STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	C 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASS HEALTHCARE AND REHAB HAWFIELDS, INC	2502 S NC 119 MEBANE, NC 27302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 12/13/2021 through 12/16/2021. The facility was found in compliance with the requirement of CFR 483.73, Emergancy Preparedness. Event ID# WK1K11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/13/2021 through 12/16/2021. Event ID# WK1K11. None of the 14 complaint allegations were substanciated.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the Assessment Reference Date (ARD) of the previous quarterly MDS assessment for 1 of 19 residents reviewed (Resident #1). Findings included: Resident #1 had been admitted on 5/21/2021. Resident #1's most recent completed quarterly MDS assessment had an ARD of 8/11/2021. A quarterly MDS assessment with an ARD of 12/03/2021 was noted as "in progress." An interview with the MDS Coordinator was conducted on 12/14/2021 at 4:23 PM. After reviewing Resident #1's assessments, she stated she had somehow looked at the date wrong. She	F 638	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1.a. 1. Quarterly MDS assessment has been	1/20/22

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

Electronically Signed | 01/14/2022

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F 638	Continued From page 1 explained there should not be more than 92 days between assessments. An interview with the Director of Nursing (DON) was conducted on 12/15/2021 at 9:12 AM. The DON stated he would expect the MDS assessments to be completed on time.	F 638	completed for resident #1 on 12/3/2021. 2. MDS coordinator/designee has conducted a facility wide audit of all residents to identify any quarterly MDS assessments that have not been completed within 92 days of the ARD of the previous quarterly assessment. No additional residents have been impacted by the deficient practice. 3. MDS coordinator was re-educated 1/13/2022 by administrator on the requirement for timely quarterly assessment completion to not exceed 92 days from the ARD of the precious quarterly assessment. MDS Coordinator and administrator/designee to review weekly, the MDS assessment report within Matrix Care (EHR), to ensure timely completion of assessments. MDS Coordinator to create and maintain an assessment calendar that is reviewed daily Monday - Friday during stand-up meeting. 4. Facility administrator/designee will conduct audits Weekly x 4 weeks, then Monthly x 3 months. Results to be reported to monthly QAPI committee meeting until a pattern of compliance is established. 5. Compliance date: 1/20/2022	
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to	F 644		1/20/22

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F 644	Continued From page 2 avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to refer a resident for PASARR (pre-admission screening assessment and resident review) screening when a resident had a new diagnosis of serious mental illness for 1 of 1 resident reviewed for PASARR (Resident #69). The resident continued to receive antipsychotic medication for psychosis without a PASARR rescreening. The findings included: Review of the record revealed a PASARR level 1 that was conducted on 1/12/18. Resident #69 was admitted to the facility on 1/14/18 and had a diagnosis of dementia and anxiety. Review of the hospital discharge orders dated 1/14/18 did not include a diagnosis of psychosis and the discharge medications did not list an antipsychotic medication to be given to the resident.	F 644	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1.a. 1. PASARR screening for resident #69 was completed 12/29/2021. 2. Social worker has conducted a facility wide audit to identify other residents that could have been affected by the same deficient practice. All residents identified through the audit to have been affected, have been submitted for PASARR	

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F 644	Continued From page 3 The first psychiatry (psych) note found on the clinical record was dated 5/20/20 and noted the resident had a diagnosis of vascular dementia with hallucinations and delusions and was prescribed low dose Risperdal for behaviors. The care plan noted an additional problem of behavioral symptoms dated 5/26/21 and noted the potential for anxiety, combativeness, aggression or agitation related to a diagnosis of psychotic disorder with hallucinations. The interventions included to assess the reasons for anxiety, social withdrawal and crying, if resident becomes agitated, stop care task and re-approach later. If resident is yelling or aggressive, ask if she is in pain. Notify the nurse of increased agitation, combativeness, aggression or anxiety. Nursing to report inappropriate behaviors to the physician. Be sure to document behaviors. Review of the most recent comprehensive MDS dated 8/5/21 noted the resident was a level 1 PASARR. The most recent psych note dated 10/11/21 noted the resident's medications were effective for anxiety but continued to have delusions but was not distressed. There were no changes made to the resident's medications. The most recent Minimum Data Set (MDS) Assessment dated 11/6/21 revealed the resident had moderate cognitive impairment and no behaviors during the lookback period. The MDS noted the resident required extensive to total assistance with activities of daily living with the exception she required supervision only with eating. The MDS noted a diagnosis of psychotic disorder and the resident received an	F 644	screening. 3. Social Services Director has been reeducated to refer level 2 PASARR residents as well as all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level 2 resident review upon a significant change in status assessment or new diagnosis of mental illness. Social Services director is to attend daily clinical meeting Monday - Friday. All changes in mental, intellectual, psychological status, new diagnoses of mental illness and new anti-psychotic medication orders will be reviewed/discussed during the daily clinical meeting Monday - Friday. All applicable status changes will trigger a referral for PASARR screening. 4. Audits will be conducted Weekly x 4 weeks, then Monthly x 3 months. Results to be reported to monthly QAPI committee meeting until a pattern of compliance is established. 5. Compliance date: 1/20/2022	

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F 644	Continued From page 4	F 644		

antipsychotic medication for 7 days during the lookback period and received the antipsychotic medication on a routine basis.

Review of the current physician's orders for Resident #69 revealed an order for Risperdal (antipsychotic medication) 0.25 milligrams (mg) every night at bedtime.

There was not a PASARR screen found on the record since the one dated 1/12/18.

On 12/15/21 at 10:03 AM an interview was conducted with the facility's Social Worker who stated the resident was admitted from the hospital on 1/14/18 and the hospital discharge orders did not include an antipsychotic medication or a diagnosis of psychosis with hallucinations. The Social Worker confirmed the resident had not been referred for a PASARR re-screening since admission to the facility.

On 12/15/21 at 3:34 PM a second interview was conducted with the Social Worker. The Social Worker stated all residents must have a PASARR on admission to the facility and since most of the residents are admitted from the hospital the screening was usually done at the hospital. The Social Worker stated she requested a re-screening if the resident had a change in status but did not always do this when residents were put on an antipsychotic medication, but she did receive the psychiatry notes when residents were seen by psychiatry. The Social Worker further stated she was not aware that residents with a new psychiatric diagnosis needed to have a PASARR re-screening done.

On 12/16/21 at 1:49 PM the Director of Nursing

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F 644	Continued From page 5 stated in an interview that when the resident had a new diagnosis of mental illness the resident should have been referred the for a PASARR rescreening.	F 644		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to have RN (Registered Nurse) coverage for 8 hours a day for 2 of 77 days reviewed (August 1-31, November 1-30 and December 1-16). The findings included: The staff postings were reviewed for August 1-31, 2021, November 1-30, 2021 and December 1-16, 2021. There was no RN listed to work on November 27 or 28, 2021. On 12/16/21 an interview was conducted with the Director of Nursing (DON). The DON stated the	F 727	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. No residents were affected during the	1/20/22

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F 727	Continued From page 6 RN supervisor left the facility in early November and he had been trying to hire another RN but had not been able to do so. The DON further stated he and the MDS (Minimum Data Set) Coordinator were the only 2 RNs employed by the facility and he had tried to cover with agency but was not always able to do so.	F 727	identified days without required RN coverage. Effective 12/1/2021, the facility executed a contract with a travel agency RN to provide weekend coverage/supervision and to meet RN staffing requirements. 2. An audit was completed by Director of Nursing Services on 1/10/2021 of the nursing schedule between 09/1/2021 to 1/10/2022 to ensure that proper RN coverage was maintained and no other instances of lack of RN (Registered Nurse) coverage (8 consecutive hours per day) were identified. 3. Director of Nursing Services, Nurse Managers and Staffing Coordinator were Re-educated on 01/07/2021 by Administrator on requirements for proper RN coverage. The Facility hired a temporary RN Supervisor to ensure RN coverage was maintained (8 consecutive hours per day). Facility Administration has increased the RN wage scale to be more competitive and enhance the recruitment efforts to ensure that proper RN coverage is maintained per requirements. 4. Effective 01/10/2021 the Director of Nursing Services/Designee will review staff schedules to ensure proper RN coverage maintained. Administrator and/or Director of Nursing will audit daily (Sunday – Saturday) schedules 5 days per week x 12 weeks to ensure proper RN coverage. Any negative outcomes identified will be addressed promptly. This audit will be reviewed and documented in clinical stand-up meeting. Effective 01/10/2022 the Director of Nursing Services will report the finding to the	

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F 727	Continued From page 7	F 727	Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. 5. DATE OF COMPLIANCE: 1/20/2022	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 30 medication opportunities, resulting in a medication error rate of 10% for 2 of 4 residents (Resident #21 and Resident #67) observed during medication pass. The findings included: 1-a. On 12/14/21 at 8:45 AM, Nurse #2 was observed as she prepared and administered medications to Resident #21. The medications included one and one-half (1 ½) - 50 milligrams (mg) tablets of sertraline (an antidepressant medication) administered by mouth for a total dose of 75 mg.	F 759	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. Effective 12/15/2021 the Director of Nursing Services notified the medical provider of the medication errors. Nurse 1 and nurse 2 were re-educated by the Director of Nursing Services on the facility	1/20/22

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F 759	Continued From page 8 A review of Resident #21's medication orders included an order written on 6/14/21 for 50 mg sertraline to be given as 1 ½ tablets (for a total dose of 75 mg) once each morning. The review also revealed this order was discontinued on 12/6/21. A new physician's order indicated the dose of Resident #21's sertraline was increased to 100 mg with an initiation date of 12/7/21 for the treatment of major depressive disorder. An interview was conducted on 12/14/21 at 1:42 PM with Nurse #2. During the interview, the nurse reviewed the resident's Medication Administration Record (MAR) and medications available on the medication cart. The observation of the med cart confirmed a bubble pack card containing one and one-half tablets of 50 mg sertraline was stored with Resident #21's current medication cards. Nurse #2 reported a review of the provider's orders showed the Nurse Practitioner had put in an order on 12/6/21 to start 100 mg sertraline for the resident on 12/7/21. At the time of the interview, the nurse looked in the bottom drawer of the med cart where new meds and extra bubble pack cards for residents were stored. A bubble pack card containing 100 mg tablets of sertraline was identified to be stored in the bottom drawer of the med cart for Resident #21. Nurse #2 stated this card was the one that should have been used during the morning med pass. She reported an additional 25 mg sertraline needed to be administered to Resident #21 to equal her currently prescribed dose (100 mg). The nurse was observed as she prepared to administer one-half tablet of 50 mg sertraline (25 mg dose) to Resident #21. An interview was conducted on 12/16/21 at 9:50 AM with the facility's Director of Nursing (DON).	F 759	medication administration policies, specifically the 6 rights of medication administration, and oral inhalation administration. 2. All residents in the facility were identified as having the potential to be affected by the deficient practice. 3. Effective 1/10/2022 The Director of Nursing Services/ Designee will re-educate all licensed nurses and certified medication aides on facilities policy on medication administration, specifically the six rights of medications administration and oral inhalation administration. Effective 1/20/2022 any licensed nurse and certified medication aides not in-serviced by 1/20/2020 will not be allowed to work until they have completed the in-service conducted by the Director of Nursing/designee. Effective 1/20/2022 all new licensed staff and certified medication aides will be in-serviced during the new employee orientation and prior to working in resident care by the Director of Nursing/designee. 4. Effective 01/20/2022 the Director of Nursing Services/Designee will complete 5 random medication observation passes to include all shift and weekends, to ensure medications are administered according to physicians orders and facility policies, per week times 4 weeks then weekly times 2 months. Any potential medication errors identified will be addressed promptly and the prior to administration. This audit will be reviewed and documented in clinical stand-up meeting. Effective 01/20/2022 the Director of Nursing Services will report the finding	

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F 759	Continued From page 9 During the interview, concerns identified during the medication administration observation were discussed. When asked what his expectation was for medication administration, the DON stated if the nurse had followed the 6 rights of medication administration (the right patient, the right drug, the right dose, the right time, the right route and the right documentation) in accordance with the facility's policy, the error would have been avoided. 1-b. Resident #21 was admitted to the facility on 3/9/21 with a cumulative diagnoses which included chronic obstructive pulmonary disease. A review of Resident #21's active Physician Orders included a current order for 160 microgram (mcg) / 4.5 mcg Symbicort to be administered as two puffs inhaled two times a day (initiated 3/9/21). Symbicort is an inhaled medication containing a combination of two medications, budesonide (a steroid) and formoterol. It is used for the management of asthma and/or chronic obstructive pulmonary disease. On 12/14/21 at 8:45 AM, Nurse #2 was observed as she prepared and administered medications to Resident #21. The medications pulled for administration included 160 mcg / 4.5 mcg Symbicort. The resident was observed as she inhaled two puffs of the aerosol medication. The nurse did not prompt the resident to rinse her mouth out with water; no water was offered to the resident so she could rinse and spit out the water after the Symbicort inhaler was used. After the Symbicort was administered, Nurse #2 administered Resident #21's oral medications, then gave her a cup of water to drink. The resident was observed to drink (and swallow)	F 759	to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. 5. DATE OF COMPLIANCE: 1/20/2022	

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F 759	Continued From page 10	F 759		

water to take the oral medications.

A review of the full prescribing information from the manufacturer of Symbicort (Revised 7/2019) included the following Administration Information, in part: "Symbicort should be administered as 2 inhalations twice daily (morning and evening, approximately 12 hours apart), every day by the orally inhaled route only. After inhalation, the patient should rinse the mouth with water without swallowing." Additionally, the Patient Information Guide (Revised 12/2017) for Symbicort specified the following administration guidelines: "Rinse your mouth with water and spit the water out after each dose (2 puffs) of Symbicort. Do not swallow the water. This will help to lessen the chance of getting a fungus infection (thrush) in the mouth and throat."

An interview was conducted on 12/14/21 at 8:55 AM with Nurse #2. During the interview, the nurse confirmed she did not provide water or coaching / instruction to Resident #21 to rinse her mouth without swallowing after using the Symbicort inhaler.

An interview was conducted on 12/16/21 at 9:50 AM with the facility's Director of Nursing (DON). During the interview, concerns identified during the medication administration observation were discussed. When asked what his expectation was for medication administration, the DON stated if the nurse had followed the 6 rights of medication administration (the right patient, the right drug, the right dose, the right time, the right route and the right documentation) in accordance with the facility's policy, the error would have been avoided.

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F 759	Continued From page 11	F 759		

2. On 12/14/21 at 8:24 AM, Nurse #1 was observed as she prepared and administered medications to Resident #67. The medications included 240 milligrams (mg) docusate (a stool softener) obtained from a stock bottle stored on the medication cart and administered by mouth to the resident.

A review of Resident #67's medication orders included an order initially written on 3/26/20 for 100 mg docusate to be given as one tablet by mouth every 12 hours for the treatment of constipation.

An interview was conducted on 12/14/21 at 1:27 PM with Nurse #1. During the interview, the nurse was asked to review Resident #67's medication order for docusate. Upon review, the resident's Medication Administration Record (MAR) indicated a 100 mg dose of docusate was ordered (not a 240 mg dose). An observation of the stock medications on the med cart was also conducted with the nurse at this time. The medication cart contained both a stock bottle of 240 mg docusate and a stock bottle of 100 mg docusate tablets. The nurse was shown the bottle of 240 mg docusate observed to supply the oral medication for this resident during the observation of the morning med pass. At that time, the nurse reported she had intended to give Resident #67 the 100 mg dose of docusate instead of the 240 mg dose administered.

An interview was conducted on 12/16/21 at 9:50 AM with the facility's Director of Nursing (DON). During the interview, concerns identified during the medication administration observation were discussed. When asked what his expectation was for medication administration, the DON

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F 759	Continued From page 12 stated if the nurse had followed the 6 rights of medication administration (the right patient, the right drug, the right dose, the right time, the right route and the right documentation) in accordance with the facility's policy, the error would have been avoided.	F 759		
F 880 SS=F	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	F 880		1/20/22

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F 880	Continued From page 13 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. 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, staff interviews, record review, Center for Disease Control (CDC) guidelines for the use of Personal Protective	F 880	F880 Infection Prevention and Control This plan of correction constitutes a written allegation of compliance.	

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F 880	Continued From page 14 Equipment (PPE), and the CDC COVID-19 Data Tracker for Alamance county's level of community transmission, all facility staff failed to wear eye protection during resident encounters. This failure occurred during a COVID-19 pandemic. In addition, the facility failed to follow infection control standards of practice by placing an indwelling urinary catheter bag on the floor for 1 of 2 residents reviewed for urinary catheters (Resident #38). The findings included: 1. The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic (updated 9/10/21) read in part: "Implement Universal Use of Personal Protective Equipment for HCP: If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below:" The list of PPE included "Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters." The CDC COVID-19 Data Tracker was accessed and reviewed on 12/13/21 for Alamance county (where the facility was located). The level of community transmission for COVID-19 within the county was reported as "High." The facility policy entitled "Coronavirus (Covid-19) Prevention and Control" last revised December 2021 was reviewed. The policy read in part "upon	F 880	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1.a. Effective 12/14/2021, All facility staff were provided “Eye Protection (i.e., goggles or a face shield that covers the front and side of the face)” and were instructed to wear them during all patient encounters. 1.b. Effective 12/15/2021, The Director of Nursing Services was informed by the surveyor of the urinary drainage bag being on the floor. The Director of Nursing Services informed the primary care nurse/cna and that the urinary drainage bag for resident # 38 was on the floor and this was corrected. The urinary drainage bag was secured to the resident’s chair and was not in contact with the floor. 2.a. All residents in the facility had potential to be affected by the alleged deficient practice of not wearing PPE, specifically “Eye Protection (i.e., goggles or a face shield that covers the front and side of the face) not being worn during patient encounters. All residents tested negative for COVID19 on 1/3/2022. 2.b. All other residents identified as having a urinary drainage bag were audited by the director of Nursing Services and no other residents were affected by the	

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F 880	Continued From page 15 each entry into the facility, staff must take a temperature, answer screening questions, and wear a mask." Observation made on 12/14/2021 at 9:08 A.M. revealed a Physical Therapist was providing therapy to a resident in the resident's room. The PT wore a surgical mask and no eye protection. Observation made on 12/14/2021 at 10:15 A.M., Nurse #1 was at a resident's bedside administering medication. Nurse #1 was wearing a surgical mask and no eye protection. An observation and interview were conducted on 12/14/2021 at 12:24 P.M. with Nurse Aide (NA) #2 as she walked out of a room after a resident encounter. The observation revealed NA #2 was wearing a surgical mask and no eye protection. During the interview NA#2 was asked what PPE she was required to wear when she worked in the facility, NA#2 revealed she was required to wear a surgical mask. NA#2 further stated eye protection was not required since the Covid-19 vaccines had been released and administered to staff and residents at the facility. An observation and interview were conducted on 12/14/2021 at 12:30 PM with Nurse Aide #3. The observation revealed NA#3 sat at a resident's bedside and provided feeding assistance. NA #3 was observed to be wearing a surgical face mask and no eye protection. During the interview with NA #3, it was revealed eye protection was only required to be worn when care was provided to newly admitted unvaccinated resident. NA stated she was only required to wear a face mask on her assignment.	F 880	alleged deficient practice. 3.a. Effective 1/10/2020 the Facility administrator, Director of Nursing Services and Infection Preventionist ensured that they are receiving all communications from the CDC and CMS regarding recommendations, updates and revisions regarding Infection Prevention and Control. Effective 01/20/2022 The Facility administrator, Director of Nursing Services and Infection Preventionist will meet weekly during clinical stand up to review all CDC and CMS recommendations, updates and revisions regarding Infection Prevention and Control. Facility leadership to participate in Bi-weekly meeting/call with Corporate Compliance Representative to review and implement new updates/guidance issued by public health agencies. Effective 01/20/2022 the Director of Nursing Services/Designee re-educated all facility employees on the CDC Interim Infection Prevention and Control Recommendation for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (Covid-19) Pandemic (updated 9/10/21) regarding PPE, specifically “Eye Protection (i.e., goggles or a face shield that covers the front and side of the face) should be worn during all patient encounters.” Any facility staff not in serviced regarding appropriate PPE use by 01/20/2021 will not be allowed to work until they have completed the in-service. New employees will be in-serviced during the new employee orientation and prior to working in resident care.	

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F 880	Continued From page 16 An interview conducted with the Director of Nursing (DON) on 12/14/2021 at 12:39 PM revealed he received Covid-19 updates via email from multiple organizations. During the interview the DON stated he was unaware when the country transmission rate was moderate or high, staff were required to wear eye protection during resident encounters. 2. Resident #38 was admitted to the facility on 6/11/21 and had a diagnosis of obstructive and reflux uropathy (condition in which the urine flow is blocked). The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 9/10/21 revealed the resident had severe cognitive impairment and required extensive to total assistance with activities of daily living that included total assistance with toileting. The MDS noted the resident had an indwelling urinary catheter. The resident's current care plan noted the resident had an indwelling urinary catheter. One of the interventions stated: "Do not allow tubing or any part of the drainage system to touch the floor." On 12/13/21 at 10:47 AM Resident #38 was observed sitting in a reclining chair in her room. The urinary drainage bag was lying flat on the floor. On 12/14/21 at 12:15 PM Resident #38 was observed sitting in a reclining chair in her room eating lunch. The urinary drainage bag was lying	F 880	3.b. Effective 01/20/2022 the Director of Nursing Services/Designee re-educated all licensed and non-licensed nursing staff regarding Urinary Drainage Bags not coming on contact with the floor. Any licensed and non-licensed nursing staff not in serviced by 01/20/2022 will not be allowed to work until they have completed the in-service. New employees will be in-serviced during the new employee orientation and prior to working in resident care. MONITORING PROCESS 4.a. Effective 01/20/2022 The Director of Nursing Services/Designee will review complete 5 random observation of staff wearing appropriate PPE, (specifically eye protection during patient care encounters, Monday – Friday for 4 weeks, then weekly for 4 weeks, then monthly for 1 month or until a pattern of compliance is maintained. Any negative outcomes identified will be addressed promptly. This audit will be reviewed and documented in clinical stand-up meeting. 4.b. Effective 01/20/2022 The Director of Nursing Services/Designee will review complete observations of resident with urinary drainage bags to ensure the drainage bags are not in contact with the floor, Monday – Friday for 4 weeks, then weekly for 4 weeks, then monthly for 1 months or until a pattern of compliance is maintained. Any negative outcomes identified will be addressed promptly. This audit will be reviewed and documented in clinical stand-up meeting. Effective 01/20/2022 the Director of Nursing Services will report the finding to	

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F 880	Continued From page 17 flat on the floor near the resident's feet. On 12/15/21 at 9:36 AM Resident #38 was observed sitting in a reclining chair. The urinary drainage bag was lying flat on the floor. During the observation Nursing Assistant (NA) #1 entered the room to answer the resident's call light. The NA was asked why the resident's urine drainage bag was on the floor and NA #1 responded that there was nowhere to hang the bag and the NA left the room and the urine drainage bag remained on the floor. On 12/15/21 at 1:59 AM the Director of Nursing (DON) was in the resident's room and was asked about the urinary drainage bag being on the floor. The DON stated the urinary drainage bag should not be on the floor and was an infection control issue. The DON further stated they would find a way to hang the bag so that it was not on the floor.	F 880	the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. 5) Date of Compliance 01/20/2022	