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	345128	A. BUILDING _____ B. WING _____	C 09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

(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 survey was conducted on 08/30/21 through 09/03/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: PRSH11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 08/30/21 through 09/30/21. Event ID: PSHR11. There were 43 complaint allegations and 17 were substantiated.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		10/15/21

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

Electronically Signed | 09/30/2021

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and Resident interviews the facility failed to respect a Resident's individuality and provide a clean gown to wear as the Resident had become accustomed (Resident #4). The facility also failed to have clean clothes available for a Resident (Resident #57) for 2 of 3 residents reviewed for dignity. The finding including: 1. Resident #4 was admitted to the facility on 04/14/16 with diagnoses that included cerebral vascular accident with right hemiplegia. The quarterly Minimum Data Set (MDS) dated 07/25/21 revealed Resident #4's cognition was moderately intact and had the ability to understand others as well as could make himself understood. The MDS also revealed the Resident required extensive assistance with the help of two staff for bed mobility and dressing.	F 550	F550 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How corrective action will be accomplished for those residents found to have been affected by the deficient practice;	

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On 09/01/21 at 9:38 AM an observation and interview were made of Resident #4 while he was in bed. The Resident only wore a brief. Resident #4 reported that for four nights in a row he had to sleep without a gown on because the staff told him that the facility did not have any gowns clean. The Resident stated that he was not accustomed to sleeping partially naked and had worn the facility's gowns since he was admitted to the facility five years ago.

An interview was conducted with Nurse Aide #1 on 09/01/21 at 4:00 PM. The NA confirmed she worked with Resident #4 on 08/30/21 and 08/31/21 on the evening shift and put the Resident to bed on those nights. The NA explained that she searched all the linen carts and the facility was out of clean gowns for both nights. The NA continued to explain that on the night of 08/30/21 she put Resident #4's shirt on him and thought she had found a gown later in the shift and put the gown on Resident #4.

During a follow up interview with Resident #4 on 09/01/21 at 4:46 PM the Resident explained that the facility has not had clean gowns to wear for at least four nights in a row. The Resident stated he slept in his day shirt on the night of 08/30/21 because he was told that there were no gowns clean for the residents to wear. The Resident explained that he did not like to wear his clothes to bed and preferred to wear the facility gowns for which he was accustomed to wearing.

Attempts were made to interview Nurse Aides who worked the evening shift on 08/29/21 and 08/28/21 but the attempts were unsuccessful.

The facility failed to respect resident #4 individuality and provide a clean gown to wear as the Resident had become accustomed to.

Resident #4 was provided a clean gown on 9/2/2021

The facility also failed to have clean clothes available for resident #57.

Resident #57 was provided with clean clothes on 9/2/2021

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Effective 9/30/2021, Housekeeping Manager reviewed par level of gowns to ensure gowns were available to residents. Effective 9/30/2021, Housekeeping Manager reviewed laundry room to ensure residents clothes were cleaned and distributed to current residents.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/27/2021 the Housekeeping Manager and/or designee will educate the current laundry staff on maintaining clean gowns to be readily available for residents. In person and/or via phone.

Effective 9/27/2021 Director of Nursing and/or designee will educate the nursing

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An interview was conducted with the Director of Nursing on 09/02/21 at 3:31 PM. The DON explained that it was unacceptable for gowns to not be readily available for the residents to wear if they chose to use them.

During an interview with the Administrator on 09/03/21 at 3:54 PM she indicated that it was her expectation that the facility have clean gowns available for the residents to be able to sleep in facility gowns if they desired.

2. Resident #57 was readmitted to the facility on 12/07/20.

Review of the comprehensive Minimum Data Set (MDS) dated 08/01/21 revealed that Resident #57 was cognitively intact and required extensive assistance of 2 staff members with dressing. The MDS further revealed that Resident #57 had impairments to bilateral lower extremities.

An observation and interview were conducted with Resident #57 on 09/02/21 at 12:36 PM. Resident #57 was up in his wheelchair propelling himself around the facility telling staff that he had no pants to put on. He was observed to have 2 bilateral lower extremity amputations and was dressed in a black t-shirt with both of his stumps exposed as was the brief he was wearing. Resident #57 was concerned that he had a doctors appointment on 09/03/21 and he had no pants to wear and stated, "I cannot go like this." With Resident #57's permission his closet was observed for personal clothes, there were 5 t-shirts and 2 long sleeve jackets but no shorts or pants for Resident #57 to put on. Resident #57 indicated he could not go to the doctor's office with no pants and that would be so embarrassing

staff on where to find clean gowns and if gowns are not available on the clean linen carts to speak with laundry staff to provide clean gowns on linen carts.

Effective 9/27/2021 the Housekeeping Manager and/or designee will educate the current laundry staff on maintaining clean clothes to be readily available for residents. In person and/or via phone.

Effective 9/27/2021 Director of Nursing and/or designee will educate the nursing staff speak with laundry staff to provide clean clothes for residents if none are available.

Effective 10/1/2021 any nursing staff that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee.

Effective 9/27/2021 all housekeeping staff and nursing staff including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on "maintaining clean gowns to be readily available for residents, where to find clean gowns and if gowns are not available on the clean linen carts to speak with laundry staff to provide clean gowns on linen carts, and maintaining clean clothes to be readily available for residents.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

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for him.

An observation of Resident #57 was made on 09/02/21 at 4:45 PM. Resident #57 continued to propel himself around the facility asking staff for something to cover up with. Again, Resident #57 was dressed in a black t-shirt and had nothing on his lower extremities. Both of his above knee amputations were visible as was the brief he wore. Nurse #1 and Nurse Aide (NA) # 3 were stopped and asked to assist Resident #57 with no response. The linen carts were observed to have no sheets or towels only washcloths which was not big enough to cover Resident #57's lower body.

Nurse #1 was interviewed on 09/02/21 at 4:50 PM. Nurse #1 confirmed that she had heard Resident #57 requesting something to cover up with but stated she was busy with a medication pass and could not stop what she was doing to get him something to cover with. Nurse #1 added she had planned on assisting Resident #57 when she had the time, at which point Nurse #1 left the medication cart and proceed to the laundry room and obtained a sheet to cover Resident #57's lower extremities with.

Nurse Aide (NA) #3 was interviewed on 09/02/21 at 5:00 PM. NA #3 stated that Resident #57 was always rolling around asking for things and she had heard him but had not really paid attention to what he was requesting. NA #3 stated she had not noted that he did not have any pants or shorts on and that if she had she would have gotten him something to cover up with. NA #3 stated she did not know anything about why Resident #57 did not have any clothes to put on and that would be a laundry issue.

Housekeeping Manager and/or designee will review laundry room and clean linen carts to ensure par levels of gowns are correct and readily available for residents 2 X daily X 12 weeks.

Housekeeping Manager and/or designee will interview 10 residents to ensure residents clothes are clean and available weekly X 12 weeks.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X3 for further problem resolution if needed. Administator will review the results of weekly audits to ensure any issues identified are corrected.

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The Environmental Service Director (EVS) was interviewed on 08/31/21 at 2:48 PM. The EVS Director confirmed that he was also responsible for the laundry department. The EVS Director stated that a couple of weeks ago they had an issue in the laundry room where the laundry drainage overflowed and flooded the laundry room and for several days in a row, they were unable to do personal laundry and they have been unable to catch up with the personal laundry since then. He continued to explain that he only had one full time laundry personnel and that just was not enough to get them caught up from the weekend when they could not wash clothes. The EVS Director stated that he had a large container right now in the laundry room of personal items that were dirty and needed to be washed and he was doing the best he could to get it washed and returned to the residents. He added that several residents had been to the laundry department and asked about their clothes and he stated he kept telling them that he was working on getting them back to them as soon as possible.

The Regional Director of EVS was interviewed on 09/03/21 at 12:47 PM and explained that approximately 4 months ago they "just lost staff" and they have been recruiting on every level since then to get staff in the building. He explained that they currently only had 1 full time laundry personnel and they attempted to cross train all the employees in the laundry department. He further explained that he had a plan that he just put into place to address the personal laundry and distribution of the laundry and that plan included hiring another full-time laundry personnel.

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F 550	Continued From page 6 The Director of Nursing (DON) was interviewed on 09/03/21 at 11:52 AM. The DON stated that they had talked to the Regional Director of EVS, and they quickly recognized that the laundry department did not have adequate staff and called another building and got someone to help in the laundry department in the facility on 09/03/21. She explained that several weeks ago the laundry department had flooded and for a few days and they were unable to do laundry and they had gotten behind and had not been able to get caught up yet. The DON stated that if a resident requested something to cover up with that it should be provided per the resident choice and for privacy issues as well. The Administrator was interviewed on 09/03/21 at 4:33 PM. The Administrator stated she had only been at the facility for a week and had not had time to gauge the laundry issue but would certainly look into how and why they were behind.	F 550		
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	F 565		10/15/21

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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 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 review, resident and staff interview the facility failed to demonstrate their response to group grievances filed during 3 of 5 resident council meetings (May 2021, June 2021, and July 2021).

The findings included:

Review of the Grievance Policy dated 10/28/20 read in part, The Administrator or Social Services Director has been designated as the Grievance Coordinator (GC) for the facility. "The GC is the gatekeeper for the grievance process. Upon receiving a grievance, the GC will log the grievance on the Grievance Tracking Log and place the original in the Grievance Binder. The GC will begin an investigation of the allegations,

F565

It was identified that group grievances were not followed up on.

The administrator will review May, June and July of 2021 resident council minutes for any unresolved grievances. Any unresolved grievances will be brought to the attention of the department heads for a prompt resolution. Resolutions will be reviewed in next resident council meeting.

Education was done on 9/23/2021 by the Administrator to the department heads on providing a written timely response to the Activity Director for review at next resident

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maintaining the confidentiality necessary to conduct a non-biased investigation. Department Managers must be notified of specific allegations related to their respective departments so an investigation can be conducted, and a response prepared. The GC is accountable for managing the grievance process from submission of the grievance through its conclusion, including a written response to the resident and/or responsible party."

Review of the resident council meeting note dated 05/25/21 read in part, new business: rooms not getting cleaned routinely and bathrooms not getting cleaned unless requested. Clothes not being returned. The resident council meeting notes were signed by the Resident Council President (RCP).

Review of the follow up to the 05/25/21 resident council meeting revealed no follow up to the concerns that resident rooms were not being cleaned and bathrooms were not being cleaned unless requested. There was also no follow up for the concern that clothes were not being returned to the residents.

Review of the resident council meeting note dated 06/29/21 read in part, new business: laundry is not being returned to the residents. The resident council meeting notes were signed by the RCP.

Review of the follow up to the 06/29/21 resident council meeting revealed no follow up to the concern that residents' clothes were not being returned to them.

Review of the resident council meeting note

council meeting.

Effective 9/28/2021 Activity Director will write up any concerns from the resident council on a follow up form and give to the appropriate departments for a response. Administrator will follow-up with the department heads before the next resident council meetings to ensure concerns are being addressed on the follow-up.

Monitoring will be done by Administrator or designee to ensure group grievances are resolved. Monitoring will occur monthly x 3 months.

Results of monitoring, with tracking and trending, will be reported by Administrator to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.

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dated 07/27/21 read in part, current business: laundry not returning resident clothes to them. The Resident Council meeting notes were signed by the RCP.

Review of the follow up to the 07/27/21 resident council meeting read in part, we are trying to locate the items and laundry has some staffing issues we are working on thank you for your patience.

The Environment Service Director (EVS) was interviewed on 08/31/21 at 2:48 PM. The EVS director stated the had worked at the facility for over a year but was very recently promoted to director. He stated that he had several residents come to the laundry department looking for missing clothes and due to the laundry department being so short staffed a lot of what the resident were missing were dirty and needed to be washed and he would just ask the residents to be patient while they tried to get everything caught up. The EVS director stated that he did not recall being involved with the resident council meeting since he had been promoted to supervisor but stated he knew that the residents had concerns with their clothes not being returned to them.

The RCP was interviewed on 09/02/21 at 11:00 AM and reported that the council had been reporting for over a year that they had not been getting their personal clothes back from the laundry department and had never received any follow up on the issue. She stated that she had 34 pair of shorts in her possession, and she had run out of them, so she had to wear her winter clothes in the heat of the summer because all her shorts were in the laundry. The RCP also stated

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F 565	Continued From page 10 that if the department manager had any follow up to provide to the council it was discussed in the next meeting but added the only follow up, they regularly received was from the dietary department. The Administrator was interviewed on 09/03/21 at 3:58 PM. The Administrator stated that the concerns that were voiced in resident council should be written up and given to the department head for follow up and if no follow up was provided then the Administrator should be addressing that with the individual department head. The Administrator stated that she had only been at the facility for one week and had not yet been involved in resident council process yet but would be looking into the lack of follow up to the resident council concerns.	F 565		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit	F 567		10/15/21

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any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on facility staff and resident interviews, the facility failed to provide access to resident fund accounts after 5:00 PM on weekdays and on weekends for 2 of 2 residents reviewed for management of personal funds (Resident #6 and Resident #43).

The Findings Included:

1a. Resident #6 was admitted to the facility on 09/02/17. A review of Resident #6's most recent quarterly Minimum Data Set Assessment dated 08/29/21 revealed Resident #6 to be cognitively intact for daily decision making.

During an interview with Resident #6 on 09/01/21

F567

Resident #6 on 9/01/21 was only allowed to withdraw money from her personal fund account on Tuesdays.
Resident #43 on 9/01/21 reported only allowed to take money from his personal fund account on Tuesdays.

Banking hours posted in front lobby. Funds are available for withdrawal Monday – Friday and on the weekend. Weekend receptionist or designee will have access to the fund box for funds requested on the weekend.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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at 3:43 PM, she reported she was only allowed to withdraw money from her personal fund account on Tuesdays.

b. Resident #43 was admitted to the facility on 06/14/17. A review of Resident #43's most recent quarterly Minimum Data Set Assessment dated 07/25/21 revealed Resident #43 to be moderately impaired for daily decision making.

During an interview with Resident #43 on 09/01/21 at 3:47 PM, he reported he was only allowed to take money from his personal fund account on Tuesdays when the facility staff went to purchase cigarettes for him.

During an initial interview with the Administrator on 09/02/21 at 11:53 AM, she reported the facility did not currently have a full time Business Office Director but rather was utilizing their Receptionist and a corporate staff member who worked remotely from out of town to handle the business office tasks. She reported it would be the responsibility of the Receptionist to withdraw resident funds.

During an interview with the Receptionist on 09/02/21 at 11:58 AM, she stated most of the personal fund disbursements occurred on Tuesdays when residents who smoke were provided funds to purchase cigarettes. She stated she tries "to head off" any requests that may occur on weekends as it would be difficult for weekend and after-hours staff to gain access to the petty cash box. She reported only three staff members had a key to the petty cash lockbox: the Administrator, Maintenance Director, and herself. She reported she had "recently" been informed that residents should be able to withdraw funds at

Education done on 9/23/2021 with receptionists and ABOM that funds are available to residents during banking hours and when requested.

Administrator or designee will interview five (5) random residents for funds availability to ensure residents are receiving their funds when requested. Monitoring will be completed 5 times weekly for 4 weeks, then weekly x 4 weeks, monthly x 1 month.

Results of monitoring, with tracking and trending, will be reported by Administrator to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes x 3 months.

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F 567	Continued From page 13 any time of day and every day of the week but reported due to constraints with staffing shortages, it was difficult to ensure that happened. During an interview with the Administrator on 09/02/21 at 4:15 PM, she reported not knowing if she had a key to the petty cash lock box and that she was not sure of the facility's procedures for residents who wanted to withdraw funds after hours or on weekends. She was aware that residents should have the ability to withdraw personal funds at will and expected them to be able to.	F 567		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on facility staff and resident interviews and record review the facility failed to provide quarterly statements for 2 of 2 resident fund accounts reviewed for personal funds (Resident #6 and Resident #43).	F 568	F568 Resident #6 did not know how much money was in her resident trust account or receiving a statement. Resident #43 did not know how much	10/15/21

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The Findings Included:

1a. Resident #6 was admitted to the facility on 09/02/17. A review of Resident #6's most recent quarterly Minimum Data Set Assessment dated 08/29/21 revealed Resident #6 to be cognitively intact for daily decision making.

During an interview with Resident #6 on 09/02/21 at 3:43 PM, she reported she did not know how much money she had in her resident fund account. She reported she had not received a statement from the facility regarding her resident fund account balance and was not sure if she had to ask for one or if the facility should be providing one to her. She reported it would be nice to know how much money she had in her account because she was wanting to purchase some new clothing but did not know if she had enough funds in her account to do so.

A review of Resident #6's electronic medical record revealed she was her own responsible party.

b. Resident #43 was admitted to the facility on 06/14/17. A review of Resident #43's most recent quarterly Minimum Data Set Assessment dated 07/25/21 revealed Resident #43 to be moderately impaired for daily decision making.

During an interview with Resident #43 on 09/02/21 at 3:47 PM, he reported he had never received a statement from the facility regarding his personal fund account and that he currently did not know how much money he had in the account. He stated he did not know how to go about getting one and that he was not even sure if he asked that the facility would provide a money was in her resident trust account or receiving a statement.
Resident #6 and Resident #43 received a current statement of their balance on 9/24/21 resident trust statement.
Residents were informed that statements will be provided quarterly and upon request.

An audit completed and quarterly statement given to residents/RP that did not receive a quarterly statement from previous quarter.

Effective 9/27/21 Business Office Manager or designee will print the Quarterly statements from RFMS and deliver to the resident and/or mailed to the responsible party of the resident.

Education done on 9/27/2021 with Business office manager or designee that quarterly statements are provided to the residents within 30 days after the end of the quarter, and upon request.

Monitoring will be conducted by Administrator or designee to ensure statements are sent out quarterly. Administrator will audit (8) residents as follows: 2 times x 2 quarters.

Results of monitoring, with tracking and trending, will be reported by Administrator to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.

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F 568	Continued From page 15 statement to him. A review of Resident #43's electronic medical record revealed he was his own responsible party. During an initial interview with the Administrator on 09/02/21 at 11:53 AM, she reported the facility did not currently have a full time Business Office Director but rather was utilizing their Receptionist and a corporate staff member who worked remotely from out of town to handle the business office tasks. During an interview with Receptionist on 09/02/21 at 11:58 AM, she reported she did not provide residents with personal fund statements unless they specifically asked for it. She reported she was unaware that personal fund account statements were to be provided at least quarterly and when requested.	F 568		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services	F 582		10/15/21

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specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on record review and facility staff F582

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interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Notice to Medicare Provider Non-coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) prior to discharge from Medicare Part A skilled services to 2 of 3 residents reviewed for beneficiary protection notification review (Resident #336 and Resident #30).

The Findings Included:

1. Resident #336 was admitted to the facility on 05/05/21.

A review of Resident #336's medical record revealed a (NOMNC) and a SNF ABN were not issued to Resident #336 which explained Medicare Part A coverage for skilled services would end on 07/02/21.

During an interview with the Social Worker on 09/02/21 at 3:26 PM, she reported she had been at the facility for 1 month. She stated she was working with a corporate consultant who let her know which residents needed to have NOMNC and SNF ABN notices provided. She reported she did not know why the required forms were not provided to Resident #336. She verified it was the social worker's responsibility to issue the forms and they should have been issued to Resident #336 48-72 hours before his Medicare Part A coverage ended.

During an interview with the Administrator on 09/02/21 at 3:29 PM, she reported she did not know why Resident #336 was not provided a NOMNC or SNF ABN notice. She stated those notices should always be provided to residents

Resident #336 discharged from facility and did not receive a NOMNC prior to last cover days. Resident #336 is no longer in the facility.

Resident #30 discharged from facility and did not receive a NOMNC prior to last cover days.
Resident #30 is no longer in the facility.

Social Service Director will review 30 days of discharges to ensure NOMNC was given within the appropriate time frame.

Education was done on 9/23/2021 by Administrator to Social Service Director on NOMNC to ensure residents are being informed of their last cover day of services. Informed within 48 hours prior to discharge.

Effective 10/1/2021 newly hired Social Service Directors will be educated during orientation by Staff Development Coordinator or designee regarding the policy and procedure for issuing a NOMNC.

MDS will monitor discharges to ensure NOMNC is given appropriately as follows: weekly x 12 weeks.

Results of monitoring, with tracking and trending will be reviewed by Administrator to the Quality Assurance Performance Improvement committee for recommendations and suggestions for

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F 582	Continued From page 18 prior to the end of their Medicare Part A coverage ended. 2. Resident #30 was admitted to the facility on 02/05/21. A review of Resident #30's medical record revealed a (NOMNC) and SNFABN were not issued to Resident #30 which explained Medicare Part A coverage for skilled services would end on 03/05/21. During an interview with the Social Worker on 09/02/21 at 3:26 PM, she reported she had been at the facility for 1 month. She stated she was working with a corporate consultant who let her know which residents needed to have NOMNC and SNF ABN notices provided. She reported she did not know why the required forms were not provided to Resident #30. She verified it was the social worker's responsibility to issue the forms and they should have been issued to Resident #30 48-72 hours before his Medicare Part A coverage ended. During an interview with the Administrator on 09/02/21 at 3:29 PM, she reported she did not know why Resident #30 was not provided a NOMNC or SNF ABN notice. She stated those notices should always be provided to residents prior to the end of their Medicare Part A coverage ended.	F 582	improvements and changes.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		10/15/21

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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 sound levels.
This REQUIREMENT is not met as evidenced by:

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Based on observations, record review and family and staff interviews the facility failed to repair and/or paint dry wall in resident rooms (Room #104, Room #109, Room #110, Room #111, Room #113, Room #122, Room #128, Room #132, Room #219, Room #223, Room #231, and Room #232) for 12 of 53 resident rooms on 2 of 4 resident hallways, failed to clean resident rooms (Room #108, Room #109, Room #111, and Room #217) for 4 of 53 resident rooms on 2 of 4 resident hallways from debris and litter, failed to provide clean linen (Resident #5) for 1 of 4 resident reviewed for linen, and failed to protect resident personal belonging from being lost or misplaced (Resident #43, Resident #16, and Resident #51) for 3 of 4 residents reviewed for personal property.

The findings included:

1a. An observation of Room #104 was made on 09/03/21 at 11:30 AM. Behind both residents' beds were large areas of damaged dry wall. Some of the areas had been patched with spackle and some areas had not been repaired. None of the repaired areas had been painted and were a different color than the other wall area.

1b. An observation of Room #109 was made on 08/30/21 at 10:47 AM. There were 8 patches of spackle that had been used to repair the walls behind the bed and along the entrance of the room. There was a large area that measure approximately 12 inches by 8 inches that had been spackled. None of the spackled areas had been painted and were rough to touch.

An observation of Room #109 was made on 09/03/21 at 11:31 AM. There were 8 patches of

Based on observations in Room #104, #109, #110, #111, #113, #122, #128, #132, #219, #223, #231 and #232 unfinished repair and/or paint dry wall. Failed to clean resident room #108, #109, #111, #217. Failed to provide clean linen resident #5. Failed to protect resident belonging from being lost or misplaced resident #43, resident #16, resident #51.

1. Dry wall in rooms 104, 109-111, 113, 122, 128, 132, 219, 223, 231, 232 were repaired, spackled, and painted to match the wall color by 10/15/2021. Room 111 wardrobe was replaced.

Rooms 108, 109, 111, 217 were deep cleaned and the privacy curtain in room 217 was changed out for a clean curtain, and hallways cleaned of debris by 10/15/21.

Resident #5 pillow cases were changed.

Resident #51 family was interviewed to confirm missing items (reading glasses, family portraits) and grievance initiated. Reading glasses were found and returned. Resident #43 was interviewed to confirm missing items (several shorts, other clothing items) and grievance initiated. Resident #16 was interviewed to confirm missing items (10 sweatpants and 10 pairs of socks, 3 tee shirts) and grievance initiated. If items not located, they were replaced or family reimbursed.

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spackle that had been used to repair the walls behind the bed and along the entrance of the room. There was a large area that measured approximately 12 inches by 8 inches that had been spackled. None of the spackled areas had been painted and were rough to touch.

1c. An observation of Room #110 was made on 09/03/21 at 11:32 AM. The wall that was behind the resident beds were scattered with scratches to the dry wall. Some of the scratches had been spackled and some had not. The spackled areas were rough to touch and had not been painted and were a different color then the other wall areas.

1d. An observation of Room #111 was made on 08/30/21 at 10:14 AM. There were 2 1-inch circular holes in the long wall of the resident room that had not been repaired. The bottom of the resident wardrobe was chipped off in large chunks with the underlying particle board that was splintered and exposed.

An observation of Room #111 was made on 08/31/21 at 9:59 AM. There were 2 1-inch circular holes in the long wall of the resident room that had not been repaired. The bottom of the resident wardrobe was chipped off in large chunks with the underlying particle board that was splintered and exposed.

An observation of Room #111 was made on 09/03/21 at 11:33 AM. There were 2 1-inch circular holes in the long wall of the resident room that had not been repaired. The bottom of the resident wardrobe was chipped off in large chunks with the underlying particle board that was splintered and exposed.

2. Resident rooms inspected by Maintenance Director or Designee by 10/15/21 and a list generated for needed repairs. Room repairs will occur on a schedule until all rooms have been repaired for holes, or incomplete repairs. Deep clean schedule was initiated and deep clean rooms reported daily in morning meeting. Strike team was brought in by Next Level and all rooms were deep cleaned week of 9/27/21. Resident personals were delivered on 9/2/21 and clothing without labels were displayed for residents to claim. Residents interviewed on 9/28/2021 and list generated of missing items. If items not located they were replaced by 10/15/21.

3.Effective 10/15/2021 all staff will be educated on reporting repairs into TELS that will automatically alert Maintenance Director of a work order generated.

Social Worker or designee will interview resident and observe the rooms of (5) five random residents M-F x 2 weeks, weekly x 2 months, and monthly x 2 months to ensure their rooms are free of holes, scratches, incomplete repairs, ensure room and linen is clean and, and ensure that they are not missing personal items. Any areas discovered addressed immediately.

4. Results of audits were reviewed by Administrator in monthly QAPI meeting to ensure substantial compliance is met.

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1e. An observation of Room #113 was made on 09/03/21 at 11:34 AM. There were various sizes of areas on the 2 main walls of the resident room that had been repaired with spackle. The areas were rough to the touch and had not been painted and were a different color then the other walls of the room.

1f. An observation of Room #122 was made on 09/03/21 at 11:35 AM. The wall behind the resident bed was damaged and scratched with various sizes of scratches. The scratches had not been repaired and were of varying depths. The bottom of the resident wardrobe was chipped off in large chunks with the underlying particle board that was splintered and exposed.

1g. An observation of Room #128 was made on 09/03/21 at 11:36 AM. The wall behind the resident beds were scratched through the drywall. The scratches were of varying sizes and depths and had not been repaired with spackle.

1h. An observation of Room #132 was made on 09/03/21 at 11:37 AM. The 2 main walls in the resident room were noted to have damage to the dry wall. The areas were of various sizes, shapes, and depths. Some of the areas had been repaired with spackle but were rough to the touch and had not been painted. The other areas had not been repaired with spackle.

1i. An observation of Room #219 was made on 09/03/21 at 11:38 AM. The walls of the resident room were observed to have damage to the drywall. The areas were of various sizes, shapes, and depths. Most of the areas had not been repaired with spackle and were rough to the

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touch.

1j. An observation of Room #223 was made on 09/03/21 at 11:39 AM. The walls of the resident room were observed to have damage to the drywall. The areas were of various sizes, shapes, and depths. Most of the areas had not been repaired with spackle and were rough to the touch.

1k. An observation of Room #231 was made on 09/03/21 at 11:40 AM. The walls of the resident room were observed to have damage to the drywall. The areas were of various sizes, shapes, and depths. Most of the areas had not been repaired with spackle and were rough to the touch.

1l. An observation of Room #232 was made on 09/03/21 at 11:41 AM. The entrance wall of the resident room was observed to have damage to the dry wall. The areas were of various sizes, shapes, and depths. Most of the areas had not been repaired with spackle and were rough to the touch. None of the areas had been painted and were a different color than the other walls of the room.

The Maintenance Director was interviewed on 09/01/21 at 3:49 PM. The Maintenance Director stated he was filling the spot-on interim basis. He stated that he was responsible for doing routine maintenance checks on things in the facility and making sure equipment was in good working order. He stated that the staff would generally verbally tell him of any repairs needed and at times would fill out a work order and give to him and he would get to the repair as quickly as possible but stated they had been short staffed,

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and it was tough to get everything done that needed to be done. The MD stated he was aware of the condition of the walls and dry wall but just had not had the time to get all the required repairs done.

During an interview with the Environmental Service Director (ESD) on 09/02/21 at 3:03 PM he stated that he needed 4 housekeepers and only had 3 housekeepers but was looking to hire more. The Director explained that the housekeepers were responsible for dusting, wiping down the frequently touched surfaces, sweeping and mopping the floors and emptying the trash cans in the residents' room every day and if there were other issues that needed to be taken care of such as repairs, the housekeepers could fill out a requisition or verbally relay it to him or the maintenance department and they would get to the repairs as soon as they could. The Director continued to explain that every resident room was deep cleaned once a month that included the resident being moved out of the room for a while so the deep cleaning could be done.

An interview was conducted with the Administrator on 09/03/21 at 3:54 PM. The Administrator explained she had only been employed by the facility for about 2 weeks and had already assessed the environmental situation throughout the facility. The Administrator stated they were actively hiring to fill the positions and she expected the environmental issues would be taken care of.

2a. An observation of Room #108 was made on 08/30/21 at 10:27 AM. Room #108 was observed to be littered with trash all over the floor that

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contained balled up Kleenex, opened salt packets, and an empty tube of Systane gel under the bed. The trash can was observed to have no trash bag in it and the area around the trash can was littered with paper debris.

An observation of Room #108 was made on 08/31/21 at 10:49 AM. Room #108 was observed to be littered with trash all over the floor that contained balled up Kleenex, opened salt packets, and an empty tube of Systane gel under the bed. The trash can was observed to have no trash bag in it and the area around the trash can was littered with paper debris.

Housekeeper #2 was interviewed on 08/31/21 at 3:48 PM who confirmed she was responsible for cleaning Room #108. She stated that the facility was short staffed in the housekeeping and laundry department and she routinely hurried to clean her rooms so she could help in laundry which meant her rooms did not get cleaned as well as they should. Housekeeper #2 observed Room #108 and stated she should have taken more time to clean the room and make it comfortable for the resident, but she was trying to help get the laundry caught up and was in a hurry.

During an interview with the Environmental Service Director (ESD) on 09/02/21 at 3:03 PM he stated that he needed 4 housekeepers and only had 3 housekeepers but was looking to hire more. The Director explained that the housekeepers were responsible for dusting, wiping down the frequently touched surfaces, sweeping and mopping the floors and emptying the trash cans in the residents' room every day and if there were other issues that needed to be taken care of such as repairs, the housekeepers

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could fill out a requisition or verbally relay it to him or the maintenance department. The Director continued to explain that every resident room was deep cleaned once a month that included the resident being moved out of the room for a while so the deep cleaning could be done.

2b. An observation of Room #109 was made on 08/30/21 at 10:49 AM. Room #109 was observed to have brown spots of what looked like a nutritional supplement scattered all over the floor between the two residents' bed in the room. There was paper debris littered in the floor around the trash can that sat between the two beds as well.

An observation of Room #109 was made on 08/31/21 at 10:31 AM. Room #109 was observed to have the same brown spots of what looked like a nutritional supplement scattered all over the floor between the two residents' bed in the room. The paper debris littered in the floor around the trash can remained as well.

Housekeeper #2 was interviewed on 08/31/21 at 3:48 PM who confirmed she was responsible for cleaning Room #109. She stated that the facility was short staffed in the housekeeping and laundry department and she routinely hurried to clean her rooms so she could help in laundry which meant her rooms did not get cleaned as well as they should. Housekeeper #2 observed Room #109 and stated she should have taken more time to clean the room and make it comfortable for the resident, but she was trying to help get the laundry caught up and was in a hurry.

During an interview with the Environmental Service Director (ESD) on 09/02/21 at 3:03 PM

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he stated that he needed 4 housekeepers and only had 3 housekeepers but was looking to hire more. The Director explained that the housekeepers were responsible for dusting, wiping down the frequently touched surfaces, sweeping and mopping the floors and emptying the trash cans in the residents' room every day and if there were other issues that needed to be taken care of such as repairs, the housekeepers could fill out a requisition or verbally relay it to him or the maintenance department. The Director continued to explain that every resident room was deep cleaned once a month that included the resident being moved out of the room for a while so the deep cleaning could be done.

2c. An observation of Room #111 was made on 08/30/21 at 11:39 AM. Room #111 was observed to have blue and red sticky substances on the floor under the bedside table. There was paper debris that littered the floor around the trash can and under the resident bed.

An observation of Room #111 was made on 08/31/21 at 9:59 AM. Room #111 was observed to have the same blue and red sticky substances on the floor under the bedside table. The paper debris that littered the floor around the trash can and under the resident bed remained.

Housekeeper #2 was interviewed on 08/31/21 at 3:48 PM who confirmed she was responsible for cleaning Room #111. She stated that the facility was short staffed in the housekeeping and laundry department and she routinely hurried to clean he rooms so she could help in laundry which meant her rooms did not get cleaned as well as they should. Housekeeper #2 observed Room #111 and stated she should have taken

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more time to clean the room and make it comfortable for the resident, but she was trying to help get the laundry caught up and was in a hurry.

During an interview with the Environmental Service Director (ESD) on 09/02/21 at 3:03 PM he stated that he needed 4 housekeepers and only had 3 housekeepers but was looking to hire more. The Director explained that the housekeepers were responsible for dusting, wiping down the frequently touched surfaces, sweeping and mopping the floors and emptying the trash cans in the residents' room every day and if there were other issues that needed to be taken care of such as repairs, the housekeepers could fill out a requisition or verbally relay it to him or the maintenance department. The Director continued to explain that every resident room was deep cleaned once a month that included the resident being moved out of the room for a while so the deep cleaning could be done.

2d. An observation of Room #217 was made on 08/31/21 at 3:55 PM. Room#217 revealed numerous shredded papers on the floor around both sides of the Resident's bed, the floor around the Resident's bed was sticky, an empty fruit cup was on the floor on the left side of the bed, the Resident's privacy curtain had a brown substance that appeared to have been splashed on the curtain and there were 4 dried wads of paper stuck to the closet door.

An observation of Room #217 was made on 09/01/21 at 3:30 PM. The observations of the Resident's privacy curtain remained as the day before and the 4 paper wads remained on the closet door. The Resident stated she asked the Housekeeper earlier to get the paper off the

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closet door and the Housekeeper told her that she did not put it up there.

An observation of Room #217 was made on 09/02/21 at 10:50 AM revealed the brown substance remained on the privacy curtain and the 4 paper wads remained on the closet doors.

An interview was conducted on 09/02/21 at 2:21 PM with the Housekeeper #1 assigned to clean Room #217 on 08/31/21, 09/01/21 and 09/03/21. The Housekeeper confirmed she was responsible for cleaning the Resident's room. She explained that her working hours were 7:00 AM to 3:00 PM five days a week and she worked as fast as she could to clean the residents' rooms because they were often short of housekeepers. She stated that the normal number of housekeepers needed a day was 3 and as of that day on 09/02/21 there was only 2 housekeepers working. Accompanied the Housekeeper to Room #217 where she pointed out the sticky floors, the brown substance on the privacy curtain, the 4 wads of paper stuck to the closet doors and a brown liquid substance on the wall behind the Resident's bed and explained that the brown substance had been on the wall behind the bed ever since she had been employed at the facility approximately 2 months prior. The Housekeeper continued to explain that she had spoken with the current Environmental Service Director (ESD) and the previous one as well about the condition of Room #217 and asked that she be able to conduct a deep clean that would mean the Resident be moved out of the room for a while so the deep clean could be conducted. The Housekeeper also stated that the privacy curtains were not the responsibility of the housekeepers to maintain that it was maintenance that changed the privacy curtains.

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During an interview with the Environmental Service Director (ESD) on 09/02/21 at 3:03 PM he stated that he needed 4 housekeepers and only had 3 housekeepers but was looking to hire more. The Director explained that the housekeepers were responsible for dusting, wiping down the frequently touched surfaces, sweeping and mopping the floors and emptying the trash cans in the residents' room every day and if there were other issues that needed to be taken care of such as repairs, the housekeepers could fill out a requisition or verbally relay it to him or the maintenance department. The Director continued to explain that every resident room was deep cleaned once a month that included the resident being moved out of the room for a while so the deep cleaning could be done. As far as the privacy curtains, the maintenance department was responsible for changing the privacy curtains in the resident rooms once a month and since the maintenance department had been short staffed lately, he was changing the privacy curtains to help them out. The Director could not recall when the privacy curtain in Room #217 was changed last. The Director also stated that Housekeeper #1 had not reported any extra cleaning that needed to be done in Room #217. The Director provided a deep cleaning schedule that indicated the last time the Resident's room was deep cleaned was on 08/24/21.

3. An observation of Resident #5 was made on 08/30/21 at 11:39 AM. Resident #5 was resting in bed with his eyes open. He was observed to have 2 large circular spots of a dried dark red substance on the end of his pillowcase near the end that opened.

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An observation of Resident #5 was made on 08/31/21 at 9:59 AM. Resident #5 was resting in bed with his eyes open. He was observed to have 2 large circular spots of dried dark red substances on the end of his pillowcase near the end that opened.

An observation of Resident #5 was made on 09/02/21 at 9:00 AM. Resident #5 was resting in bed with his eyes open. He was observed to have 2 large circular spots of dried dark red substances on the end of his pillowcase near the end that opened.

An observation of Resident #5 was made on 09/03/21 at 10:12 AM. Resident #5 was resting in bed with his eyes open. He was observed to have 2 large circular spots of dried dark red substances on the end of his pillowcase near the end that opened.

An interview was conducted with Nurse Aide (NA) #5 on 09/03/21 at 10:50 AM. NA #5 stated she worked at the facility through an agency and had been coming to the facility for about 2 months. NA #5 stated that she routinely changed resident bed linen everyday that she worked but stated that when she arrived for her shift and began gathering her supplies there was no sheets available and so she could not change any of the beds. NA #5 stated that the dried dark red substances appeared to be blood and should have not been there stated that she would go and find a pillowcase to change it out.

The Director of Nursing (DON) was interviewed on 09/03/21 at 11:52 AM. The DON stated that she expected the resident's room and bed linens be clean and in condition to reduce the risk of

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infection.

4. Resident #51 was readmitted to the facility on 09/05/17 with diagnoses that included dementia. Review of the quarterly Minimum Data Set (MDS) dated 07/29/21 indicated Resident #51 was moderately impaired for daily decision making and required extensive assistance with activities of daily living.

The facility's grievance log was requested for the last 2 years. The facility could only locate the last year and no grievances were noted from Resident #51 or his family.

Resident #51's family was interviewed on 08/30/21 at 3:23 PM. The family member stated that Resident #51 had been at the facility for several years and during the last year and half had been moved from room to room due to the COVID 19 pandemic. The family stated that when they moved Resident #51, she was notified that they would pack and store his belongings and they would be returned to him when he returned to his room. The family member stated that since she had been able to visit Resident #51 again, she had noted that he was missing his reading glasses and approximately 15-20 family portraits that were kept in his room of his various family members and she had not seen them since he has moved the most recent time approximately 3-4 months ago. The family member stated that she had reported the missing items to a male employee in the front office but has not heard anything about it since then.

The Environmental Service Director (EVS) was interviewed on 08/31/21 at 2:48 PM. The EVS stated that he had worked at the facility for a year

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but was recently promoted to director. He stated that if he is aware of missing items, he would look for them and if he could not find them then he would let the Administrator know. The EVS stated that during the COVID 19 pandemic he was tasked with moving resident as needed to different rooms and he recalled in one day moving 16 residents to different rooms. The EVS stated that most of their belongings stayed in their room and the resident and a couple days of worth of clothes were moved to the new room and the plan was to move the resident back to their original room as soon as possible but stated that is not what occurred, and he was not sure what happened to the resident belongings. The EVS was not aware that Resident #51 was missing his reading glasses and family portraits but stated he would look for them.

The Director of Nursing (DON) was interviewed on 09/03/21 at 12:24 PM. The DON stated that she had only been the interim DON for a short time and was not aware of any missing items that Resident #51 had. She stated that if she had been aware of missing items, she would have attempted to track the missing items down.

The Administrator was interviewed on 09/03/21 at 3:58 PM. The Administrator confirmed that she had only been at the facility for a week and was unable to locate the previous years of grievances. She stated that she was not aware of any missing items that Resident #51 had but stated that his personal items should have been left in his room or returned to him when he returned to the room.

5. Resident # 43 was admitted to the facility on 06/14/17 with diagnoses that included major depressive disorder, anxiety disorder, hemiplegia,

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and hypertension.

Review of the quarterly Minimum Data Set (MDS) assessment dated 07/25/21 revealed resident #43 was moderately impaired for daily decision making. The MDS further revealed resident #43 was an extensive assist with a 1-person physical for all activities of daily living (ADL) except for eating which was supervision with setup assistance only.

An observation of resident #43 on 08/30/21 at 11:10 AM revealed the resident was up in a wheelchair, dressed in black shorts, an orange tee shirt and tennis shoes.

An interview with resident #43 on 08/30/21 at 3:28 PM stated he had several pair of shorts missing from the laundry and he had talked to them but hadn't heard anything back from them yet. Resident #43 further stated they had brought him 2 pair of shorts about a month ago, but currently he didn't have any in his closet. Resident #43 revealed he had discussed this issue in the Resident Council meeting last month and it had been an issue with others in the facility as well.

The Environmental Service Director (EVS) was interviewed on 08/31/21 at 2:48 PM. The EVS stated that he had worked at the facility for a year but was recently promoted to director. He stated that if he is aware of missing items, he would look for them and if he could not find them then he would let the Administrator know. The EVS stated that during the COVID 19 pandemic he was tasked with moving resident as needed to different rooms and he recalled in one day moving 16 residents to different rooms. The EVS

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stated that most of their belongings stayed in their room and the resident and a couple days of worth of clothes were moved to the new room and the plan was to move the resident back to their original room as soon as possible but stated that is not what occurred, and he was not sure what happened to the resident belongings. He added that the laundry department had gotten behind from a few weeks ago when the laundry room flooded, and they were unable to do laundry for a couple of day and they had gotten really behind. The EVS stated that Resident #43's missing clothing items may in the laundry waiting to be washed and returned to him.

The Director of Nursing (DON) was interviewed on 09/03/21 at 12:24 PM. The DON stated that she had only been the interim DON for a short time and was not aware of any missing items that Resident #43 had. She stated that if she had been aware of missing items, she would have attempted to track the missing items down.

The Administrator was interviewed on 09/03/21 at 3:58 PM. The Administrator confirmed that she had only been at the facility for a week and was unable to locate the previous years of grievances. She stated that she was not aware of any missing items that Resident #43 had but stated that his personal items should have been left in his room or returned to him when he returned to the room.

6. Resident #16 was admitted to the facility on 05/11/20 with diagnoses that included acute kidney failure.

Review of the quarterly Minimum Data Set (MDS) assessment dated 06/24/21 revealed resident #16 was cognitively intact for daily decision

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making. The MDS further revealed resident #16 was a minimal assist with a 1-person physical assist for all activities of daily living (ADL) except for eating which was set-up only.

An observation of resident #16 on 08/30/21 at 2:46 PM revealed the resident was sitting in a wheelchair, dressed in black sweatpants, white tee shirt and tennis shoes with no socks.

An interview with resident #16 on 08/31/21 at 9:35 AM revealed resident was missing many pairs of sweatpants and socks. He further revealed he had no socks to wear now. Resident #16 stated he didn't know exactly how many he had but it was around 10 pair of sweatpants and about 10 pair of socks.

An interview with resident #16 on 09/02/21 at 9:14 AM revealed he had received several pair of shorts, 3 pair of sweatpants and 3 tee shirts from the laundry that morning but no socks.

The Environmental Service Director (EVS) was interviewed on 08/31/21 at 2:48 PM. The EVS stated that he had worked at the facility for a year but was recently promoted to director. He stated that if he was aware of missing items, he would look for them and if he could not find them then he would let the Administrator know. The EVS stated that during the COVID 19 pandemic he was tasked with moving resident as needed to different rooms and he recalled in one day moving 16 residents to different rooms. The EVS stated that most of their belongings stayed in their room and the resident and a couple days of worth of clothes were moved to the new room and the plan was to move the resident back to their original room as soon as possible but stated that

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F 584	Continued From page 37 is not what occurred, and he was not sure what happened to the resident belongings. He added that the laundry department had gotten behind from a few weeks ago when the laundry room flooded, and they were unable to do laundry for a couple of day and they had gotten behind. The EVS stated that Resident #16's missing clothing items may in the laundry waiting to be washed and returned to him. The Director of Nursing (DON) was interviewed on 09/03/21 at 12:24 PM. The DON stated that she had only been the interim DON for a short time and was not aware of any missing items that Resident #16 had. She stated that if she had been aware of missing items, she would have attempted to track the missing items down. The Administrator was interviewed on 09/03/21 at 3:58 PM. The Administrator confirmed that she had only been at the facility for a week and was unable to locate the previous years of grievances. She stated that she was not aware of any missing items that Resident #16 had but stated that his personal items should have been left in his room or returned to him when he returned to the room.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive	F 636		10/15/21

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

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes

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prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment for 1 of 4 resident reviewed for resident assessment (Resident #2).

Findings included:

Resident #2 was admitted to the facility on 07/01/21 with diagnoses that included Parkinson's Disease and Diabetes.

Review of Resident #2's medical record revealed the admission MDS dated 07/06/21 was not signed as completed until 07/21/21.

An interview on 09/01/21 at 9:47 AM with MDS Nurse #1 and MDS Nurse #2 which revealed the Admission MDS dated 07/06/21 was completed after the required deadline. Neither MDS nurse was able to give an explanation as to why the assessment was completed late, but both acknowledged all Admission MDS assessments must be completed by the 14th day of admission.

An interview on 09/02/21 at 6:30 PM with the Interim Director of Nursing (DON) revealed she

F636

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility failed to complete a Comprehensive Minimum Data Set assessment for resident #2, within 14 days.

Resident #2 Comprehensive assessment on 7/21/2021.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Effective 9/22/2021 current residents were reviewed by MDS Nurses to ensure Comprehensive Assessments was completed within the required timeframe.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not

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F 636	Continued From page 40 was unaware Resident #2's assessment had been completed outside the guidelines. The DON stated she expected all assessments to be completed timely. An interview on 09/02/21 at 7:00 PM with the Administrator revealed she was unaware Resident #2's assessment had been completed late. She stated she expected all assessments to be completed timely.	F 636	recur: Effective 9/1/2021 Regional MDS Consultant educated MDS nurses on completing the comprehensive MDS within the required timeframe. Effective 9/3/2021 newly hired MDS staff will be educated during orientation or training by Regional MDS Consultant or designee on completing the comprehensive assessment within the required timeframe. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will audit 5 comprehensive assessments weekly to ensure comprehensive assessments are completed within the required timeframe. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F 640		10/15/21

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(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or,

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for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to transmit two discharge assessments timely for 2 of 5 residents reviewed for resident assessment (Resident #3 and Resident # 286).

Findings included:

1.Resident #3 was admitted to the facility on 01/19/21 with diagnoses that included chronic respiratory failure with hypoxia and diabetes.

A review of Resident #3's medical record revealed a Discharge Minimum Data Set (MDS) dated 04/28/21 with a completion date of 05/05/21.

Further review of Resident #3's medical record revealed the Discharge MDS dated 04/28/21 was not transmitted until 08/31/21 which indicated it was transmitted late. The medical record further showed a rejected assessment attempt on 05/05/21.

An interview on 09/01/21 at 9:47 AM with MDS Nurse #1 and MDS Nurse #2 revealed Resident #3's discharge MDS dated 04/28/21 was transmitted after the required deadline. MDS Nurse #2 indicated she could not locate the assessment as being accepted in her files, so she collected a new batch for transmission and transmitted the assessment on 08/31/21. Both MDS Nurse #1 and MDS Nurse #2 stated they knew all Discharge MDS assessments must be

F640

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility failed to transmit two discharge assessments timely for resident #3 and resident #286.

Resident #3 assessment was transmitted on 8/31/2021.

Resident # 286 assessment was transmitted on 8/31/2021.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Effective 9/1/2021 Minimum Data Set Nurses reviewed two months of discharge residents to ensure assessments were transmitted within required timeframe.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/3/2021 Regional MDS Consultant educated MDS nurses on transmitting discharge assessments

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transmitted within 14 days of the completion date. MDS Nurse #2 indicated they were taught to batch and transmit assessments and to rely on the electronic medical record to notify the MDS nurse if an assessment was not accepted because they no longer access the transmission reports from the system.

An interview on 09/02/21 at 6:30 PM with the Interim Director of Nursing (DON) revealed she was unaware Resident #3's assessment had been transmitted outside the guidelines. The DON stated she expected all assessments to be transmitted timely.

An interview on 09/02/21 at 7:00 PM with the Administrator revealed she was unaware Resident #3's assessment had been transmitted late. She stated she expected all assessments to be transmitted timely.

2. Resident #286 was admitted to the facility on 01/06/21 with diagnoses that included COVID-19.

A review of Resident #286's medical revealed a Discharge Minimum Data Set (MDS) dated 04/15/21 with a completion date of 04/19/21.

Further review of Resident #286's medical record revealed the Discharge MDS dated 04/15/21 was not transmitted until 08/31/21 which indicated it was transmitted late. The medical record further showed a rejected assessment dated 04/19/21.

An interview on 09/01/21 at 9:47 AM with MDS Nurse #1 and MDS Nurse #2 revealed Resident #286's discharge MDS dated 04/28/21 was transmitted after the required deadline. MDS Nurse #2 indicated she could not locate the

within the required timeframe.

Effective 9/3/2021 newly hired MDS staff will be educated during orientation by Regional MDS Consultant or designee on transmitting discharge assessments within the required timeframe.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Administrator will audit 5 discharge assessments weekly to ensure discharge assessments are completed within the required timeframe.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected.

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assessment as being accepted in her files, so she collected a new batch for transmission and transmitted the assessment on 08/31/21. Both MDS Nurse #1 and MDS Nurse #2 stated they knew all Discharge MDS assessments must be transmitted within 14 days of the completion date. MDS Nurse #2 indicated they were taught to batch and transmit assessments and to rely on the electronic medical record to notify the MDS nurse if an assessment was not accepted because they no longer access the transmission reports from the system.

An interview on 09/02/21 at 6:30 PM with the Interim Director of Nursing (DON) revealed she was unaware Resident #286's assessment had been transmitted outside the guidelines. The DON stated she expected all assessments to be transmitted timely.

An interview on 09/02/21 at 7:00 PM with the Administrator revealed she was unaware Resident #286's assessment had been transmitted late. She stated she expected all assessments to be transmitted timely.

F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		10/15/21

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 2 residents reviewed for discharge (Resident #86), for 1 of 5 residents reviewed for unnecessary medications (Resident

F641

How corrective action will be accomplished for those residents found to have been affected by the deficient

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#48), and for 1 of 5 residents reviewed for resident assessment (Resident #68).

The findings included:

1. Resident #86 was admitted to the facility on 05/05/21 with diagnoses that included deep vein thrombosis (blood clots).

The admission Minimum Data Set (MDS) dated 05/10/21 revealed Resident #86 was cognitively intact and required supervision assistance with bed mobility, eating, personal hygiene and bathing.

A review of a Social Service Progress Note dated 07/19/21 at 11:19 AM revealed Resident #86 planned to discharge on 07/22/21. The Resident would receive Home Health services and the Physician requested the Resident have wound care services provided by the wound center. An appointment was made with the Resident's Primary Care Physician.

A review of a Progress Note dated 07/22/21 at 3:02 PM revealed Resident #86 was discharged home via a cab. The note indicated the Resident was discharged with all medications and prescriptions as well as the notification of his upcoming appointments.

The discharge Minimum Data Set (MDS) assessment dated 07/22/21 revealed the discharge assessment indicated Resident #86 was discharged with his return anticipated and as an unplanned discharge.

An interview was conducted with the Minimum Data Set Nurse (MDS Nurse) #1 on 09/03/21 at

practice;

The facility failed to accurately code the Minimum Data Set for resident #86, resident #48 and resident #68.

The facility modified resident #86 to reflect discharge as "planned" on discharge assessment on 9/3/2021 and retransmitted on 9/7/2021.

The facility modified resident #48 to reflect "gradual dose reduction date" on quarterly assessment on 9/3/2021 and retransmitted on 9/7/2021.

The facility modified resident #68 to reflect "resident not receiving insulin nor anticoagulation medications" on significant change assessment on 8/30/2021 and retransmitted on 8/31/2021.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Effective 9/16/2021 Minimum Data Set Nurses reviewed 30 days of discharge residents to ensure accuracy of coding planned and/or unplanned.

Effective 9/2/2021 Minimum Data Set Nurses reviewed current residents with antipsychotic medications to ensure accuracy of coding GDR.

Effective 8/30/2021 Minimum Data Set Nurses reviewed current residents

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10:58 AM. The MDS Nurse explained that she thought Resident #86 was an unplanned discharge and coded the MDS as unplanned. The MDS Nurse stated she made a mistake and should have coded the discharge MDS as planned and return not anticipated.

During an interview with the Administrator on 09/03/21 at 3:54 PM she stated she expected the MDS assessments to be coded accurately and according to the residents' discharge plan.

2. Resident #48 was admitted to the facility on 02/18/20 with diagnoses that included cerebral vascular accident.

A review of Resident #48's Physician progress notes dated 05/27/20 indicated a gradual dose reduction of Risperdal was attempted but failed due to signs of psychomotor agitation and anxiety therefore, the Risperdal dose was increased back to 3 milligrams (mg) twice a day by mouth for mood disorder.

A review of Resident #48's Physician orders dated 07/01/20 revealed an order for Risperdal 3 mg two times a day by mouth for mood disorder.

The quarterly Minimum Data Set (MDS) assessment dated 07/23/21 revealed Resident #48 had severely impaired cognition and limited to extensive assistance of one staff for most of her activities of daily living. The MDS also indicated Resident #48 received 7 days of antipsychotics, a gradual dose reduction (GDR) had not been attempted and a GDR had not been documented by a physician as clinically contraindicated.

significant change assessments to ensure accuracy of coding insulin and anticoagulation medications.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 8/30/2021 and 9/2/2021 Regional MDS Consultant educated MDS nurses coding MDS assessment accurately.

Effective 9/30/2021 newly hired MDS staff will be educated during orientation by Regional MDS Consultant or designee on coding MDS assessment accurately.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Administrator will audit 5 discharge assessments weekly to ensure discharge assessments are coded accurately.

Administrator will audit 5 quarterly assessments weekly to ensure gradual dose reduction date is coded accurately.

Administrator will audit 5 significant change assessments weekly to ensure insulin and anticoagulation medications are coded accurately.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed.

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Attempts to interview Resident #48's Physician were unsuccessful.

On 09/02/21 at 4:25 PM interviews were conducted with the Minimum Data Set Nurse (MDS Nurse) #1, the MDS Nurse #2 and the Regional MDS Consultant about Resident #48's MDS dated 07/23/21 in the area of gradual dose reduction. The nurses acknowledged the last GDR was attempted in May 2020 but indicated they did not normally look back at 14 months' worth of progress notes when they completed the MDS.

During an interview with the Administrator on 09/03/21 at 3:54 PM she stated she expected the MDS assessments to be coded accurately and according to the residents' situation.

3. Resident #68 was admitted to the facility on 08/21/20 with diagnoses that included acute and chronic respiratory failure with hypoxia and hypercapnia.

A review of Resident #68's medical record revealed a Significant Change Minimum Data Set (MDS) dated 08/11/21.

Further review of Resident #68' medical record revealed the Significant Change MDS dated 08/11/21 was coded to reflect Resident #68 received insulin and an anticoagulant. The medical record further revealed Resident #68 had not had an order for an anticoagulant or insulin during the review period.

An interview on 08/31/21 at 3:45 PM with MDS Nurse #1 which revealed Resident#86's Significant Change MDS dated 08/11/21 was

Administrator will review the results of weekly audits to ensure any issues identified are corrected.

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F 641	Continued From page 48 coded to reflect Resident #68 received insulin and an anticoagulant on 2 days during the review period; however, after further review of Resident #68's physician orders, MDS Nurse #1 stated she had inadvertently coded the Significant Change MDS assessment. MDS Nurse #1 indicated she had been taught to review the physician orders and Medication Administration Record (MAR) to determine if medications were received prior to completing an MDS. An interview on 09/02/21 at 6:30 PM with the Interim Director of Nursing (DON) revealed she was unaware Resident #68's assessment had been coded to reflect medications not received by Resident #68. The DON stated she expected all assessments to be completed accurately. An interview on 09/02/21 at 7:00 PM with the Administrator revealed she was unaware Resident #68's assessment had been code to reflect Resident #68 had received 2 days of insulin and 2 days of an anticoagulant medication. She stated she expected all assessments to be completed accurately.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F 655		10/15/21

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admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

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

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident and staff interview the facility failed to develop a baseline care plan in the area of smoking within 48 hours of admission for a resident who elected to smoke for 1 of 2 residents reviewed for

F655

How corrective action will be accomplished for those residents found to have been affected by the deficient

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smoking (Resident #86).

Findings included:

Resident #86 was admitted to the facility on 08/28/21 for short term rehabilitation services.

A review of resident #86's medical record revealed the baseline care plan dated 08/28/21 did not include any care areas related to Resident #86's wish to smoke.

A smoking assessment dated 08/28/21 revealed it to be partially completed but indicated Resident #86 was a known smoker.

An observation and interview on 09/02/21 at 3:00 PM revealed Resident #86 was sitting outside in his wheelchair in the designated smoking area. Resident #86 was observed to be smoking a recently lit cigarette and holding an additional cigarette in his other hand. When asked about his smoking habits, Resident #86 stated he had just been readmitted to the facility over the weekend and he currently did not have his own cigarettes, so he had to "bum" some each time he wanted to smoke.

An interview with the Director of Nursing (DON) on 09/02/21 at 3:30 PM revealed she was not aware Resident #86 was a current smoker and stated she would find out further information.

An additional interview with the DON on 09/02/21 at 6:30 PM revealed all residents should be assessed for their wish to smoke upon admission and a smoking assessment should be completed by the admitting nurse within 24 hours of admission and included on the baseline care plan

practice;

The facility failed to develop a baseline care plan in the area of smoking within 48 hours of admission for resident #86.

Smoking was added to the baseline care plan of resident #86 on 9/3/2021

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Effective 9/16/2021 Director of Nursing reviewed current residents for smoking.

Effective 9/16/2021 Minimum Data Set Nurses reviewed current residents care plan to ensure care plan reflects the resident smokes.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/27/2021 Director of Nursing and/or designee educated current license nurses on if the resident is a smoker to update the baseline care plan within 48 hours of admission.

Effective 10/1/2021 any License Nurses that has not been educated will not be allowed to work until receive education in-person or via telephone by Director of Nursing and/or designee.

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F 655	Continued From page 51 within 48 hours of admission if the resident wished to smoke. An interview with the Administrator on 09/02/21 at 7:00 PM revealed she expected Resident #86 to have a baseline care plan completed within 48 hours of admission and the care plan should have reflected his wish to smoke.	F 655	Effective 9/27/2021 all License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on " if the resident is a smoker to update the baseline care plan within 48 hours of admission. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit admissions to ensure if resident that are smokers are on the baseline care plan daily (Monday □ Friday) X 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review and facility staff and resident interviews, the facility failed to provide showers for 2 of 5 dependent resident reviewed	F 677	F677 How corrective action will be	10/15/21

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for Activities of Daily Living (Resident #6 and Resident #18).

The Findings Included:

1. Resident #6 was admitted to the facility on 09/02/17 with diagnoses that included tremor, atrial fibrillation, polyneuropathy, heart failure, and chronic pain.

Review of Resident #6's most recent care plan last updated on 06/16/21 revealed a care plan for "[Resident #6] has an ADL (Activity of Daily Living) self-care performance deficit related to deconditioning". Interventions included the need for 1-person physical assistance with bathing.

A review of Resident #6's most recent quarterly Minimum Data Set Assessment dated 08/29/21 revealed Resident #6 to be cognitively intact for daily decision making with no behaviors or instances of rejecting care. Resident #6 was coded as requiring extensive assistance with bathing.

During an interview with Resident #6 on 09/02/21 at 11:27 AM, she reported she had not received a shower "in over a month." She reported she would like to have at least 2 showers per week but never gets them. Resident #6 reported because she does not get her showers, she has to stand and wash her hair and body at her sink in her room.

A review of Resident #6's shower documentation in her electronic medical record revealed Resident #6 had not had a shower coded in the system within the past 30 days. Resident #6 was scheduled to receive her showers on Tuesdays

F 677

accomplished for those residents found to have been affected by the deficient practice:

The facility failed to provide showers for resident #6 and resident #18.
Showers were provided to the resident #6 and resident #18 on 9/3/2021
How the facility will identify other residents having the potential to be affected by the same deficient practice:

Effective 9/27/2021, Director of Nursing and/or designee reviewed current dependent residents to ensure showers were given according to the plan of care and to their preference.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/27/2021 the Director of Nursing and/or designee will educate the current Certified Nursing Assistants on when the dependent residents are to receive a shower. In person and/or via phone.

Effective 10/1/2021 any Certified Nursing Assistants that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee.

Effective 9/27/2021 all Certified Nursing Assistants, including Agency staff before their first assignment, will be educated in

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and Fridays on 1st shift.

Review of facility provided staffing schedules revealed Nurse Aide (NA) #4 was scheduled to work 1st shift on 08/31/21.

During an interview with NA #4 on 09/02/21 at 3:12 PM, she reported she was an agency NA and had worked in the facility for approximately 2 months. She verified she worked on 08/31/21 and was responsible for providing care to Resident #6. She stated she could not remember if Resident #6 had received a shower on 08/31/21 or not. She reported if one had been given, it should be coded in Resident #6's electronic medical record. She indicated if the shower was not recorded in the electronic medical record, it probably was not provided. She stated there were days where showers were not able to be provided to all residents who were scheduled to receive them. She stated this was due to a lack of staff working in the building and her being too busy providing other care. NA #4 stated Resident #6 required assistance with bathing.

During an interview with the Director of Nursing on 09/02/21 at 3:54 PM, she reported she did not feel it was a fair assessment to assume if showers were not coded in the electronic medical record, then they were not provided. She stated there has been an ongoing issue with staff incorrectly documenting showers on physical "Shower sheets" and that documentation was not making it into the electronic medical record. She indicated that showers should be provided as scheduled and stated she would provide all physical shower sheets she had for Resident #6.

A review of physical shower sheets provided by

orientation in person by Director of Nursing and/or designee on "where to locate the shower schedule to ensure dependent resident receive a shower.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The DON and/or designee will monitor 5 residents to ensure residents are receiving showers 3x weekly x 4 weeks, weekly x 4 weeks, bi-weekly x 4 weeks.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.

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the Director of Nursing on 09/02/21 at 4:48 PM, revealed 2 shower sheets for Resident #6. One shower sheet was dated 07/01/21 and the other was dated 07/22/21.

2. Resident #18 was re-admitted to the facility on 1/28/21 with diagnoses that included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and diabetes.

A quarterly Minimum Data Set (MDS) dated 06/27/21 revealed Resident #18 to be cognitively intact and required extensive assistance of 1 staff member assistance for bathing.

Review of Resident #18's self-care deficit care plan with interventions dated 07/21/21 revealed he required extensive assistance of 1 staff member for bathing/showering activities.

A review of Resident #18's electronic medical record revealed documentation for the month of August 2021 that he had been independent for showers on 10 separate occasions. Nurse Aide #1 provided documentation on the following dates: 8/12/21, 8/19/21, 8/20/21, 8/23/21, 8/25/21, 8/26/21 which reflected Resident #18 to be independent for showers.

An interview with Resident #18 on 08/30/21 at 12:31 PM revealed he needed assistance for showers; however, he had not received showers as scheduled. Resident #18 was observed to have clothing that was both stained and had food and smokeless tobacco on the surface. Resident

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#18's hair appeared oily and slight body odor was present. Resident #18 stated he had not been showered in over a month, but could not recall the exact date of his last shower.

An interview with Nurse #3 on 09/01/21 at 3:44 PM revealed he was the nurse assigned to care for Resident #18 on 09/01/21 during day shift. Nurse #3 indicated Resident #18 should require extensive to total care for all bathing activities and should be taken to the shower room on his scheduled shower days of Monday, Wednesday, and Saturday on the evening shift.

An interview with Nurse Aide (NA #6) and Nurse Aide #7 (NA #7) on 09/01/21 at 3:50 PM revealed they were assigned to provide a shower to Resident #18 on 09/01/21. NA #7 said she was a new to the facility and both NA #6 and NA #7 stated that neither had been assigned or provided Resident #18 a shower before 09/01/21.

An observation of NA #6 and NA #7 on 09/01/21 at 5:00 PM revealed they assisted Resident #18 to the shower room. Resident #18 demonstrated his ability to clean his torso and arms but was unable to reach his legs or buttocks and required assistance.

A follow-up interview with NA #6 and NA #7 on 09/01/21 at 5:15 PM revealed they both now knew Resident #18 required extensive assistance for showers. NA #6 again explained she had never provided Resident #18 a shower before because she thought he bathed himself.

An interview with the Director of Nursing (DON) on 09/02/21 at 6:30 PM revealed she expected all showers to be provided according to the

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F 677	Continued From page 56 resident's preference and as listed on the shower schedule then documented accordingly. An interview with the Administrator on 09/02/21 at 7:00 PM revealed she expected staff to provide showers according on their assigned days and times and as requested by the resident.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that 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 observation, record reviews and interviews the facility failed to hold an anticoagulation medication as ordered for 1 of 5 residents (Resident #48) reviewed for unnecessary medications and failed to provide a daily treatment as ordered for 1 of 1 resident (Resident #15) reviewed for skin condition. The findings included: 1. Resident #48 was admitted to the facility on 02/18/20 with diagnoses that included cerebral vascular accident and coagulation disorder. A review of Resident #48's June 2021 Physician orders revealed orders for Coumadin (an anticoagulation medication given to thin the	F 684	F684 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to hold an anticoagulation medication as ordered for resident #48. Resident #48 was assessed by NP and PT/INR was for under therapeutic range and resident was able have surgery with no delay. The facility failed to provide a daily treatment for resident #15. Treatment for resident #15 was changed on 9/2/2021	10/15/21

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blood) 2.5 milligrams (mg) by mouth in the evenings on Tuesday, Thursday, Saturday and Sunday. The orders also revealed Coumadin 5 mg by mouth in the evenings on Monday, Wednesday and Friday.

The quarterly Minimum Data Set (MDS) assessment dated 07/23/21 revealed Resident #48 had severely impaired cognition and required limited assistance of one staff member for transfers. The MDS also indicated the Resident also received 7 days of anticoagulation medications.

A review of Resident #48's medical record revealed preop orders dated 08/13/21 8:01 AM that indicated Resident #48 was scheduled for external fixation of the right lower leg on 08/20/21 at an area Orthopedic Center. The orders also indicated the Coumadin should be held 5 days before surgery which indicated the last dose of Coumadin should be given on 08/14/21.

A review of Resident #48's Medication Administration Record for August 2021 revealed the Coumadin was given on 08/15/21, 08/16/21, 08/17/21 and 08/18/21.

Unsuccessful attempts were made to interview the nurses responsible for medicating Resident #48 on 08/15/21, 08/16/21, 08/17/21 and 08/18/21.

On 09/03/21 at 9:35 AM a telephone interview was conducted with the Assistant Nurse Manager (ANM) at the area Orthopedic Center. The ANM explained that the Center received a call from the facility's Director of Nursing (DON) on 08/18/21 who explained that the facility was not aware of per physician order.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

Effective 9/27/2021, Director of Nursing and/or designee reviewed current residents receiving anticoagulation medication to ensure hold orders entered into the resident electronic record.

Effective 9/27/2021, Director of Nursing and/or designee reviewed current residents receiving treatments to ensure treatments are done according to physicians orders.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/27/2021 the Director of Nursing and/or designee will educate the current License Nurses on entering hold orders for anticoagulation medications per physician orders. In person and/or via phone.

Effective 9/27/2021 the Director of Nursing and/or designee will educate the current License Nurses on following physicians orders for residents that are receiving treatments. In person and/or via phone.

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the order for Resident #48's Coumadin to be held after the 14th in preparation for her surgery scheduled for 08/20/21. The DON reported that the orders were discovered when the Resident had a routine weekly PT/INR level drawn on 08/18/21. The ANM continued to explain that the DON notified the Surgeon on 08/19/21 and reported that the Coumadin was not held as ordered and the Surgeon ordered for the Coumadin to be held on that day (08/19/21) and to proceed with the surgery as scheduled on 08/20/21. The ANM stated Resident #48 completed the surgery as planned without complications and was transferred back to the facility on 08/21/21 which was pre planned for an overnight stay in observation. The ANM stated that the Surgeon ordered the Coumadin to be restarted after surgery at the amount the Resident was taking before surgery.

An interview was conducted with the Director of Nursing on 09/03/21 at 11:19 AM. The DON explained that Resident #48 had an outpatient orthopedic surgery scheduled for 08/20/21 that was arranged by the family on 08/13/21. She continued to explain that they did not realize that there were preop orders that addressed when to stop giving Resident #48 the Coumadin before her surgery until 08/18/21 when she had a routine PT/INR level drawn that was 1.94 and the Nurse Practitioner (NP) was notified of the results. The NP instructed her the to notify the Surgeon that the Coumadin had not been held as per the preop orders which she did on 08/19/21. The DON explained the that Surgeon ordered for the Coumadin to be held on that day (08/19/21) and to proceed with the surgery as planned. The DON continued to explain that it was unclear as to why Resident #48's preop orders were not received by

Effective 10/1/2021 any License Nurses that has not been educated will not be allowed to work until receive education in-person or via telephone by Director of Nursing and/or designee.

Effective 9/27/2021 all License Nurses, including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on "entering hold orders for anticoagulation medications per physician orders and following physicians orders for residents that are receiving treatments.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The DON and/or designee will monitor residents with anticoagulation orders to ensure hold orders are entered into the resident electronic record daily (Monday □ Friday) x 4 weeks, 2 x weekly x 4weeks, and weekly x 4 weeks.
The DON and/or designee will monitor residents with treatment orders to ensure treatments done on the correct date 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, and weekly x 4 weeks.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.

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the Nurse taking care of Resident #48 on 08/13/21.

During an interview with the Medical Records Director (MRD) on 09/03/21 at 11:40 AM she confirmed she scanned Resident #48's preop orders into her electronic health record on 08/13/21 at 10:09 AM. The MRD explained that she met the Resident's family member at the front entrance who had given the preop orders to the Social Worker (SW) and advised the SW to give the preop orders to the Nurse taking care of Resident #48 because there were orders pertaining to her scheduled surgery. The MRD stated she took the preop orders from the SW to scan them into her electronic health record before the SW took the orders back to the Nurse. She stated she gave the orders back to the SW and told her to give them to the Unit Manager (UM) #2 responsible for Resident #48.

During an interview on 09/03/21 at 11:38 AM with Unit Manager #2 who acknowledged that she was the UM responsible for Resident #48 and explained that she was not given preop orders for the Resident nor was she aware of there being preop orders until the day before the scheduled surgery. She stated that when the preop orders were discovered they had already been scanned into her electronic health record. The UM further explained that the person who medicated Resident #48 on 08/13/21 was Medication Aide and the DON was her overseer that day.

An interview was conducted with Medication Aide (MA) #1 09/03/21 at 12:11. The MA explained that she vaguely remembered Resident #48 going for preop appointment for her surgery but stated she was not given preop paperwork when the

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Resident returned to the facility. The MA continued to explain that the DON would have been her overseer that day and should have gotten the paperwork.

During an interview with the Social Worker on 09/03/21 at 12:19 PM she explained that she remembered meeting Resident #48's family member at the entrance door the morning of 08/13/21 and the family member told her that there were orders pertaining to the Resident's surgery that needed to be given to the Nurse but that she was never given any orders to give to the Nurse. The SW stated she remembered she spoke with UM #2 and told her what the family had reported but that she never gave the UM any paperwork for the Resident.

An interview was conducted with the Nurse Practitioner (NP) on 09/03/21 at 12:49 PM. The NP explained that she was not aware that the facility had not held Resident #48's Coumadin until the DON notified her on 08/18/21 of the Resident's routine PT/INR level which was 1.94. She stated that before she gave further orders for the Coumadin, she wanted the Surgeon to be notified that the Coumadin had not been held in case it altered the scheduled surgery.

On 09/03/21 at 2:35 PM an interview was conducted with the Surgeon who conducted the external fixation on Resident #48. The Surgeon explained that he was notified by the facility on 08/19/21 that the Resident's Coumadin had not been held per the preop orders. He stated that he ordered for the Coumadin to be held on that day and to proceed with the surgery as planned then they could continue to give the Coumadin as it was originally ordered. The Surgeon continued to

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explain that the preop orders for the Coumadin were general preop orders given to everyone and because of the type of non-invasive surgery that Resident #48 had there would not be much blood loss and therefore, he was not as concerned that the Coumadin was not held.

During an interview with the Director of Nursing and the Regional Director of Clinical Operations on 09/03/21 at 3:37 PM. The DON stated she felt that the situation happened because there were too many people involved and there was no system in place to prevent the transcription error. Regardless, the DON stated she expected the Physician's orders to be transcribed and carried out as written.

An interview was conducted with the Administrator on 09/03/21 at 3:54 PM. The Administrator stated that her expectation was for the facility to receive and transcribe the Physician's orders as they were written as the Physician intended.

2. Resident #15 was admitted to the facility on 07/16/16 with diagnoses that included arthritis and dementia.

The quarterly Minimum Data Set (MDS) dated 06/22/21 revealed Resident #15 was cognitively intact and required extensive assistance of one staff with her activities of daily living.

A review of an Incident Report (IR) dated 08/24/21 6:13 PM revealed the Nurse was notified of a skin tear to Resident #15's right outer shin with scant amount of bleeding. The Resident stated she did not know how the skin tear happened and a treatment was set up. The IR

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also indicated the Provider and responsible party were notified.

A review of Resident #15's medical record dated 08/26/21 revealed an order for "Clean skin tear to the right outer leg with normal saline, pat dry, apply a specific medicated pad and cover with ABD pad, wrap with kling every day. Monitor for drainage or signs and symptoms of infection." The treatment was scheduled for every day on day shift.

A review of Resident #15's August 2021 Treatment Administration Record (TAR) revealed the treatment for the Resident's dressing to her right lower shin was last documented on 08/27/21.

On 08/31/21 at 4:03 PM an interview and observation were made of Resident #15. The dressing on the Resident's right lower leg was dated 08/27/21. Resident #15 stated she not sure how long it had been since the dressing had been changed. Nurse Aide #1 was present during the observation and confirmed the date of the dressing was 08/27/21.

An interview was conducted with Nurse #3 on 08/31/21 at 4:28 PM who confirmed he was Resident #15's day shift nurse and that the treatment on the Resident's right lower leg was scheduled to be done every day. The Nurse stated that Nurse #4 was responsible for treatments on that day (08/31/21).

An interview was conducted with Nurse #4 on 08/31/21 at 4:39 PM. The Nurse stated she was responsible for the treatments for that day and stated she had already removed the dressing

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from Resident #15 right leg and confirmed the date on the dressing was 08/27/21. The Nurse reviewed the Resident's TAR and stated the Nurse responsible for Resident #15's treatment the day before on 08/30/21 was Nurse #5.

During an interview with Nurse #5 on 08/31/21 at 4:52 PM she explained that she was so busy on 08/30/21 that she did not have time to perform Resident #15's dressing change to her right leg. The Nurse stated she passed it on to the oncoming Nurse that she was unable to change the Resident's dressing and asked her to complete the dressing change.

On 09/01/21 at 3:57 PM during an interview with Nurse #3 he confirmed that he worked on 08/28/21 with Resident #15. The Nurse acknowledged he did not perform the dressing change on the Resident's right lower leg and stated that he was too busy to complete all the treatments for the shift.

An interview with the Nurse Practitioner (NP) was conducted on 09/01/21 at 2:58 PM. The NP stated she was made aware of the skin tear on Resident #15's right lower leg when it happened. The NP stated she expected the dressing changes be conducted as they were ordered to be done.

An interview was conducted on 09/02/21 at 9:17 AM with Nurse #6 who confirmed she worked the evening shift on 08/30/21 and received report from Nurse #5. Nurse #6 explained that Nurse #5 did not pass on to her that the dressing change to Resident #15 needed to be done.

Attempts were made to interview the Nurse who

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F 684	Continued From page 64 worked on 08/29/21 on the 7:00 AM to 7:00 PM shift but the attempts were unsuccessful. An interview was conducted with the Director of Nursing (DON) on 09/02/21 at 3:17 PM. The DON stated her expectation was that the nurses perform the residents' treatments as the order indicated. During an interview with the Administrator on 09/03/21 at 3:54 PM she stated her expectation was that the treatments be conducted according to the physician's orders.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Resident interviews, the facility failed to provide a pressure ulcer treatment as ordered for 1 of 2 residents (Resident #15) reviewed for pressure ulcers.	F 686	F686 How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	10/15/21

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The finding included:

Resident #15 was admitted to the facility on 07/16/16 with diagnoses that included dementia and arthritis.

The quarterly Minimum Data Set (MDS) assessment dated 06/22/21 revealed the Resident had intact cognition and required extensive assistance of one staff for bed mobility and personal hygiene. The MDS also indicated Resident #15 was incontinent and had one stage 3 pressure ulcer that was present on admission. The MDS revealed the Resident was on a pressure reducing device on her bed and received pressure ulcer care.

A review of Resident #15's electronic health record revealed an order dated 08/05/21 for the sacral wound to be cleaned with a wound cleaner and a hydrocolloid dressing to be applied every 3 days and as needed.

A review of the Wound Physician's progress note dated 08/26/21 revealed Resident #15's stage 3 sacral wound measured 0.7 x 0.7 x 0.2 centimeters with a scant amount of exudate. The note also indicated to continue the current treatment plan for one week.

A review of Resident #15's August 2021 Treatment Administration Record (TAR) revealed the treatment for the Resident's sacral dressing was last documented on 08/27/21.

On 08/31/21 at 3:55 PM an interview and observation were made of Resident #15 while she was in bed. The Resident reported she had a sore on her bottom that was getting better.

The facility failed to provide a pressure ulcer treatment as ordered for resident #15. Resident #15 treatment was changed on 9/2/2021 per physician order.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

Effective 9/23/2021 the Director of Nursing and/or designee assess current residents with pressure ulcer treatments to ensure treatments were done per physician orders.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/27/2021 the Director of Nursing and/or designee will educate current licensed nurses on changing pressure ulcer treatment per physician orders. In person or via telephone.

Effective 10/1/2021 any License Nurses that has not been educated will not be allowed to work until receive education in-person or via telephone by Director of Nursing and/or designee.

Effective 9/27/2021 all License Nurses, including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on " changing pressure ulcer treatment per physician

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On 08/31/21 at 4:05 PM an observation was made of Nurse Aide (NA) #1 turning Resident #15. During the procedure, the NA rolled the Resident to her right side using the turning device and revealed a dressing on the Resident's sacrum that was dated 08/27/21. The NA acknowledged the date on the dressing.

An interview was conducted with Nurse #3 on 08/31/21 at 4:28 PM who confirmed he was Resident #15's day shift nurse and that the treatment for the Resident's sacral pressure ulcer was scheduled to be done every 3 days and as needed. The Nurse stated that he did not work on 08/30/21 when the sacral dressing was due to be changed but that Nurse #4 was responsible for treatments on that day (08/31/21).

An interview was conducted with Nurse #4 on 08/31/21 at 4:39 PM. The Nurse stated she was responsible for the treatments for that day (08/31/21) and stated she had already removed the dressing from Resident #15 sacrum and confirmed the date on the dressing was 08/27/21. The Nurse reviewed the Resident's TAR and stated the Nurse responsible for Resident #15's treatment the day before on 08/30/21 was Nurse #5.

During an interview with Nurse #5 on 08/31/21 at 4:52 PM she explained that she was so busy on 08/30/21 that she did not have time to perform Resident #15's sacral dressing change. The Nurse stated she passed it on to the oncoming Nurse that she was unable to change the Resident's dressing and asked her to complete the dressing change.

orders.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Director of Nursing and/or designee will audit 5 residents with pressure ulcer treatment orders to ensure treatments are completed per physician orders, 3 X weekly X 4 weeks, weekly X 4 weeks, and Bi-weekly X 4.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.

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F 686	Continued From page 67 An interview was conducted on 09/02/21 at 9:17 AM with Nurse #6 who confirmed she worked the evening shift on 08/30/21 and received report from Nurse #5. Nurse #6 explained that Nurse #5 did not pass on to her that Resident #15's dressing change to her sacrum needed to be done. An interview with the Nurse Practitioner (NP) was conducted on 09/01/21 at 2:58 PM. The NP stated she was made aware of the Resident #15's stage 3 sacral pressure ulcer and that the Resident was being followed by the wound care services. The NP stated she expected the dressing changes be conducted as they were ordered to be done. An interview was conducted with the Director of Nursing (DON) on 09/02/21 at 3:17 PM. The DON stated her expectation was that the nurses perform the residents' treatments as the order indicated. During an interview with the Administrator on 09/03/21 at 3:54 PM she stated her expectation was that the treatments be conducted according to the physician's orders.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		10/15/21

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§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:
Based on observations, record review, family, and staff interview the facility failed to apply a hand splint per the functional maintenance program for 1 of 2 resident reviewed with limited range of motion (Resident #51).

The findings included:

Resident #51 was readmitted to the facility on 09/05/17 with diagnoses that included peripheral vascular disease, dementia, heart disease, and others.

Review of the Functional Maintenance Program for Resident #51 dated 07/07/21 read in part, don T Bar splint at 7:00 AM, doff at 7:00 PM. If any skin breakdown notify the nurse immediately. The form further stated that each employee signatures signifies acknowledgment that they have received training from the therapist on the functional maintenance program outline above and they have a copy of the application handout. In addition, each employee's signature acknowledges their commitment to become familiar with the information and their understanding that this information supersedes all previously communicated information on this

F688

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

The facility failed to apply a hand splint per the functional maintenance program for resident #51. Resident # 51 was assessed by therapy on 9/3/2021 and splint was applied on 9/3/2021 per the functional maintenance program.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

Effective 9/16/2021, Director of Nursing and/or designee reviewed current residents with splints to ensure application was done per the functional maintenance program.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not

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topic and was signed by staff including Nurse Aide (NA) #4 on 07/08/21.

Review of the quarterly Minimum Data Set (MDS) dated 07/29/21 indicated Resident #51 was moderately impaired for daily decision making and required extensive to total assistance with activities of daily living. The MDS further indicated that Resident #51 rejected care to 1 to 3 days during the assessment reference period.

An observation of Resident #51's room was made on 08/30/21 at 10:55 AM. There was a sign posted at the head of Resident #51's bed that stated see splinting instructions on inside of resident closet. The splinting information on the closet read in part, -assess skin for breakdown and complete left-hand hygiene, -complete range of motion with left digits in extension, -don T bar splint at 7:00 AM, -doff at 7:00 PM, -check skin for skin breakdown, -notify the nurse immediately if skin breakdown is noted. The instructions included detail pictures of the splint on Resident #51. Resident #51 did not have any splint in place at the time of the observation.

An interview was conducted with Resident #51's family on 08/30/21 at 3:12 PM. The family member stated that Resident #51 did at one point have a splint that they put on his left hand to keep his hand open and keep his fingers from digging into his palm. The family member stated she had visited with Resident #51 on 08/29/21 around 4:00-4:30 PM and Resident #51 did not have a splint in place to his left hand.

An observation of Resident #51 was made on 08/31/21 at 10:52 AM. Resident #51 was resting in bed with his head of bed elevated. He was

recur:

Effective 9/27/2021 the Director of Nursing and/or designee will educate the current Certified Nursing Assistants and License Nurses on where to find if the resident has a splint to apply and when to apply it. License Nurses are to ensure splints are applied per the functional maintenance program. In person and/or via phone.

Effective 10/1/2021 any Certified Nursing Assistants and License Nurses that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee.

Effective 9/27/2021 all Certified Nursing Assistants and License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on " where to find if the resident has a splint to apply and when to apply it. License Nurses are to ensure splints are applied per the functional maintenance program."

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The DON and/or designee will monitor residents with splints to ensure applied per the functional maintenance program as follows: 6 residents 3x weekly x 4 weeks, then 4 residents weekly x 4 weeks, then 3 residents bi-weekly x 4

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observed to have no splint to his left hand in place.

An observation of Resident #51 was made on 09/01/21 at 12:31 PM. Resident #51 was resting in bed with his head of bed elevated. He was observed to have no splint to his left hand in place.

An observation of Resident #51 was made on 09/02/21 at 10:39 AM. Resident #51 was resting in bed with his head of bed elevated. He was observed to have no splint to his left hand in place.

An interview was conducted with NA #4 on 09/02/21 at 12:00 PM. NA #4 confirmed that she routinely cared for Resident #551 and stated that she had seen Resident #51 wear a splint before, but she did not apply them and stated, "therapy was applying them."

The Director of Therapy (DOT) was interviewed on 09/02/21 at 12:03 PM. The DOT stated that there were 2 splint books one at each nursing station and each book contained the splinting schedule for all the residents. He added that he kept the books updated periodically and was responsible for educating the nursing staff on the application of the splints. The DOT stated that Resident #51 went through the therapy process and once completed a functional maintenance program was developed and put into place with the nursing staff applying the splints per the program posted in Resident #51's room. The DOT added that during Resident #51's time in therapy he did not refuse or resist the splint to his left hand.

weeks.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.

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The Director of Nursing (DON) was interviewed on 09/03/21 at 12:24 PM. The DON stated she had only been the interim DON for a short period of time and was not familiar with Resident #51 or his splinting schedule. She stated that she expected any splint or device to be used appropriately as directed by the plan of care.

F 689 SS=D Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) — F 689 — 10/15/21

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and resident and staff interviews, the facility failed to complete a new admission smoking assessment to determine if the resident was a safe smoker or needed supervision while smoking cigarettes for 1 of 2 residents reviewed for smoking (Resident #86).

Findings included:

Resident #86 was admitted to the facility on 08/28/21 for short term rehabilitation.

A review of resident #86's medical record revealed the baseline care plan dated 08/28/21 that did not include any care areas related to Resident #86's wish to smoke.

F689

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility failed to complete a new admission smoking assessment to determine if the resident was a safe smoker or needed supervision while smoking cigarettes for resident #86.

Resident #86 smoking assessment was updated to ensure the resident is a safe smoker on 9/2/2021

How the facility will identify other residents

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A smoking assessment dated 08/28/21 revealed it to be partially completed but indicated Resident #86 was a known smoker.

A review of a document provided by the facility of unsupervised smokers did not include Resident #86's name.

Resident #86's medical record revealed he did not have a care plan for unsupervised smoking.

A Brief Interview of Mental Status (BIMS) interview dated 08/28/21 was partially completed and indicated Resident #86 to be severely cognitively impaired.

An observation and interview on 09/02/21 at 3:00 PM revealed Resident #86 was sitting outside in his wheelchair in the designated smoking area. Resident #86 was observed to be smoking a lit cigarette and holding an additional cigarette in his other hand. When asked about his smoking habits, Resident #86 stated he had just been readmitted to the facility over the weekend and he currently did not have his own cigarettes, so he had to "bum" some each time he wanted to smoke.

An interview with the Director of Nursing (DON) on 09/02/21 at 3:30 PM revealed she was not aware Resident #86 was a current smoker and stated she would find out further information.

An additional interview with the DON on 09/02/21 at 4:50 PM revealed she had spoken with Resident #86 on 09/02/21 since the initial interview and he had explained to her that he did not have any cigarettes and had not smoked in almost 2 weeks. The DON stated she offered

F 689

having the potential to be affected by the same deficient practice;

Effective 9/24/2021 the Director of Nursing and/or designee assessed current residents to identify if they are safe smokers and smoking assessments were updated accurately.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/27/2021 Director of Nursing and/or designee educated current license nurses on assessing the resident to identify if a smoker and completed the assessment accurately.

Effective 10/1/2021 any License Nurses that has not been educated will not be allowed to work until receive education in-person or via telephone by Director of Nursing and/or designee.

Effective 9/27/2021 all License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on "assessing the resident to identify if a smoker and completed the assessment accurately.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Director of Nursing and/or designee will

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F 689	Continued From page 73 Resident #86 a smoking cessation patch since he did not currently have any cigarettes. She indicated after speaking with Resident #86, she had completed an additional smoking assessment to reveal Resident #86's history of smoking and agreement to stop smoking with the use of a smoking cessation patch. The DON also explained she had the Minimum Data Set (MDS) Nurse update Resident #86's care plan to reflect the history of smoking. An observation and interview with Resident #86 on 09/02/21 at 5:30 PM revealed he had obtained another cigarette and was planning to go smoke. An additional interview with the DON on 09/02/21 at 6:30 PM revealed all residents should be assessed for their wish to smoke upon admission and a smoking assessment should be completed by the admitting nurse within 24 hours of admission and be included on the baseline care plan within 48 hours of admission if the resident wished to smoke. Resident #86's comprehensive care plan should reflect his preference to smoke before being allowed to smoke unsupervised. An interview with the Administrator on 09/02/21 at 7:00 PM revealed she expected Resident #86 to be assessed for smoking on admission and determined if he would be allowed to smoke without supervision.	F 689	audit admissions to ensure if residents smoking assessment is correct daily (Monday □ Friday) X 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 692		10/15/21

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enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview the facility failed to have thickened liquids available at bedside for a resident that was at risk for dehydration for 1 of 2 resident reviewed for hydration (Resident #5).

The findings included:

Resident #5 was readmitted to the facility on 12/22/20 with diagnoses that included Alzheimer's Disease and chronic obstructive pulmonary disease.

Review of a physician order dated 08/10/21 read, Nectar thick liquids.

Review of the quarterly Minimum Data Set (MDS) dated 08/29/21 revealed that Resident #5 was moderately impaired for daily decision making and required limited assistance with eating and

F692

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility failed to have thickened liquids available at bedside for resident #5.

Thickened liquids was made available to resident #5 on 9/3/2021.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Effective 9/24/2021 the Director of Nursing and/or designee assessed current residents that are receiving

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was prescribed a mechanically altered diet.

An observation of Resident #5 was made on 08/30/21 at 11:39 AM. Resident #5 was resting in bed with his head of bed elevated There was a sign posted on his closet door that stated, "aspiration precautions" and instructed staff to read the information that indicated Resident #5 was on nectar thick liquids. There were no nectar thick liquids available in Resident #5's room at the time of the observation. There was a small cooler noted sitting on his nightstand. The cooler contained a melted ice pack and empty water cups.

An observation of Resident #5 eating lunch in the dining room was made on 08/30/21 at 12:55 PM. Resident #5 was observed to be feeding himself the lunch tray and ate 100% of the meal and fluid intake and asked for more. Resident #5 was provided additional food and fluid items and consumed 100% of the additional items requested.

Review of a care plan revised on 08/31/21 read, Resident #5 has the potential for fluid deficit related to confusion. The goal read; Resident #5 will be free of symptoms of dehydration and maintain moist mucous membranes and good skin turgor through the next review period. The interventions included: encourage fluid intake to meet daily requirements, invite to activities that promote additional fluid intake, offer drinks during one-on-one visit, ensure that all beverages comply with diet/fluid restrictions and consistency requirements, give thyroid replacement therapy as ordered, and obtain and maintain diagnostic work as ordered.

thickened liquids to ensure thickened liquids are available at bedside and within reach.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/27/2021 Director of Nursing and/or designee educated current Certified Nursing Assistances and License Nurses on ensuring residents have thickened liquids available at bedside and within reach.

Effective 9/27/2021 Director of Nursing and/or designee educated current Certified Nursing Assistances and License Nurses on ensuring water is passed q shift and as needed.

Effective 10/1/2021 any Certified Nursing Assistances and License Nurses that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee.

Effective 9/27/2021 all Certified Nursing Assistances and License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on ensuring residents have thickened liquids available at bedside and within reach.

Indicate how the facility plans to monitor its performance to make sure that

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An observation of Resident #5 was made on 08/31/21 at 10:00 AM. Resident #5 was up in his wheelchair at bedside. There were no thickened liquids available to Resident #5 at bedside. There was a small cooler noted sitting on his nightstand. The cooler contained a melted ice pack and empty water cups.

An observation of Resident #5 was made on 08/31/21 at 4:33 PM. Resident #5 was up in his wheelchair at bedside. There were no thickened liquids available to Resident #5 at bedside. There was a small cooler noted sitting on his nightstand. The cooler contained a melted ice pack and empty water cups.

An observation of Resident #5 was made on 09/01/21 at 9:00 AM. Resident #5 was up in his wheelchair at bedside and his oral mucosa was pink and moist. There were no thickened liquids available to Resident #5 at bedside. There was a small cooler noted sitting on his nightstand. The cooler contained a melted ice pack and empty water cups.

An observation of Resident #5 was made on 09/01/21 at 4:40 PM. Resident #5 was up in his wheelchair at bedside and his oral mucosa was pink and moist. There were no thickened liquids available to Resident #5 at bedside. There was a small cooler noted sitting on his nightstand. The cooler contained a melted ice pack and empty water cups.

An observation of Nurse Aide (NA) #3 was made on 09/02/21 at 10:32 AM. NA #3 was observed to be passing ice to Resident #5's roommate. She filled a Styrofoam cup with ice and thin water and sat it on the roommates bedside table and exited

solutions are sustained:

Director of Nursing and/or designee will audit (3) residents with thickened liquids to ensure thickened liquids are available at the bedside and within reach 3 X week X 4 weeks, weekly X 4 weeks, and bi-weekly X 4 weeks.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.

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the room to the room next door. She did not place any thickened water in Resident #5's room for him to have available. NA #3 stated that she routinely passed ice twice during her 12-hour shift, once in the morning and then again before the end of her shift. She stated that residents that were on thickened water were given a Styrofoam cup with thickened water in it. NA #3 stated that she did not have any thickened water on her ice cart and stated she would have to bring some back for Resident #5 later. There was a small cooler noted sitting on his nightstand. The cooler contained a melted ice pack and empty water cups.

An observation of Resident #5 was made on 09/02/21 at 10:34 AM. Resident #5 was resting in bed with his eyes open. He was alert and nonverbal. His oral mucosa was pink and moist and there were no thickened liquids available for Resident #5 at bedside. There was a small cooler noted sitting on his nightstand. The cooler contained a melted ice pack and empty water cups.

An observation of Resident #5 was made on 09/02/21 at 4:03 PM. Resident #5 was resting in bed with head of bed elevated. He was observed to have a large Styrofoam cup with red thickened liquids in it sitting on his bedside table. Resident #5 was observed to pick up the cup and take a large gulp with no issues noted.

An interview was conducted with the Speech Therapist (ST) on 09/02/21 at 3:55 PM. The ST stated that she had evaluated Resident #5 yesterday because he was at the point cognitively where he needed to be fed by staff and had recent weight loss. She stated that the goal for

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Resident #5 was to initiate task and to answer simple yes/no questions to help keep him safe. The ST stated she observed Resident #5 drink nectar thick liquids from on open cup with no glaring signs of aspiration. She added that because Resident #5 was on nectar thick liquids that automatically placed him at high risk for dehydration simply because they were harder to obtain, and the resident generally liked them less. However, the ST stated that Resident #5 was able to get the cup to his mouth with no issue and took the liquids well but stated he would drink the whole cup in one gulp, and she wanted to work with him on the safety part of that. The ST stated that she expected Resident #5 to have nectar thick liquids available to him during meals and when he was in his room to keep him hydrated.

The Director of Nursing (DON) was interviewed on 09/03/21 at 11:41 AM. The DON stated she expected each resident to have whatever liquids they were supposed to have easily accessible to them. She stated that the staff should know which liquids each resident was on and offer them each time they enter the room to help prevent weight loss and/or dehydration. The DON stated that they used to keep thickened liquids in a cooler in the resident room with an ice pack that was an old practice, and they did not use that anymore.

The Registered Dietician (RD) was interviewed on 09/03/21 at 3:11 PM. The RD stated that she had recently reviewed Resident #5's medical record for a recent significant weight loss. She stated that he was on puree diet with nectar thick liquids. She stated that she had added a nutritional intervention to be on the safe side but questioned the weight loss was a true weight loss or not. The RD stated that Resident #5 generally

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F 692	Continued From page 79 ate and drank everything that was put in front of him including his nectar thick liquids and added that he should receive the same amount of fluids as the other residents despite being on altered consistency. The RD stated that she expected Resident #5 to always have thickened liquids available to him unless he was fluid restricted which he was not to prevent dehydration and subsequent weight loss.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756		10/15/21

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be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

Based on record review, staff, Consultant Pharmacist, and Nurse Practitioner interview the facility failed to carry out and follow through with the medical doctors' orders in response to a consultant pharmacist recommendation for 1 of 5 residents reviewed for unnecessary medications (Resident #5).

The findings included:

Resident #5 was readmitted to the facility on 12/22/20 with diagnoses that included hypothyroidism.

Review of a Consultant Pharmacist Recommendation to the Physician/Prescriber dated 06/14/21 read, Resident #5 was receiving Synthroid (used to treat hypothyroidism) 25 micrograms (mcg) give 1.5 tablets in the morning for hypothyroidism. Recent thyroid stimulating hormone (TSH) on 05/31/21 was 0.31 (low) and resident with recent weigh loss after having COVID 19. "It is possible thyroid may be contributing to weight loss as his recent TSH is on the low end. May consider evaluate if dose reduction in Synthroid is warranted at this time

F756

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility failed to carry out and follow through with the medical doctors' orders in response to a consultant pharmacist recommendation for resident #5.

Physician orders were carried through for resident #5 on 9/9/2021.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Effective 9/16/2021 the Director of Nursing and/or designee reviewed August pharmacy consult recommendation to ensure completion of any recommendation.

Address what measures will be put into

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F 756	Continued From page 81	F 756		

and repeat in 6 weeks?"

Review of a physician order dated 06/14/21 read, decrease Synthroid to 25 mcg and recheck TSH and Fasting lipid panel (FLP) in 6 weeks. The orders were signed off by Unit Manager (UM) #1.

Review of the June 2021 Medication Administrator Record (MAR) revealed that on 06/14/21 Resident #5's Synthroid was decreased to 25 mcg as ordered.

Review of Resident #5's medical record revealed no record of the TSH or FLP that were drawn since the order of 06/14/21.

Review of a quarterly Minimum Data Set (MDS) dated 08/29/21 indicated that Resident #5 was moderately impaired for daily decision making and required extensive assistance with activities of daily living.

The Nurse Practitioner (NP) was interviewed on 09/01/21 at 4:35 PM and stated that the Medical Doctor (MD) had entered the orders on 06/14/21 and UM #1 had signed them off but for some reason the lab orders had not been carried over to the laboratory system to be drawn as ordered. The NP stated that when orders were entered into the system the expectation was that they were carried out to completion and entered wherever they were needed to ensure the completion.

UM #1 was interviewed on 09/01/21 at 5:04 PM and stated that she was only in the UM role for a couple of weeks and had recently stepped down to take another position. UM #1 stated that she confirmed the order in the electronic medical

place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/23/2021 Regional Director of Clinical Services educated Director of Nursing on the process of ensuring completion of any recommendations from the pharmacy consultant.

Effective 10/4/2021 Director of Nursing will educate the nurse manager on completing the pharmacy recommendations timely. The Director of Nursing will keep a copy of the recommendations to follow up on the completion. If completion not done, the Director of Nursing will follow up with nurse manager and/or physician.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Director of Nursing and/or designee will audit recommendations from the pharmacy consultant to ensure completion monthly X 3 months.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.

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record and carried them out but could not recall why the laboratory orders were not entered or drawn. UM #1 stated that at one point they were having issues with the laboratory company coming out to perform the ordered lab draws and the facility had to keep rescheduling them but again stated she could not recall why the lab orders did not get entered into their system for completion. UM #1 stated if the lab orders were carried out and performed, they would be in the lab system and in Resident #5's electronic medical record.

The Consultant Pharmacist (CP) was interviewed via phone on 09/03/21 at 9:38 AM. The CP stated that she visited the facility monthly and conducted the review of each resident medical record. Normal procedure for the monthly review was to ensure the previously issued recommendations had been addressed by the provider and if not follow up and see what was going on. The CP stated that for lab draws she generally gave them 6-12 week for completion before she would be concerned. However, the CP stated that if the medical provider specified a time frame like 6 weeks for lab draws then the expectation would be that the order would be carried out to completion in that time frame specified by the provider.

The Director of Nursing (DON) was interviewed on 09/03/21 at 11:41 AM. The DON stated she expected UM #1 to enter the orders into the electronic medical record and carry them out to the correct system and ensure completion of all orders including the orders for Resident #5 that were ordered on 06/14/21.

An attempt to speak to the Medical Doctor (MD)

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F 756	Continued From page 83 was made on 09/03/21 at 2:16 PM with no success.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to remove expired insulin from one of four medication carts reviewed (200 hall back medication cart). The findings included:	F 761	F761 How corrective action will be accomplished for those residents found to have been affected by the deficient practice;	10/15/21

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An observation of the 200 hall back medication cart was made on 09/02/21 at 4:38 PM with Medication Aide (MA) #1. The observation revealed 2 insulin aspart flex prefilled pens that had an open date of 08/04/21 and a discard date of 09/01/21. MA #1 confirmed that the insulin was good for 28 days and should have been discarded on 09/01/21. She added that she had just taken over the medication cart because the previous nurse had an emergency and had to leave and had not had the opportunity to go through the medication cart since taking it over.

The Consultant Pharmacist (CP) was interviewed on 09/03/21 at 9:38 AM. The CP stated that the insulin aspart was a short acting Novolog (insulin) and once opened and kept at room temperature was good for 28 days. After 28 days the pen should be discarded, and a new pen obtained per the CP. The CP added that the manufacturer says do not use past 28 days, but she was unaware of any negative side effects that could come from using the insulin past the 28 days.

The Director of Nursing (DON) was interviewed on 09/03/21 at 12:15 PM. The DON stated that the facility kept insulin pens in the refrigerator until opened and then once opened kept on the medication cart for 28 days and then discarded and a new pen obtained. She added that if the insulin aspart was opened on 08/04/21 then it should have been discarded 28 days later which was 09/01/21.

The Administrator was interviewed on 09/03/21 at 4:31 PM. The Administrator stated that she expected the staff to follow all guidelines in regard to dating insulin and then discarding it on

The facility failed to remove expired insulin from 200 hall medication cart.

Expired insulin was discarded properly on 9/2/2021.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Effective 9/21/2021 pharmacy consultant audited medication carts and medication rooms and expired medications were removed and discarded properly.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/27/2021 Director of Nursing and/or designee will educate License Nurses and Medication Aides on removing and discarding expired insulin properly.

Effective 10/1/2021 any License Nurses and Medication Aides that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee.

Effective 9/27/2021 all License Nurses and Medication Aides including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on removing and discarding expired insulin

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F 761	Continued From page 85 or before the expired date.	F 761	properly. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit medication carts to ensure expired insulin is discarded properly weekly x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.	
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those	F 790		10/15/21

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circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;

§483.55(a)(4) Must if necessary or if requested, assist the resident;
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services location; and

§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident and staff interview the facility failed to obtain dental care by a dentist for a resident with broken or caried teeth for 1 of 1 resident reviewed for dental (Resident #38).

The findings included:

Resident #38 was admitted to the facility on 09/25/20 and readmitted on 07/09/21 with diagnoses that included end stage renal disease.

Review of an admission assessment dated 09/25/20 revealed that Resident #38 had broken or carious teeth. The admission assessment was completed by Nurse #2.

F790

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility failed to obtain dental care by a dentist for a resident with broken or caried teeth for resident #38.

Resident #38 was seen by a dentist for dental care on 10/5/2021.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

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Review of the quarterly Minimum Data Set (MDS) dated 07/01/21 indicated that Resident #38 was cognitively intact and required extensive assistance with personal hygiene. The MDS further revealed no issues under dentation during the assessment reference period.

Review of a care plan updated on 08/01/21 read in part, Resident #38 has an activity of daily living (ADL) self-care performance deficit related to deconditioning and decreased mobility. The goal read; Resident #38 will maintain current level of function in ADLs through the review date. The interventions included: oral care routine extensive assist with mouth care.

An observation and interview were conducted with Resident #38 on 08/31/21 at 4:17 PM. Resident #38 was resting in bed with eyes open. Resident #38 stated that he had been at the facility for almost a year and needed to see a dentist because his back teeth were breaking off and it was hard for him to chew. Resident #38 opened his mouth to expose his back teeth that were breaking off and stated that he had told several staff members including one of the facility's previous Social Worker (SW) since as early as January 2021 that he needed to see the dentist and they would tell me that I was on the list to see the dentist but when the dentist came, I was never seen. Resident #38 stated that he had one family member in charge of his financial affairs and one family member in charge of his medical issue and he had set aside funds for things like this and all they needed to do was contact his family member that managed his financial affairs and he would take care of it. Resident #38 could not recall the names of the staff member he had talked about his dental

Effective 9/28/2021 Director of Nursing and/or designee assessed current residents for the need of dental care. Dental services are due in the facility on 10/12/21.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/27/2021 Director of Nursing and/or designee will educate current staff on notifying Social Worker, Director of Nursing, and/or Administrator if resident is in need of dental services. Services will be set up with facility provider and/or services will be outsourced.

Effective 10/1/2021 any current staff that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee.

Effective 9/27/2021 all current staff including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on notifying Social Worker, Director of Nursing, and/or Administrator if resident is in need of dental services.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

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issue with but stated he knew he had spoke to one of the former SWs in the facility and to the Speech Therapist (ST), but the ST has been gone for while from the facility as well, but he had yet to see the dentist when they visited the facility.

The former ST was interviewed via phone on 08/30/21 at 12:27 PM. The former ST stated that she worked at the facility in December 2020 for a few weeks and recalled Resident #38 reporting that he needed to see a dentist for some issues he was having with his teeth. The former ST stated that she had relayed that information to the facility SW at the time but could not recall who that was.

The Account Manager (AM) for the dental service with the facility was interviewed on 09/01/21 at 4:07 PM. The AM confirmed that Resident #38 had not been seen by the dentist since he had been at the facility and was not seen on the most recent visit to the facility on 07/07/21 or 08/05/21. The AM also confirmed that Resident #38 would be financially responsible for his service but there had been no consent or family approval initiated for the service which she said could be done with the help of the facility staff.

The former SW was interviewed via phone on 09/02/21 at 12:40 PM. The former SW stated that she left the facility in March 2020 and stated that there had been several SW there since. The former SW stated that she was not familiar with Resident #38 and could not recall if he had reported to her that he needed to see a dentist or not. The former SW stated that if he had she would have arranged the visit with the AM from the local dentist that visited the facility.

Director of Nursing and/or designee will interview and/or evaluate 5 residents for the need of dental services weekly x 12 weeks.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.

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The current SW was interviewed on 09/02/21 at 12:43 PM. The current SW stated she had no interaction with Resident #38 since she started with the facility a couple of weeks ago.

An attempt to speak to Nurse #2 was made on 09/03/21 at 3:00 PM with no success.

The Director of Nursing (DON) was interviewed on 09/03/21 at 12:31 PM. The DON stated that she had only been the DON for a few weeks, and she was not aware of Resident #38's dental issues. She stated that she wished she knew who Resident #38 had told so that she could follow up but stated that someone needed maintain control of that program to ensure that the resident received the dental services either internally or externally.

F 810 SS=D — Assistive Devices - Eating Equipment/Utensils — CFR(s): 483.60(g) — F 810 — 10/15/21

§483.60(g) Assistive devices
The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview the facility failed to consistently provide a provale (sippy cup with 2 handles that only delivered a small amount of liquid) cup for drinking liquids as ordered for 1 of 2 resident reviewed for hydration (Resident #78).

The findings included:

F810

Resident #78 observed during mealtime without her provale cup as ordered. Resident was provided the prevail cup upon notification.

Current residents□ orders were audited on 9/20/21 by SLP to ensure adaptive

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Resident #78 was admitted to the facility on 09/30/13 with diagnoses that included chronic congestive heart failure, dementia, and dysphagia.

A physician order dated 11/17/20 read, Provale cup 5 milliliters (ml) for thin liquids.

The quarterly Minimum Data Set (MDS) dated 07/01/21 revealed that Resident #78 was severely cognitively impaired for daily decision making and required set up assistance of one staff member with eating. The MDS further revealed that Resident #78 was ordered a mechanically altered diet.

A care plan revised on 07/13/21 read in part, Resident #78 was at nutritional risk related to age, dementia, significant weight loss, underweight and need for modified consistency diet for dysphagia. The goal read: Resident #78 will maintain adequate nutritional status as evidenced by maintaining weight with no significant change and no signs or symptoms of swallowing problem through the review period. The interventions included: monitor/document and signs of dysphagia, observe and record intake at each meal, provide diet as ordered with assistance at meals as needed, provide supplements as ordered, and weights per routine.

An observation of Resident #78 was made on 08/30/21 at 10:50 AM. Resident #78 was resting in bed with eyes open and head of bed elevated. There was a sign posted on her closet door that read; "all liquids consumed with provale cup with blue/brown lid at all times to decrease aspiration/choking risk." There was no provale cup noted in Resident #78's room. There was a

equipment is being provided as ordered. Completed by RDCS on 9/16/21 Meal tickets and resident orders were reviewed to ensure accuracy of adaptive equipment.

Education was done on 9/27/2021 by DON or designee to direct care (Nurse Aides, Nurses) and dietary staff to ensure adaptive equipment is given as ordered.

Monitoring will be conducted by DON or Therapy services through observation rounds on random shifts to ensure adaptive equipment are being always provided. Visual audit of 3 residents per day as follows: 3 times per week x 4 weeks, weekly x 1 month and monthly x 3 month.

Results of monitoring, with tracking and trending, will be reported by Administrator to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.

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large white Styrofoam cup of clear liquid sitting on her nightstand.

An observation of Resident #78 was made on 08/31/21 at 8:45 AM. Resident #78 was up in her wheelchair at bedside. There was a sign posted on her closet door that read; "all liquids consumed with provale cup with blue/brown lid at all times to decrease aspiration/choking risk." There was no provale cup noted in Resident #78's room. There was a large white Styrofoam cup of clear liquid sitting on her nightstand.

An observation of Resident #78 was made on 09/01/21 at 8:54 AM. Resident #78 was noted to have her breakfast tray in front of her. There was no provale cup on the tray only one small clear plastic drinking cup that was empty was observed on her tray. The sign on Resident #78's closet door that read; "all liquids consumed with provale cup with blue/brown lid at all times to decrease aspiration/choking risk" had been removed.

An interview was conducted with the Dietary Manager (DM) on 09/01/21 at 11:28 AM. The DM stated that any assistive device that was ordered for the residents that were used for eating or drinking were sent out with the meal tray. The DM stated if the assistive device for some reason failed to come on the meal tray the nursing staff could always come to the kitchen and get what was needed. She stated that the dietary department sent Resident #78's provale cup on her meal trays and then the staff would return them to the kitchen for cleaning. The DM was unaware that Resident #78 required the provale cup with all liquids and stated they would send it on the meal tray and the nursing staff would ensure that she had the provale cup at the other

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times.

An observation of Resident #78 was made on 09/01/21 at 12:12 PM. Resident #78 was observed eating lunch in the dining room and had fed herself 100% of the meal tray. She was observed to have a provale cup with a blue lid that had a dark brown liquid in it.

An observation of Nurse Aide (NA) #3 was made on 09/02/21 at 10:32 AM. NA #3 was observed to be passing ice on the unit. She filled a Styrofoam cup with ice and thin water and sat it on Resident #78's nightstand. NA #3 stated that she routinely passed ice twice during her 12-hour shift, once in the morning and then again before the end of her shift. NA #3 stated that she worked at the facility through an agency and was not aware that Resident #78 required a provale cup with all her liquids. She stated that at times one would come on her meal tray but after the meal they would return the cup to dietary for cleaning. NA #3 was not aware if the provale cup could stay in Resident #78' s room after meals or not but stated she would find out.

An observation of Resident #78 was made on 09/02/21 at 10:37 AM. Resident #78 was up in her wheelchair at bedside. She was observed to have no provale cup at bed but did have a large white Styrofoam cup of clear liquid on her nightstand.

An observation of Resident #78 was made on 09/02/21 at 12:33 PM. Resident #78 was observed in the dining room feeding herself the lunch tray. She was observed to have a provale cup with a blue lid that had a dark brown liquid in it.

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The Speech Therapist (ST) was interviewed on 09/02/21 at 3:49 PM. The ST stated she had only been at the facility for about a month and recently screened Resident #78 for tolerance of her diet. The ST stated that Resident #78 required the use of provale cup for thin liquids and that should be used with all liquids because it allows for a slower intake of liquids. From the observations that the ST made of Resident #78 she was not a big gulp taker nor was she impulsive but for safety she would expect Resident #78 to use a provale cup as ordered with all liquids.

An observation of Resident #78 was made on 09/02/21 at 6:36 PM. Resident #78 was in bed and had eaten 100% of her supper tray. She was observed to have a provale cup with a blue lid that had a dark brown liquid in it. There was a large white Styrofoam cup of clear liquid on her nightstand.

An observation of Resident #78 was made on 09/03/21 at 8:34 AM. Resident #78 was eating breakfast in her room and was noted to have no provale cup on her tray. She was observed to have a small regular glass that had an orange liquid in it. Nurse #7 entered room and confirmed that Resident #78 was supposed to have a provale cup on her tray and stated, "she should not have been drinking out of the small regular cup" and Nurse #7 proceed to go to the kitchen and obtain the provale cup and return it to Resident #78. Nurse #7 stated that Resident #78 was to use a provale cup with all her liquids not just at mealtime.

An observation of Resident #78 was made on 09/03/21 at 10:11 AM. Resident #78's breakfast

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tray had been removed from her room as was her provale cup. There was a large white Styrofoam cup of clear liquid on her nightstand.

The Director of Nursing (DON) was interviewed on 09/03/21 at 12:28 PM. The DON stated she expected that staff would use the assistive devices as ordered and if the order specified to be always used then she would expect the device to be always in use.

The Administrator was interviewed on 09/03/21 at 4:27 PM. The Administrator stated she expected the staff to follow the physician orders and implement assistive devices as ordered.

F 812 SS=E — Food Procurement,Store/Prepare/Serve-Sanitary — CFR(s): 483.60(i)(1)(2) — F 812 — 10/15/21

§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

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by:
Based on observation, staff interviews, and record reviews, the facility failed to discard expired food and label a frozen food item stored in 1 of 1 walk-in freezer. These practices had the potential to affect food served to residents.

Findings include:

An initial tour of the kitchen on 08/30/21 at 9:45 AM with the cook revealed a white cake mix with an expiration date of 04/02/20. The tour of the walk in freezer showed frozen diced chicken, wrapped in clear plastic wrap undated.

During an interview with the cook on 08/30/21 at 9:45 AM, the cook stated everyone who opens items should be sealing them and dating them with a sticker. The cook further stated the white cake mix should have been discarded after the expiration date.

An interview with the Dietary Manager on 09/01/21 at 11:28 AM revealed she was made aware of the items that were opened and undated and all of the items were discarded along with the frozen diced chicken and expired cake mix. The Dietary Manager further revealed she expected all items to be sealed and dated when opened and all foods to be discarded after the expiration date.

During an interview on 09/03/21 at 11:45 AM the Administrator and Regional Director of Operations stated food should be discarded by the expiration date and sealed and dated when opened.

F812

1. Open and undated food items found in dry storage and freezer section of the kitchen were discarded.

2. Dietary staff will be responsible for checking the dry storage and freezer section daily for open and undated food items.

3. a. Education was done on 8/30/21 by Dietary Manager to dietary staff on checking the dry storage and freezer section for open and undated food items.

b. An audit will be completed by Dietary Manager or designee as follows: 5 times per week times 4 weeks, 2 times per week times 4 weeks, then monthly times 3 months.

4. Monitoring will be conducted by Dietary Manager by checking dry storage and freezer section for open and undated food items. Results of monitoring, with tracking and trending, will be reported by Dietary Manager to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.

F 835 SS=E	Administration	F 835	10/15/21

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§483.70 Administration.
A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews the facility failed to have sufficient housekeeping and laundry staff to ensure the residents had clean clothes available (Resident #57), clean linen for their bed (Resident #5), and clean gowns available as the resident had become accustom to wearing (Resident #4), the facility also failed to have enough staff to clean resident rooms (Room #108, Room #109, Room #111, and Room #217) on 2 of 4 hallways.

The findings included:

This tag is cross referred to:

F550: Based on observations, record reviews, staff, and Resident interviews the facility failed to respect a Resident's individuality by not having a clean gown available to wear as the Resident had become accustomed (Resident #4). The facility also failed to have clean clothes available for a Resident (Resident #57) for 2 of 3 residents reviewed for dignity.

F584: Based on observations, record review, family, and staff interview the facility failed to repair and/or paint dry wall in resident rooms (Room #104, Room #109, Room #110, Room #111, Room #113, Room #122, Room #128,

F835

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility failed to have sufficient housekeeping and laundry staff to ensure the residents had clean clothes available for resident #57, clean linen for the bed of resident #5 and clean gowns for resident #4.

The facility failed to have enough staff to clean resident rooms #108, #109, #111, and #217.

Resident #57 bed was provided clean clothing and linen on 9/1/21

Resident #4 was provided a clean gown on 9/1/21.

Rooms 108, 109, 111, 217 were deep cleaned and the privacy curtain in room 217 was changed out for a clean curtain, and hallways cleaned of debris by 10/15/21.

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Room #132, Room #219, Room #223, Room #231, and Room #232) on 2 of 4 resident hallways, failed to clean resident rooms (Room #108, Room #109, Room #111, and Room #217) of 2 of 4 resident hallways from debris and litter, failed to provide clean linen (Resident #5) for 1 of 4 resident reviewed for linen, and failed to protect resident personal belonging from being lost or misplaced (Resident #43, Resident #16, and Resident #51) for 3 of 4 residents reviewed for personal property.

An interview was conducted with the Environmental Service Director (EVS) on 08/31/21 at 2:48 PM. The EVS director stated that he had been at the facility for a year but was recently promoted to director. He explained that a few weekends ago the laundry room had flooded and there were a couple of days that they could not wash linen or personal clothes and they had gotten further behind. He stated that they had been short staffed for some time and were behind but when the laundry room flooded, they got even further behind and had been unable to pull themselves out of the hole. The EVS director stated that the had complaints recently of missing clothes and they may be in the laundry either waiting to be washed or waiting to be returned to the resident. He added that normally the laundry department had 3 full time staff members and they currently only had 1 full time laundry aide and had been trying to hire additional staff, but the background check process took months to complete at times.

An interview was conducted with Housekeeper #2 on 08/31/21 at 3:48 PM. Housekeeper #2 stated that they were short staffed housekeepers and laundry personnel. She stated that she was

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Effective 9/10/21 Administrator and RDO reviewed staffing with Housekeeping manager and open assignments. Discussed measures to increase recruitment and scheduled regular check ins with Regional Housekeeping Director, Administrator, and RDO to measure progress.

Effective 9/10/21 Housekeeping Manager reviewed par level bed linen to ensure clean linen is available to change beds.

Effective 9/10/21 Housekeeping Manager reviewed par level of gowns to ensure gowns is available to residents.

Effective 9/10/21 Housekeeping Manager reviewed laundry room to ensure residents clothes were cleaned and distributed to current residents.

Effective 9/27/21 resident rooms were deep cleaned by regional strike team and inspected by Administrator. Deep cleaning schedule to continue and scheduled deep cleans reported in Monday-Friday in morning stand up meeting. Administrator to inspect deep cleaned rooms upon completion to ensure cleanliness.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not

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crossed trained to do housekeeping duties and to do laundry as well. Housekeeper #2 stated that most days she hurriedly cleaned the resident rooms so she could go to laundry and try to get caught up but that meant her resident rooms did not get cleaned as good as they should. She added that she had reported the staffing issue to the EVS director, but she did not like to complain because that would not help get caught up.

An interview was conducted on 09/02/21 at 2:21 PM with the Housekeeper #1. The Housekeeper confirmed she was responsible for cleaning the Resident's room. She explained that her working hours were 7:00 AM to 3:00 PM five days a week and she worked as fast as she could to clean the residents' rooms because they were often short of housekeepers. She stated that the normal number of housekeepers needed a day was 3 and on 09/02/21 there were only 2 housekeepers working.

The Director of Nursing (DON) was interviewed on 09/03/21 at 11:52 AM. The DON stated she expected clean linens to be available to residents and expected resident rooms to be clean and comfortable for the resident and in an environment to decrease the risk of infection. The DON stated that they had talked with the Regional Director of Environmental Services and he fully recognized that there was not enough staff, and he called another building and rerouted staff to come to the facility and help. The DON stated that they were going to add a full-time laundry position for second shift and retrain all the staff on the linen process which would help with the distribution of linen.

The Regional Director of Environmental Services

recur:

Effective 9/10/21 Administrator will hold staffing and recruiting meetings with Housekeeping manager and progress in hiring will be reported.

Effective 10/1/2021 newly hired laundry staff will be educated during orientation by Housekeeping manager or designee on the process of maintaining clean gowns and clean clothes to be readily available for residents.

By 10/15/21 the Housekeeping Manager and/or designee will educate the current laundry staff on maintaining clean gowns to be readily available for residents. In person and/or via phone.

By 10/15/21 the Housekeeping Manager and/or designee will educate the current laundry staff on maintaining clean clothes to be readily available for residents. In person and/or via phone.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Social Worker or designee will interview resident and observe the rooms of (5) five random residents M-F x 2 weeks, weekly x 2 months, and monthly x 2 months to ensure their rooms are free of holes, scratches, incomplete repairs, ensure room and linen is clean and, and ensure that they are not missing personal items. Any areas discovered addressed

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(RDEVS) was interviewed on 09/03/21 at 12:47 PM. The RDEVS stated that over the last 4 months they had just lost staff and they had been recruiting on every level but stated that a lot of candidates did not pass the background check process. The facility required 5 housekeepers 7 days and week and currently was running 3 housekeepers and the RDEVS further explained that the staff were cross trained in both laundry and housekeeping and currently they were looking to hire another full-time laundry aide. He explained that he had put a whole plan into place including setting par levels for linen, buying a labeling machine to label all personal laundry, reeducating staff on the process, ordering additional linens, setting up collection times so everyone was aware when the soiled linen would be picked up and fresh linen returned. He also stated that he established a backup plan for an offsite service if the laundry room was not useable in the future. The RDEVS stated he felt like the plan he had created would get the facility caught up and back on track to have clean linen available and clean rooms for the residents.

The Regional Director of Operations was interviewed on 09/03/21 at 4:33 PM. The Regional Director of Operations stated that the problem in laundry was lack of process and the staffing issue was an issue everywhere but the RDEVS was trying to get it done. The Regional Director of Operations stated that the large bin of laundry that was reported to be dirty on 08/31/21 was clean and needed to be given out to the residents which the Administrative staff had pulled together to return some of the clean clothes to the residents but stated we must have the proper process in place.

immediately.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.

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F 835	Continued From page 100 The Administrator was interviewed on 09/03/21 at 4:45 PM. The Administrator stated she had only been at the facility for a week and had not had time to fully assess the situation.	F 835		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		10/15/21

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communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to follow general infection control guidelines when 1 of 1 staff member (Nurse Aide #1) by throwing a feces soiled washcloth in the floor after providing care

F880

How corrective action will be accomplished for those residents found to have been affected by the deficient

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to 1 of 2 residents (Resident #15) reviewed for pressure ulcer care. The facility also failed to remove gloves and perform hand hygiene between providing care to 2 residents who reside in the same room (Resident #15 and Resident #32).

The findings included:

A review of the facility's Hand Hygiene Policy dated 11/01/20 revealed: All staff will perform proper hand hygiene procedures by washing with soap and water or using an alcohol-based hand rub to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility. Under #6 for Additional Considerations: a) the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.

A review of the facility's Laundry Policy dated 11/01/20 revealed: The facility launders linen and clothing in accordance with current CDC guidelines to prevent transmission of pathogens. 4. A. Linens shall be bagged separately at the point of use.

On 08/31/21 at 4:05 PM an observation was made of Nurse Aide (NA) #1 turning Resident #15. During the procedure, the NA rolled the Resident to her right side using the turning device and revealed a flattened piece of fecal matter approximately 3 x 2 centimeters that was stuck on top of the Resident's air mattress. With gloved hands the NA removed the fecal matter with a washcloth and threw the soiled washcloth in the floor next to the trash can. The NA then retrieved

F 880

practice;

On 08/31/21 at 4:05 PM an observation was made of Nurse Aide (NA) #1 turning Resident #15. During the procedure, the NA rolled the Resident to her right side using the turning device and revealed a flattened piece of fecal matter approximately 3 x 2 centimeters that was stuck on top of the Resident's air mattress. With gloved hands the NA removed the fecal matter with a washcloth and threw the soiled washcloth in the floor next to the trash can. The NA then retrieved a wet washcloth and proceeded to wipe the area of the mattress where the fecal matter was and threw the washcloth in the floor next to the first washcloth she threw in the floor. It was noted that the trash can had an extra trash can liner hanging off the end of the trash can. The NA then proceeded to go to the roommate, Resident #32 and repositioned her wheelchair and overbed table and rearranged the Resident's water cup that was on her over bed table while still wearing the same pair of gloves.

Effective 9/28/21 the Director of Nursing educated Nurse Aide #1 on doffing gloves between residents and performing proper hand hygiene.

Effective 9/28/21 the Director of Nursing educated Nurse Aide#1 on properly handling soiled linen.

Effective 9/28/21 Nurse Aide #1 received corrective action.

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a wet washcloth and proceeded to wipe the area of the mattress where the fecal matter was and threw the washcloth in the floor next to the first washcloth she threw in the floor. It was noted that the trash can had an extra trash can liner hanging off the end of the trash can. The NA then proceeded to go to the roommate, Resident #32 and repositioned her wheelchair and overbed table and rearranged the Resident's water cup that was on her over bed table while still wearing the same pair of gloves. Before leaving the residents' room the NA was asked if she realized what she had done and the NA explained that she should have removed her gloves and washed her hands after she removed the feces from Resident #15's bed and before she assisted Resident #32. The NA also stated she should not have thrown the washcloths in the floor and that she should have retrieved a trash bag to use for the soiled washcloths. The NA stated she attended an infection control inservice a few days prior that included hand hygiene.

An interview was conducted with the Infection Control Nurse (ICN) who was also the Director of Nursing (DON) on 09/02/21 at 3:31 PM. The ICN/DON explained that Nurse Aide #1 should have removed her gloves and performed hand hygiene by washing her hands with soap and water or using hand sanitizer between physical interaction with the residents. The ICN/DON also explained that the soiled linen should be bagged at the site using the trash bags provided for the staff's use. The ICN/DON stated the facility recently had an infection control inservice that covered the issues and she expected the staff to abide by the infection control policy.

During an interview with the Administrator on

How the facility will identify other residents having the potential to be affected by the same deficient practice;

All residents have the potential to be affected by the alleged deficiency.

Effective 10/15/21 current staff members were observed donning, doffing gloves and performing proper hand hygiene after doffing gloves.

Effective 10/15/21 current staff member were observed on properly handling soiled linen.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 9/29/21 Director of Nursing and/or will educate current staff on performing proper hand hygiene between residents.

Effective 10/15/21 any staff that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee.

Effective 10/15/21 all staff including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on "performing proper hand hygiene between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345128	A. BUILDING _____ B. WING _____	C 09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

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F 880	Continued From page 104 09/03/21 at 3:54 PM she stated her expectation was that the staff in all departments follow the infection control policy.	F 880	residents. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing will audit three designated staff members weekly x 4 weeks, bi-weekly x 4 weeks, monthly x 1. Results of the audit will be reported to the Administrator. Any staff found not to be following infection control protocols will have progressive disciplinary action. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.	
F 925 SS=E	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 interview the facility failed to control the presence of flies in 5 out of 5 resident rooms (Room #101, Room #109, Room #111, Room #120, and Room #202) on 2 of 4 resident hallways (front 200 hallway and back 100 hallway) reviewed for pest control program. The findings included:	F 925	F925 Pest(flies) were sighted in rooms #101, 109, 111, 120, and 202 and in the front 200 hallway and back 100 hallway. Maintenance director or designee inspected rooms #101, 109, 111, 120, and 202 to ensure no pest sightings. Facility provided containers for residents to store	10/15/21

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F 925	Continued From page 105	F 925		

Review of the facility's invoice from a local pest control company dated:

05/11/21 read in part; the service period was monthly and target pest treatment was mice and cockroaches and the service areas was listed as the kitchen area interior, exterior area, and break room interior.

06/07/21 read in part; the service period was monthly and target pest treatment was mice and cockroaches and the service area was listed as kitchen area interior, hallways interior, lobby door, dining interior, exterior area, and side door.

07/13/21 read in part; the service period was monthly, and the target pest treatment was mice and cockroaches, and the service areas was listed as kitchen interior, exterior area, front door, and side door.

1a. An observation of Room #101 was made on 08/30/21 at 10:59 AM. There was a resident resting in her bed with her eyes closed. There was fly noted to buzz around the resident head and arms and landed on the residents' bedspread.

1b. An observation of Room #109 was made on 08/30/21 at 10:49 AM. There was a female resident resting in bed and was holding a teddy bear. There was fly observed to be buzz around the resident and her teddy bear and would land periodically on the resident and/or the teddy bear.

An observation of Room #109 was made on 08/31/21 at 10:31 AM. The same female resident remained in the bed. There were no flies noted flying around the resident but there was a dead fly

food items and ensured that screens are in place on windows. This was completed by 10/15/21. Facility has 5 pest zappers around the building, 2 pest zappers were not functioning maintenance will ensure that all pest zappers are plugged in. Ecolab will be in the facility monthly and as needed.

Maintenance director or designee inspected all other rooms to ensure no pest was sighted.

Effective 10/15/2021 all staff will be educated on reporting pest sighted into TELS that will automatically alert Maintenance Director of a work order generated.

Effective 10/15/2021 all department heads will be educated on reporting pest sighted while conducting angel rounds to the Administrator.

Maintenance Director or designee will monitor for pest through observation rounds 5 times per week x 4 weeks, weekly times 4 weeks, then monthly times 3 months.

Results of these audits will be reviewed at Quarterly Quality Assurance Meeting x3 for further problem resolution if needed
Completion Date: 10/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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lying on top of the air conditioner unit next to her bed.

An observation of Room #109 was made on 09/01/21 at 8:54 AM. The female resident was eating breakfast next her bed in her wheelchair. There was fly noted to land on top of the female resident head while she was eating her breakfast meal.

1c. An observation of Room #111 was made on 08/30/21 at 11:39 AM. There was a male resident resting in the bed and was noted to have a fly buzz around his left arm and hand. The fly was noted to land on his left hand before flying off.

An observation of Room #111 was made on 09/02/21 at 10:34 AM. The same male resident was resting in bed and was noted to have a fly buzz around his mid chest and face area. The fly would intermittently land and then fly off but remained in/on the male resident during the observation.

1d. An observation of Room #120 was made on 09/03/21 at 11:30 AM. There was female resident in Room #120 and there were 5 flies crawling on the bed that the resident resided in.

1e. An observation of Room #202 was made on 08/31/21 at 4:17 PM. There was a male resident resting in the bed. There was a fly noted to land on the male resident's right cheek and then to the sheet that was covering him. During the observation there was also a dead fly located in the windowsill next to the male resident bed.

2. A observation was made of the front 200 hallway on 09/01/21 at 3:56 PM. There was a

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male resident in a wheelchair propelling himself around the unit. There was a fly buzzing around him landing frequently on his feet and legs.

An observation was made of the back 100 hallway on 09/02/21 at 12:36 PM. There was another male resident propelling self around on the unit. There was a fly that seemed to be following him up and down the hallway landing intermittently on his arms and upper body.

An interview was conducted with the Housekeeping Supervisor (HS) on 08/31/21 at 3:48 PM. The HS stated that she had noticed he increase in fly activity and she attributed it to the fact that a lot of the resident rooms did not have screens in them.

Housekeeper #2 was interviewed on 08/31/21 at 3:50 PM. Housekeeper #2 stated that she had noticed the increase in flies but really did not know what to do about it. She stated that the dead flies should have been wiped up and the surface cleaned and was unacceptable to have those in resident rooms.

The Maintenance Director (MD) was interviewed on 09/01/21 at 3:49 PM. The MD stated he was filling the spot-on interim basis. He stated that he had noticed the excessive flies in the building but was not sure when the pest control company came to the facility and was not aware of what they treated for. The MD added that he had called the pest company to come out on 08/18/21 because they had noticed ants in the facility, and they came and treated some of the rooms. The MD stated he was not aware where any of the logs or records of the pest control company visits were at.

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An attempt to speak to the local pest control company technician was made on 09/01/21 at 3:52 PM with no return call obtained.

The Regional Vice President of Operations (RVPO) was interviewed on 09/01/21 at 3:55 PM and stated that they had problems with the grease traps at the facility and they were trying to get someone to come and look to see if there were clogged and maybe that was causing the increase in flies. The RVPO stated, the turnover of staff at the facility is "killing them and we have no idea where the services records are at" but she would try to locate them.

A follow up interview was conducted with the RVPO on 09/01/21 at 4:18 PM. The RVPO stated that they identified the increase in flies about 2 weeks and had someone coming to see if the grease traps were clogged and had ordered 6 addition fly traps, but they were on back order. The RVPO stated that the local pest control company came to the facility monthly and regularly treated for flies and ants.

The Director of Nursing (DON) was interviewed on 09/03/21 at 11:52 AM. The DON stated she expected the resident rooms and common area to be clean, healthy and in a state to decrease the risk of infection.

The Administrator and RVPO were interviewed on 09/03/21 at 4:33 PM. The RVPO again stated that they had identified the issue with flies and had arranged for a local company to come and check the facility's grease traps and they were waiting on the fly traps that were on back order.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345128	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/3/2021

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 577	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, facility staff, and Resident Council interviews, the facility failed to post previous State Agency survey results in an obvious and readily available area for 3 of 5 survey days. This failure had the potential to affect all residents in the facility. Findings Included: Observations completed on 08/30/21 at 09:13 AM revealed the State Agency survey results were unable to be located. Observations completed on 08/31/21 at 08:18 AM revealed the State Agency survey results were unable to be located. Observations completed on 09/01/21 at 08:26 AM revealed the State Agency survey results were unable to be located. During an interview with the Resident Council on 09/01/21 at 12:47 PM revealed they did not know where the State Agency survey results were kept. They reported before a remodel occurred in the main lobby of the facility, the results were kept in a binder sitting in a basket that was hanging on the wall. They reported once the remodeling of the lobby began, the basket was taken down and they had not seen the State Agency survey results since. They reported it had been "several months" since they had seen the State Agency survey results. During an interview with the Activities Director on 09/01/21 at 1:08 PM, she reported the State Agency survey results used to be stored in a basket that was hung on a wall in the lobby. She reported since the recent

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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remodel of the lobby, she did not know where the State Agency survey results were currently stored.

During an interview with the Director of Nursing on 09/01/21 at 1:11 PM, she reported she was unaware of where the State Agency survey results were kept.

During an interview with the Receptionist on 09/01/21 at 1:16 PM, she reported before the remodel of the front lobby, the State Agency survey results were kept in a basket that was hung on a wall in the lobby area. She reported since the remodel she had not seen the binder they were kept in and had not seen it since the remodel began. She stated she would not know where to begin to look for the State Agency survey results binder.

During an interview with the Administrator on 09/01/21 at 4:01 PM, she reported the State Agency survey results were located on a shelf in her office. She reported she did not know why or how long they had been in her office. She reported the State Agency survey results should be located in the main lobby of the facility. She verified if it was in her office then it would not be readily available for residents and guests to review.