated she would have returned to the facility on 6/21/2021 and would have applied the wound vac on that date. The WC nurse reported	F 684	ensure new admissions have the proper supplies or any special equipment upon admission. And if supplies are unable to be obtained Central Supply with notify Nursing Leadership so that they can notify Medical Director. Nursing Leadership will review new admission orders/discharge summary/and additional supplies to ensure delivery daily for verification of 2nd nurse and accuracy of orders x 12 weeks. Nursing Leadership will monitor new admission for supply deliveries 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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F 684	Continued From page 35	F 684		

staff nurses did not apply wound vacs.

The Unit Manager (UM) #1 was interviewed on 7/14/2021 at 11:12 AM. UM #1 reported she entered the admission orders for Resident #398. UM #1 reported she was not aware Central Supply staff member had not ordered the white foam for Resident #398. UM #1 reported she had not discussed the supplies needed with the Central Supply staff member.

The Director of Nursing (DON) was interviewed on 7/14/2021 at 11:44 AM. The DON reported the Central Supply staff member had not seen the white foam on the admission orders for Resident #398 and had placed an order for the white foam on 6/18/2021 at 11:42 AM. The foam was delivered to the facility on 6/18/2021 at 11:24 PM.

The Admissions staff member was interviewed on 7/14/2021 at 1:23 PM. The Admissions staff member reported she received hospital discharge orders and emailed a copy to both unit managers and all department heads, including Central Supply. The Admission staff member reported Central Supply staff member used the discharge orders to order supplies for residents.

The Central Supply staff member was not available for interview.

The Administrator was interviewed on 7/15/2021 at 3:49 PM. The Administrator reported he was not certain how admission orders for the wound vac white foam were missed. The Administrator reported it was his expectation that all supplies for new admissions were ordered timely and in place when a resident was admitted to the facility.

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F 684	Continued From page 36	F 684		

B. A review of the hospital discharge orders dated 6/17/2021 specified the Infectious Diseases physician was to manage the IV antimicrobial (includes antibiotic, antifungal and antiviral medications) therapy. The orders included directions to contact the Infectious Diseases physician and the IV port (IV access under the skin) was to be de-accessed after antimicrobials had been completed.

A nursing note dated 6/19/2021 documented Resident #398 was transferred to the hospital on 6/19/2021 by the request of the family.

A review of the emergency room notes dated 6/19/2021 revealed Resident #398 reported the IV site had been de-accessed (removed) upon admission to the facility. The note further documented the facility had not contacted Infectious Diseases physician to continue the IV antimicrobials.
Nursing notes for Resident #398 were reviewed. There was no communication documented with the Infectious Diseases physician. The IV port was not documented in nursing notes.

The Unit Manager (UM) #1 was interviewed on 7/14/2021 at 11:12 AM. UM #1 reported she entered the admission orders for Resident #398. UM #1 reported she was not aware Resident #398 had an order to contact the Infectious Diseases physician. UM #1 reported she had not known Resident #398 had an IV port. UM #1 explained she had entered the hospital discharge orders into the electronic system prior to Resident #398 ' s admission to the facility. UM #1 reported no one reviewed the orders she entered prior to transmitting to the pharmacy.

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F 684	Continued From page 37 The Director of Nursing (DON) was interviewed on 7/14/2021 at 11:44 AM. The DON reported she was not aware Infectious Diseases physician should have been contacted to update the IV medication orders for Resident #398. The DON reported she was not aware Resident #398 ' s hospital discharge orders had IV antimicrobial medications ordered or specified the Infectious Diseases physician should be contacted to update the IV medication orders for Resident #398. The Administrator was interviewed on 7/15/2021 at 3:49 PM. The Administrator reported he was not certain why the Infectious Diseases physician was not contacted for orders for Resident #398. The Administrator reported it was his expectation that all hospital discharge orders were followed.	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to provide or arrange foot care for a resident with thick and	F 687	F687 1. Facility failed to provide or arrange	8/12/21

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F 687	Continued From page 38 long toenails (Resident #42) for 1 of 1 resident who was reviewed for foot care. The findings included: Resident #42 was admitted on 4/22/21. The resident ' s diagnoses of included left sided weakness, pain, stroke, seizures, arthritis, and anxiety. Review of a document titled, Southeast Skilled Nursing Patient Consent, dated 4/27/21, revealed the resident ' s Responsible Party, who had signed the resident in, had not checked a box to approve Podiatry/Foot Care services to include management of preventive foot care. Review of Resident #42 ' s Electronic Medical Record (EMR) revealed no documentation regarding a podiatry consult as of 7/13/21. The Minimum Data Set (MDS) admission comprehensive assessment with an Assessment Reference Date (ARD) of 4/29/21 indicated Resident #42 was cognitively intact. The resident was coded as requiring extensive assistance of one to two people for Activities of Daily Living (ADLs) or personal hygiene, including bathing. The resident was identified as having had functional limitation in range of motion to one side of her upper extremity (shoulder, elbow, wrist, hand) and no impairment on the lower extremities. The care plan for Resident #42 had a care plan description which described the resident as having an ADL self-care performance deficit related to her prolonged hospitalization, debility secondary to her hospitalization, left sided	F 687	foot care for a resident with thick and long toenails for Resident #42. Foot care was provided for Resident #42 on 7/15. 2. A foot care audit was conducted for all current residents to determine if foot care is needed. If it is determined that a resident needs to be seen by a podiatrist, the appropriate referral will be made. This audit will be conducted by 8/11/2021. 3. All nursing staff was educated regarding the expectation that residents receive the proper foot care if needed. This education was completed on 8/11/2021. Director of Nursing and/or Nurse Managers will conduct audit on current residents to ensure they ensure they are receiving proper foot care or if foot care is needed. All residents identified will be put on the podiatrist list for their next visit which is scheduled for 10/01/21. This audit will consist of 20 residents per week x 4 weeks, 15 residents per week x 4 weeks, and 10 residents per week x 4 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of	

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F 687	Continued From page 39	F 687	Nursing	

weakness, right knee pain, and left-hand impaired Range of Motion (ROM). There was a care plan goal for the resident to demonstrate improvement in her ADL self-care ability and return to baseline physical functioning. The care plan was dated 5/11/21.

Review of Resident #42 ' s Electronic Medical Record (EMR) revealed a nurse ' s progress note written by Unit Manager #1, dated 5/17/21 and timed 5:33 PM, which documented the resident was seen by the Nurse Practitioner (NP); a new order for Ciclopirox to her toe nails every evening at bedtime for 48 weeks and to wash her toenails with alcohol weekly. The resident ' s Responsible Party was made aware of the new orders.

Resident #42 ' s physician ' s orders were reviewed, and an order was discovered dated 5/17/21 for Ciclopirox 8%, a topical treatment, apply to the toenails every bedtime for 48 weeks for nail fungus.

Review of Resident #42 ' s EMR revealed a nurse ' s progress note dated 5/29/21 and timed 3:40 PM which documented the resident had no new areas to her skin and the resident received anti-fungal cream to her toes.

An observation was conducted in conjunction with an interview with Resident #42 on 7/12/21 at 12:29 PM. Resident #15 was resting in bed. During the resident interview the resident pulled back the sheet at the foot of the bed and exposed her feet. The resident stated she was worried her toenails would catch on the sheet, or be caught, and pull on the toenails which would be uncomfortable, or her toenails may pull off. The resident ' s bilateral big toenails were thick, long,

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and discolored yellow. The free edge of the big toenail on the left foot was observed to extend significantly beyond nail bed and the tip of the toe and the nail was curved, hooking back toward the tip of the toe. The resident ' s other four toenails had some visible evidence of thickening of the nails but were not as long as the big toe. On the right foot all of the free edges of nails were observed to have been thick and extended beyond the tip of the toe and the nail bed and were curling back toward the tip of the toes, in a hook manner. The resident stated no one had trimmed her toenails the whole time she had been at the facility, and she would not be able to see the podiatrist for another two months.

An observation was conducted of Resident #42 on 7/14/21 at 9:29 AM and the appearance of her toenails was unchanged from the observation on 7/12/21.

During an interview conducted on 7/14/21 at 9:31 AM with Nurse #2 she stated she was assigned to Resident #42 and she was not aware of when the podiatrist had come to the facility, how often the podiatrist came to the facility, when the podiatrist would come to the facility again, if the podiatrist had seen Resident #42, or if the podiatrist would see Resident #42. She further stated she was aware the resident was receiving a fungal treatment to her toenails but was not aware of any concerns regarding her toenails.

An interview was conducted on 7/14/21 at 9:40 AM with the Nurse Practitioner (NP). The NP stated she had observed Resident #42 ' s toenails and they were very long, and she would be unable to trim or cut them. She stated the resident needed to be seen by a podiatrist

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because the resident ' s toenails were so long, and so thick, an electric mini rotary tool would most likely be needed to cut or trim the resident ' s toenails back so they would be more of a manageable length and there would not be a risk of the nail catching on something and pulling the nail off. She stated she had just started seeing the resident and had not ordered the Ciclopirox, the topical antifungal treatment.

The facility Social Worker (SW) was interviewed on 7/14/21 at 11:03 AM and during the interview she stated she coordinated the podiatrist visit to the facility and what residents the podiatrist saw when he visited the facility. The SW stated the podiatrist had come to the building on 5/10/21 and would return to the facility in August. The SW reviewed a list of residents the podiatrist had seen and confirmed Resident #42 had not been seen by the podiatrist. She explained the residents the podiatrist saw were determined by a list which was assembled by nursing. She said Resident #42 may have refused to be seen by the podiatrist, but she was unaware of any refusals.

During an interview conducted on 7/14/21 at 11:53 AM Unit Manager #2 stated she was unaware of Resident #42 having expressed concern regarding her toes or toenails. She said she was aware the resident was receiving some kind of treatment for a fungal infection to her toes.

An interview was conducted Unit Manager #2 on 7/14/21 at 11:35 AM in conjunction with an observation of Resident #42. A measurement of the resident ' s left foot big toe nail revealed a measurement of the nail being 9 millimeters beyond the nail bed and the toenail was curved in a hook manner wrapping back towards the end of

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the big toe. She stated due to the length of the toe nail, the thickness of the toe nail, the condition of the toe nail, and the resident ' s concern that it may catch on something and tear off, the resident needed to see a podiatrist. She said the resident ' s left foot big toe was the most serious of all of the toes, but there was one more toenail on the left foot which needed attention as well and the right foot big toenail, and three other toenails on the right foot. She said even though some toenails looked better than others, they probably all needed some attention from the podiatrist. She said the resident had not been seen by the podiatrist when he was in the facility in May because the podiatry consent form had not been signed by the responsible party. She stated that due to the condition of the resident ' s toenails and her concern her toenail may be torn off she would arrange a podiatry appointment for the resident. The Unit Manager further explained she did not know how come an appointment with a podiatrist had not been set up for the resident because they would have been unable to manage trimming the resident ' s toenails at the facility due to their condition. She said the nurses completed weekly skin assessments on all of the residents, but there was nothing documented regarding the condition of Resident #42 ' s toenails and the need to address their condition. She said the nurses, nor the Nursing Assistants (NAs) had made her aware of the condition of the resident ' s toenails, or they were unable to trim them, and she needed to see the podiatrist to have her toenails trimmed.

During an interview conducted on 7/14/21 at 12:26 PM with the Administrator he stated Resident #42 ' s Responsible Party had not elected for podiatry services for as part of the

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admission paperwork process therefore the resident could not receive the services of the podiatrist contracted by the facility. The Administrator did not provide information as to how come alternate podiatry services were not provided for the resident or if there were systems in place to follow up on residents who elected not to receive the services of the contracted podiatrist.

During an interview conducted on 7/15/21 at 11:57 AM with the Director of Nursing (DON) she said if Resident #42 had wanted something done with her toenails, she could have asked to see a podiatrist to have her toenails trimmed. The DON stated the condition of the resident ' s toenails should have been picked up on the admission skin assessment, but she did not know if it would have been picked up on the weekly skin assessment if it were not a new issue. The DON did not provide information as to how come alternate podiatry services were not considered for the resident or if there was a plan to follow up with the responsible party to discuss reconsidering the contracted podiatrist to see the resident due to the condition of her toenails.

An interview was conducted with the Administrator on 7/15/21 at 4:16 PM and he stated the resident was not seen by the in-house podiatrist because the responsible party had not consented to their podiatrist as part of the admission paperwork. He further stated, he felt the resident ' s need for toenail care should have been followed up on.

The resident ' s responsible party who signed the admission paperwork was not available for interview.

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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 by: Based on record reviews, and staff interviews, the facility failed to administer 2 doses of a prescribed IV antibiotic (metronidazole) for 1 of 1 resident reviewed for IV orders (Resident #398). Findings included: Resident #398 was admitted to the facility on 6/18/2021 and discharged to the hospital 6/19/2021. Diagnoses for Resident #398 included hypertension and abdominal wall abscess. A review of the hospital discharge note dated 6/17/2021 ordered metronidazole (antibiotic) 500 milligrams IV every 8 hours, stop date 6/21/2021. The orders included directions to contact the Infectious Diseases physician for further orders as well as direction for the IV port (IV access under the skin for long-term IV access) to be de-accessed after antimicrobials (includes antibiotic, antifungal and antiviral medications) had been completed. A nursing note dated 6/19/2021 documented Resident #398 was transferred to the hospital on 6/19/2021 by the request of the family. Nursing notes for Resident #398 were reviewed. There was no communication documented with the Infectious Diseases physician and the IV port was not documented in nursing notes.	F 760	F760 1. Facility failed to administer 2 doses of a prescribed IV antibiotic (metronidazole) for Resident #398 reviewed for IV orders. Resident #398 no longer resides at the facility. 2. An Audit was conducted by the Nurse Leadership team (Director of Nursing, Assistant Director of Nursing and Unit Managers) of current facility residents on IV medications to ensure no missed doses. This audit completed 8/11/2021 with no additional concerns. All residents have the potential to be affected. 3. Licensed Nurses will be re-educated on transcribing admission orders and having a second nurse perform 2nd check of discharge /summary and orders by the Assistant Director of Nursing. This education will be completed by 8/11/2021. Nursing Leadership will review new admission orders/discharge summary daily for verification of 2nd nurse and accuracy of orders x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement by the	8/12/21

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F 760	Continued From page 45 The facility admission orders dated 6/18/2021 did not include metronidazole 500 milligrams IV every 8 hours. A review of the emergency room notes dated 6/19/2021 revealed Resident #398 reported the IV site had been de-accessed (removed) upon admission to the facility. The note documented Resident #398 had blood cultures on 6/7/2021 that were positive for Bacteroides fragilis (a bacterial infection requiring metronidazole for treatment). The note further documented the facility had not administered metronidazole 500 milligrams every 8 hours. The Unit Manager (UM) #1 was interviewed on 7/14/2021 at 11:12 AM. UM #1 reported she entered the admission orders for Resident #398. UM #1 reported she was not aware Resident #398 had an IV or orders for antimicrobial therapy. UM #1 reported she had entered the hospital discharge orders into the electronic system prior to Resident #398 ' s admission to the facility. UM #1 reported no one reviewed the orders she entered prior to transmitting to the pharmacy. The Director of Nursing (DON) was interviewed on 7/14/2021 at 11:44 AM. The DON reported she was not aware Resident #398 hospital discharge orders included IV antimicrobial medications to be administered at the facility. The Administrator was interviewed on 7/15/2021 at 3:49 PM. The Administrator reported he was not certain how the admission orders for the IV antimicrobial medication were missed for Resident #398. The Administrator reported it was his expectation that all hospital discharge orders	F 760	Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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F 760	Continued From page 46 were followed.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations the facility failed to clean 40 of 40 plastic ceiling light covers, 1 of 1 microwave oven, 8 of 8 oven knobs and 1 of 1 fryer, and failed to label items in the dry storage room, walk-in refrigerator and the walk-in freezer, and stored 5 of 5 frozen food boxes on the freezer floor. These practices had the potential to affect food served to residents. Findings included: 1. a. An initial tour of the kitchen was conducted	F 812	F812 1. Facility failed to clean plastic light bulb covers, a microwave, oven doorknobs and fryer. Facility also failed to label items in the dry storage room, walk-in refrigerator and the walk-in freezer, and stored frozen food boxes on the freezer floor. Labels were corrected on 7/13/2021, microwave was cleaned on the 7/13/2021, light bulb covers were ordered on 7/13/2021 and have been installed on 8/11/2021, assistant dietary director audited the walk-in refrigerator and walk-in freezer to	8/12/21

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F 812	Continued From page 47 on 07/12/21 at 9:35 AM with the Assistant Dietary Manager (ADM). An observation was done of the white plastic tubes that covered each of the 40 ceiling lights. It was noted that 40 of the 40 ceiling plastic light covers between the stoves and the steam tables had scattered black speckled areas on the surface and some sections on the tubes were yellow. The gas stove had 2 missing knobs and 8 of the 8 existing knobs had grime, black areas and grease on them. The microwave had multiple food splatters inside on all sides and the top. The burners contained numerous crumbs and burnt uncooked macaroni. The grease fryer was off and had multiple dried pieces of dime to quarter size fried food particles along the edges of the fryer and in the 2 fry baskets. An interview was done with Cook #1 on 07/12/21 at 09:55 AM regarding the oven knobs, dirty burners, fryer and microwave. He stated the cook from the evening shift if responsible to clean the microwave and stove after dinner was prepared daily. Dietary aide #1 was interviewed on 07/15/21 at 12:00 PM and stated the microwave was cleaned every morning, and the 1st shift cook and 2nd shift cook were to clean the microwave after the cooking was done. An interview with the Assistant Dietary Manager (ADM) was completed on 7/12/21 at 9:55 AM. She stated that she had been in the role for 4 weeks. The assistant manager acknowledged the yellowed film and black speckled spots on the plastic light covers, the grease and grime on the stove knobs, the dirty burners and microwave. She stated she was not sure when the fryer was used last or the cleaning protocol, but it was not used for breakfast and should have been	F 812	ensure no boxes were stored on the floor. 2. An audit conducted by the Dietary Manager and/or Maintenance Director to ensure there were no other dirty area/equipment in the kitchen, items were labeled and dated in the dry storage room, walk-in refrigerator, walk-in freezer and also to ensure there are no boxes stored on the freezer floor. This audit conducted on 8/9/2021. 3. Dietary staff were educated on ensuring that the kitchen area and equipment are kept clean, items are to be labeled and dated in the dry storage; walk-in refrigerator, walk-in freezer are not to have boxes stored on the floor. Education completed by 8/11/2021. Dietary Manager and/or Asst. Dietary Manager will conduct and an audit to ensure that the kitchen area is kept clean, items labeled and dated in the dry storage; walk-in refrigerator, walk-in freezer are not to have boxes stored on the floor. This audit will be conducted 5x per week x 4 weeks, 3x per week x 4 weeks and weekly x 4 weeks. Administrator will review the results of the weekly audits to ensure that the kitchen area is kept clean, items labeled and dated in the dry storage, walk-in refrigerator, walk-in freezer and that boxes are not stored on the freezer floor. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement by the	

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	345183	A. BUILDING _____ B. WING _____	C 07/15/2021

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F 812	Continued From page 48 cleaned. The Assistant Dietary Manager stated she was not aware of the cleaning process for the light covers or the microwave. The ADM stated they cleaned the burners daily and had a degreaser they sprayed on everything. She said they tried to clean the knobs on the stove every other week. An interview with the Maintenance Director was done on 07/15/21 at 2:07 PM about the plastic light covers in the kitchen ceiling. He stated he stated he only cleaned the plastic tubes when dietary requested, and it had been two years since they had requested it. He said normally, the best thing to do was to replace the tubes because they were difficult to clean. An interview was done on 07/15/21 at 09:49 AM with the Administrator regarding Dietary Services. He stated he had been in the role for 1 month. He noted the kitchen had been in rough shape and he had a new Certified Dietary Manager starting the following Monday. He said he had high expectations for the kitchen and would work with the staff to ensure equipment and the plastic light covers were cleaned. b. An initial visit to the kitchen was done on 07/12/21 at 09:35 AM. The facility failed to label the following items on the package or the containers they were stored in during inspection of the: Dry storage area -Approximately 100 small cups per the ADM of breakfast syrup in a clear open plastic container with an opened date on the label of 06/18/21 and no discard date -Approximately 100 blue cheese dressing packets per the ADM that were outdated according to the	F 812	Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Dietary Manager and Asst. Dietary Manager	

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discard date label on the clear open container of 06/05/21
-Approximately 150 packets per the ADM of individual jelly containers in a clear open container that had an opened date of 7/2/21, no discard date was listed.
- Approximately 26 packs per the ADM of peanut butter crackers in an open plastic container with a prepared date of 06/08/21 and a use by date of 07/02/21 on the plastic bin
-Approximately 20 packets per the ADM of pre-packaged sugar-free shortbread cookies, with a prepared date label of 7/2/21 and no expiration date

Refrigerator/Freezer
-A 48 oz plastic container of nectar thickened iced tea with an opened date of 07/06/21
-A sealed plastic zip bag with potato salad-no prepared date or discard date
-1 Gallon of Creamy Caesar dressing opened 6/26/21 with no discard date
-2 tossed salads in small bowls covered with plastic without dates
-Opened package of American cheese 100 slices without an opened date or discard date

Freezer
-1 Loaf of garlic bread on shelf in a clear bag with ice particles on the bread, without opened or discard dates
-Approximately 50 dinner rolls per the ADM in tray packs in an open box with no open or discard date
-2 unopened whipped toppings bags that were loose in freezer with no expiration dates on bags

An interview was conducted with the Assistant Dietary Manager on 07/12/21 at 10:15 AM. She

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was asked if they had a policy or procedure for labeling items and she was not aware of one.

An interview was conducted with the Assistant Dietary Manager on 07/12/21 at 10:20 AM regarding the pre-packaged items in the dry storage area without a discard label. She stated these items should have an opened and discard date on the clear plastic containers. She was asked how long the individual jelly packets should be in the clear container in the dry storage area and she stated, "she was not sure how long they were good for."

An interview was done on 07/15/21 at 09:49 AM with the Administrator regarding Dietary Services. He stated he had been in the role for 1 month. He noted the kitchen had been in rough shape previously and he had a new Certified Dietary Manager starting the following Monday.

c. On the initial tour on 07/12/21 at 09:35 AM, 5 cardboard boxes of frozen food were stored directly on the freezer floor.

An interview was done with the Assistant Dietary Manager (ADM) on 07/12/21 and she said she was not aware that the boxes should not be stored directly on the floor. She acknowledged these were not items that had recently been delivered.

An interview was done on 07/15/21 at 09:49 AM with the Administrator regarding Dietary Services. He stated he had been in the role for 1 month. He noted the kitchen had been in rough shape and he had a new Certified Dietary Manager starting the following Monday. He said he had high expectations for the kitchen, and they were

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F 812	Continued From page 51 doing better. He noted he would work more with them on the cleaning, and removing the cardboard boxes from the dry storage area and throughout the dietary department on the floor.	F 812		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to maintain an effective pest control program as evidenced by multiple flies observed in one of one resident room reviewed for pest control (room B234). Findings included: Review of an exterminator record of treatments provided for pests on 5/26/21 revealed no record of room B234 having been treated for flies. An observation was conducted of room B234 on 7/12/21 at 9:50 AM. An observation of the bathroom revealed 31 small flies on the walls and ceiling of the bathroom which were crawling and flying. Further observation revealed a bath basin on the floor behind the toilet with a brown liquid in it and it had an additional 12 small flies which were not observed moving. An observation was conducted of room B234 on 7/13/21 at 9:33 AM. An observation of the bathroom revealed 5 small flies on the walls and ceiling of the bathroom which were crawling and flying.	F 925	F925 1. The facility failed to maintain an effective pest control program as evidenced by multiple flies observed in Resident #234 room. Pest control company was contacted on 7/14/2021 and made an onsite visit to treat for flies on 7/15/2021. 2. An audit was conducted of all resident rooms to ensure multiple flies are not present. This audit was conducted by the Maintenance Director by 8/10/2021. Any issues will be addressed by having housekeeping clean the room thoroughly and called ecolab(contracted pest control service) to treat the room. 3. Administrator educated the Maintenance Director of the expectation that the facility remains free from flies and that the Maintenance Director is to call the pest control company between scheduled visits should the flies reappear. Nursing staff and housekeeping will be educated on contacting the maintenance director or	8/12/21

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F 925	Continued From page 52 An observation was conducted of room B234 on 7/13/21 at 4:34 PM. An observation of the bathroom revealed 10 small flies on the walls and ceiling of the bathroom which were crawling and flying. Further observation revealed 6 small flies in the resident ' s room on the walls and ceiling which were crawling and flying. An observation was conducted on 7/14/21, at 8:53 AM, of room B234 in conjunction with an interview with the resident who resided in room 234 B. The observation of the bathroom revealed 14 small flies on the walls and ceiling of the bathroom which were crawling and flying. The resident stated the flies had been in his bathroom for a while and he didn ' t know where they were coming from. During an interview with Nursing Assistant (NA) #1 on 7/14/21 at 9:02 AM she stated there were a lot of flies in the room B234 and in the bathroom of room B234. She further stated she would not report the flies in the room and in the bathroom because she thought the facility should be aware of the flies. An observation was conducted of the hallway wall outside of room B234 on 7/14/21 at 9:14 AM. The observation revealed a small fly above the door of room B234. Multiple other residents were observed in the hallway during the time of the observation. An interview with Housekeeper #1 was conducted was conducted in conjunction with an observation of the bathroom and of room B234 on 7/14/21 at 9:18 AM. The observation revealed multiple flies both in the resident room, resident bathroom, and	F 925	administrator in the event flies are found during non-business hours. The maintenance director and administrator are on call during all non-business hours and are to be contacted if flies are noted to be in a specific room or rooms. Maintenance Director will conduct audits of resident rooms to ensure there are not multiple flies in rooms. This audit be conducted weekly and will consist of 20 resident rooms x 4 weeks, 15 resident rooms x 4 weeks and 10 resident rooms x 4 weeks. Administrator will review the results of the weekly audit to ensure the facility remains free from flies. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Maintenance Director	

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out in the hallway on the wall near the resident ' s room. The housekeeper stated he saw a lot of flies in the bathroom in room B234. He said he would use his routine housekeeping cleaners to clean the bathroom each day, but the flies were consistently in the bathroom and room. He explained no matter what he seemed to do in the room and in the bathroom, nothing would help with the flies. He said the facility did contract with an exterminator, but he hadn't seen the resident ' s room nor bathroom sprayed recently.

An interview with the Maintenance Director was conducted was conducted in conjunction with an observation of the bathroom and of room B234 on 7/14/21 at 11:47 AM. The observation revealed multiple flies both in the resident room, resident bathroom, and out in the hallway on the wall near the resident ' s room. He stated he had been informed by the exterminator the observed flies were fruit flies and rooms B227 and B220 had been treated for the flies, but he was unaware of there having been flies in room B234. He stated he was not aware of room B234 having been treated by the exterminator for flies.

An interview with the exterminator was conducted was conducted in conjunction with an observation of the bathroom and of room of B234 on 7/15/21 at 1:37 PM. The observation revealed multiple flies both in the resident room, resident bathroom, and out in the hallway on the wall near the resident's room. The exterminator stated the observed flies were fruit flies and he believed they were coming from the drain in the bathroom, and he had treated the drain. He stated due to the large number of flies observed in the bathroom, the source would definitely have been something in the bathroom. He said the source of the flies

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F 925	Continued From page 54 could have been almost anything organic which went down the drain or was in the room which the fruit flies would feed on. He further explained, it did not have to be just fruit for the fruit flies to feed on. He said there was no record of having treated room B234. An interview was conducted with the administrator on 7/15/21 at 4:16 PM. The Administrator stated it insect issues needed to be communicated so the exterminator could come to the facility and address the issue.	F 925		