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ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency	E 004		2/28/22

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

Electronically Signed | 02/21/2022

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E 004	Continued From page 1 Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a comprehensive Emergency Preparedness Plan which contained the required information to meet the health, safety and security needs of the resident population and staff during an emergency or disaster situation. This failure had the potential to affect all residents and staff. Findings included: The Emergency Preparedness Plan (EPP) notebook provided by the facility was reviewed on 01/28/22. The EPP notebook contained policies and procedures but did not contain a written comprehensive EPP that met federal requirements. In addition, there was no documented evidence of annual staff training of the EPP plan, facility-based and community-based risk assessments utilizing an all-hazards approach, or facility risk assessments to identify where Legionella (bacteria) and other waterborne pathogens could grow and spread in the facility's water system. During an interview on 01/28/22 at 6:24 PM, the Administrator recalled they had reviewed the EPP around September 2021 and the previous Maintenance Director was supposed to organize and update the EPP books which included facility documentation such as updated policies, staff	E 004	E 004 1.No residents cited Effective 1-31-2022 the facility administrator started the process of recreating the Emergency Preparedness Plan notebook. The notebook will contain the required information to meet the health, safety and security needs of the resident population and security during any emergency or disaster situation. 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved: The Administrator in serviced Director of Nursing and Maintenance Director on the Emergency notebook and it□s locations on 2-3-2022 3. The Master Emergency Preparedness Plan notebook will be in the Administrator office, a second Emergency notebook will be available at the west wing nursing station. 4. Administrator or Maintenance Director to educate all current facility and agency licensed nursing staff related to Emergency notebook locations. Director of Nursing or designee to audit Emergency notebook for presence at designated locations 1x/week for 6 weeks, then 1x week every other week x 6 weeks	

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E 004	Continued From page 2 training, tabletop discussions, and Legionella facility risk assessment. He added he had not been able to locate the updated EPP manual but did find an older version of the written EPP dated 2019. The Administrator explained he was not sure where the previous Maintenance Director placed the information and therefore, he would have to recreate the entire EPP manual.	E 004	5. The Administrator will bring results to our Quality Assurance and Performance Improvement meeting monthly and make changes to the Emergency Preparedness Plan notebook plan as necessary to maintain compliance POC completion date is 2/28/21.	
F 000	INITIAL COMMENTS A recertification and complaint survey were conducted from 01/24/22 through 01/28/22. Event ID# 7OZW11. A total of 29 complaint allegations were investigated and 18 substantiated. Substandard Quality of Care was identified at: CFR 483.10 at tag F550 at a scope and severity of H. An extended survey was conducted.	F 000		
F 550 SS=H	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.	F 550		2/28/22

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F 550	Continued From page 3 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal 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 record review, observations, resident and staff interviews, the facility failed to maintain residents' dignity by not providing showers, bathing, transfers, and incontinence care resulting in residents expressing feelings of being: helpless, dirty, rank, embarrassed, angry, terrible, fed up, sad, treated like a dog, smelly, and "forgotten about." This affected 5 of 5 (Residents #9, #39, #28, #13, and #360) sampled residents. Findings included:	F 550	F550 1. Residents #9, #39, #13, and #360 were cited. Residents affected were asked to confirm their shower preferences and given their showers per request. Residents #9 and #28 were asked their preferences on getting in/out of bed as well. Preferences update in resident care plan and on master shower schedules. Preferences communicated to staff by Director of Nursing on 2/18/22. Resident #28 no longer in facility.	

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F 550	Continued From page 4 1. Resident #9 admitted to the facility on 07/22/14 with multiple diagnoses that included chronic obstructive pulmonary disease (difficulty breathing), chronic pain, osteoarthritis, and anxiety. The quarterly Minimum Data Set (MDS) dated 10/05/21 indicated Resident #9 was cognitively intact and required extensive to total assistance of 1 staff member for bathing and personal hygiene. During an interview on 01/26/22 at 08:55 AM, Resident #9 expressed she pushed her call bell at 7:30 AM for staff to assist her up out of bed and was still waiting for staff to respond. Resident #9 stated she was not provided her scheduled shower yesterday and was told by staff they would "wipe her down really good" before her appointment at 1:00 PM but she was afraid the Nurse Aide (NA) would not have her ready in time. Resident #9 added she really wanted a shower and when she didn't get one, it made her "feel bad and angry. I don't like not being clean." A follow-up observation and interview was conducted with Resident #9 on 01/26/22 at 10:40 AM. Resident #9 was observed still in bed, wearing a night gown. Resident #9 looked up at the clock and stated she had pushed her call bell again at 10:10 AM for staff to assist her up out of bed to get ready for her appointment. Resident #9 added she felt staff didn't have the time or liked doing anything for her. During an interview on 01/26/22 at 10:47 AM, the MDS Coordinator stated she was covering for the scheduler and confirmed Resident #9's appointment was scheduled at 1:15 PM this	F 550	2. On 2/18/22, The Director of Nursing completed a questionnaire with all cognitively intact Residents or with Resident Representative (RR) for cognitively impaired residents to determine preferences of getting in/out of bed and bathing (showers/bed baths)type and frequency preferences. The Master Shower Schedule and Electronic Medical Record (EMR)task list were updated to reflect these preferences. Resident room rounds were also completed by the licensed nurses and incontinence care provided to maintain dignity. 3. Director of Nursing has educated current facility and agency licensed nurses and nurse aides on honoring resident preferences for bathing type/frequency and preferred times for getting up/laying down in bed, as well as providing incontinence care to dependent residents to maintain dignity. Education included process of the licensed nurse updating Master Shower Schedule and EMR task list for bathing type/frequency and preferred times for getting up/out of bed according to resident preference. Nurse aide education included providing incontinence care for dependent residents every two hours and as needed and bathing and getting residents in/out of bed per resident preference and per the EMR task list and Master Shower Schedule. Education will be completed by 2/25/22. Newly hired facility and agency licensed nurses and nurse aides will be educated prior to working as a part of orientation.	

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F 550	Continued From page 5 afternoon and she would need to be ready to leave the facility by 12:30 PM. The MDS Coordinator voiced Resident #9 started requesting to get up out of bed and ready "first thing this morning." The MDS Coordinator stated she would talk with Resident #9 to assure her she would be ready in time. A follow-up observation and interview was conducted with Resident #9 on 01/26/22 at 11:30 AM. Resident #9 was observed still in bed, wearing a night gown. Resident #9 stated she was wet and had pushed her call bell 10 minutes ago for staff to provide incontinence care. Resident #9 was tearful as she voiced being worried that staff would not be able to give her a shower or have her up and ready in time for her appointment. Resident #9 stated, "I am so fed up with this place, I don't know what I am going to do. I can't live like this." During an interview on 01/26/22 at 11:36 AM, Nurse #3 stated she was aware that Resident #9 was upset and wanting to get up out of bed. Nurse #3 added staff were fixing to get Resident #9 up out of bed for a shower and ready for her appointment. During an observation and interview on 01/26/22 at 11:50 AM, NA #6 was observed in Resident #9's room getting ready to provide her with care. NA #6 explained she was called in to assist with showers and was asked to assist Resident #9 with getting ready for her appointment. NA #6 verified Resident #9 would be taken for a shower right after she finished with incontinence care. During an interview on 01/26/22 at 11:52 AM, NA #5 explained when she arrived at work, she was	F 550	4. The Director of Nursing or Unit Manager will audit: shower/bathing care and getting in/out of bed care per preference via review of EMR task reports for compliance. Additionally, interviews will be conducted with cognitively intact resident and/or rounding observations for cognitively impaired residents to ensure care and dignity with showers, getting in/out of bed and incontinence care. Monitoring will be completed for 5 residents at a frequency of 3x week for 4 weeks then 1x per week for 4 weeks. The Director of Nursing and administrator will bring results to our Quality Assurance and Performance Improvement meeting monthly and make changes to the plan as necessary tand extend monitoring to maintain compliance with resident dignity for bathing type/frequency, preferred times for getting up/laying down and providing incontinence care for dependent residents. 5. Completion date 2/28/22.	

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originally assigned to work on the east unit but then sent to the west unit to assist with resident care. NA #5 confirmed Resident #9 was on her assignment and was aware she had been requesting to get up out of bed. NA #5 stated she had not assisted Resident #9 up out of bed because NA #6 was going to get her up and give her a shower. NA #5 added she had not noticed Resident #9's call light and was not aware that she was wet and needed changed.

A follow-up observation and interview was conducted with Resident #9 on 01/26/22 at 4:58 PM. Resident #9 was sitting up in her wheelchair in her in no apparent distress. Resident #9 stated she felt much better now that she had a shower and made it to her appointment on time.

During an interview on 01/28/22 at 4:20 PM, the Director of Nursing (DON) revealed she had received complaints from a lot of residents regarding them not getting their scheduled showers. The DON explained she would like for all residents to get at least 2 showers per week or per their preference; however, when there was only one NA on the unit, it was difficult for them to get showers completed and provide resident care. She was unaware that Resident #9 had requested to get up out of bed since 7:30 AM but did not receive staff assistance until 11:50 AM and would have expected for staff to assist Resident #9 up out of bed when first requested or as soon as possible. The DON added all staff were expected to treat residents with dignity and respect.

2. Resident #39 was admitted to the facility on 11/15/21 with multiple diagnoses that included left

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foot metatarsal (long bones of the foot) fracture, major depressive disorder, and anxiety.

The admission Minimum Data Set (MDS) dated 11/23/21 indicated Resident #39 was cognitively intact and required extensive assistance of 1 to 2 staff members for bathing and transfers.

An observation and interview was conducted with Resident #39 on 01/24/22 at 10:23 AM. Resident #39's hair appeared oily and she stated she had not had a shower or her hair washed. Resident #39 stated she received a shower approximately a week ago but prior to that, she went without a shower for over a month. Resident #39 added she had asked staff "every day" for a shower but was told there wasn't enough staff available to give one. Resident #39 added, during the time she went without a shower, she went out for an appointment with her hair "beyond greasy" which made her feel terrible and embarrassed.

During an interview on 01/26/22 at 8:09 AM, NA #2 revealed she frequently worked during the hours of 7:00 AM and 7:00 PM and had provided Resident #39's care. NA #2 stated Resident #39 had voiced concerns about not receiving her scheduled showers. NA #2 explained during the past 3 weeks, she was the only NA assigned to the west unit and was not able to provide resident showers or bed baths. NA #2 added when she worked by herself, the best she could do was keep the residents clean, dry and fed.

During an interview on 01/27/22 at 11:13 AM, NA #3 revealed she worked during the hours of 7:00 AM to 7:00 PM and often worked short-staffed with only one NA for the entire building or 2 NAs, one on each unit. NA #3 verified residents had

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complained about not getting their scheduled showers and stated when there were only one or 2 NAs to provide care, resident showers could not be done.

During an interview on 01/28/22 at 12:37 PM, NA #4 revealed she frequently worked during the hours of 7:00 AM and 7:00 PM and routinely provided Resident #39's care. NA #4 stated residents had voiced complaints about missing their scheduled showers but when there was one NA for the entire building or one NA on each unit, it was difficult to get resident showers completed because it left no one on the hall to answer call lights and/or provide care.

During an interview on 01/28/22 at 4:20 PM, the Director of Nursing (DON) revealed she had received complaints from a lot of residents regarding them not getting their scheduled showers. The DON stated she would never want a resident to feel dirty or embarrassed because of not receiving a shower. The DON added she would like for all residents to get at least 2 showers per week or per their preference; however, when there was only one NA on the unit, it was difficult for them to get showers completed and provide resident care.

3. Resident #28 was admitted to the facility on 7/1/21.

Review of the most recent quarterly Minimum Data Set (MDS) dated 11/5/21 assessed cognition was intact for Resident #28 and needs for activities of daily living as total assistance required for bed mobility, transfer, toilet use, personal hygiene, and bathing. There had not been any refusal of care behaviors during the

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MDS lookback period.

Review of the January 2022 bathing records for Resident #28 revealed a shower was given on 1/11/22 and a bed bath on 1/22/22. The bathing record indicated Resident #28 refused a shower on 1/13/22. Resident #28 shower days were scheduled on Tuesday, Thursday, and Saturday.

Review of nurse progress notes revealed Resident #28 was sent to the hospital on 1/16/22 and returned to the facility on 1/22/22.

The Care Plan in place for activities of daily living revised on 1/27/22 identified Resident #28 as having a self-care performance deficit with interventions in place for bathing and showering that include check nail length and trim and clean on bath day and as necessary.

An interview was conducted with Resident #28 on 1/24/22 at 2:05 PM. Resident #28 explained she required total assistance with transfer using a mechanical lift and stated there was not enough staff to get her out of bed upon request and not enough staff to give her showers consistently each week. Resident #28 revealed she had gone 3 to 4 weeks without a shower and stated there have been times she could smell her own body odor. Resident #28 revealed it had been almost 3 weeks since her last shower that she only gets whenever there's enough staff and shower days were inconsistent. Resident #28 stated not getting her shower made her feel helpless and forgotten about and saddened her.

An observation was made of Resident #28 on 1/24/22 at 2:05 PM. Resident #28's hair appeared greasy, tangled, and was pulled up in a ponytail.

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An interview was conducted with Nurse Aide (NA) #1 on 1/25/22 at 8:42 AM. NA #1 revealed when she arrived this morning only one NA was in the building, and she had been focusing on providing incontinence care and delivering breakfast trays.

An interview was conducted with NA #1 on 1/25/22 at 10:29 AM. NA #1 revealed she was assigned to provide care for Resident #28, and the only NA assigned on the unit. NA #1 revealed when she worked by herself on the unit residents did miss their scheduled shower.

An observation was made of Resident #28 on 1/25/22 at 4:16 PM. Resident #28's appearance had not changed, and her hair continued to appear dirty, tangled and pulled up in a ponytail.

An interview was conducted with Resident #28 on 1/25/22 at 4:16 PM. Resident #28 revealed she hadn't had her shower at this time after her request during first shift and hoped she would get one tomorrow. Resident #28 stated she mentioned her shower to NA #1, but she was the only NA on the unit. Resident #28 stated since she returned from the hospital her hair hadn't been washed, she hadn't had a complete bed bath or shower. Resident #28 revealed she could smell herself and her hair was greasy, and her last sponge bath consisted of cleaning her peri-area and applying lotion to her body.

An interview was conducted with the Director of Nursing (DON) on 1/28/22 at 4:57 PM. The DON revealed she heard complaints from residents not getting showers and had begun an audit. The DON revealed for 1 person to be assigned on the unit it would be difficult to complete care and

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provide residents their scheduled showers.

4. Resident #13 was admitted to the facility on 2/25/2021 with a diagnosis of major depressive disorder and others.

Review of Resident #13's significant change Minimum Data Set dated 10/8/2021 revealed he was cognitively intact. Resident #13 was independent for bathing with supervision.

Interview with Resident #13 on 1/24/2022 at 9:28 AM revealed he had not had a shower in months. Resident #13 indicated there was no shower room for residents. He stated there was a Tub Room on the East Wing with tubs that residents were not allowed to use. Resident #13 revealed the tubs in the Tub Room had hoses that were pulled out of the tubs and used to "hose off" residents. Resident #13 stated the set-up in the Tub Room resembled a "dog washing station and I'm not a dog." He further stated he should have the right to shower like a normal person. Resident #13 disclosed he had a shower stall in his bathroom, but there was no shower head.

Observation of the East Wing Tub Room on 1/24/2022 at 10:05 AM revealed 2 tubs and no wall-mounted showers. A single white hose was observed hanging over the side of the tub closest to the door. A shower nozzle approximately 3 inches across was attached to the end of the hose.

Observation of Resident # 13's in-room bathroom on 1/25/2022 at 12:03 PM revealed a walk-in shower. A metal pipe was jutting out of the wall at approximately 7 feet. There was no shower nozzle present and no cap over the end of the

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pipe.

Interview with Nurse Aide (NA) #1 on 1/25/2022 at 10:29 AM revealed she was familiar with Resident #13. NA #1 stated Resident #13 had complained to her about the shower room set-up and had informed her he felt humiliated about being "hosed off". NA #1 stated NAs had gone together as a group (no date could be provided) to the Administrator about their concerns and nothing had been done.

Interview with NA #2 on 1/26/2022 at 8:09 AM revealed she was familiar with Resident #13. NA #2 stated Resident #13 was in his right mind, did not like to be treated disrespectfully and had been very vocal with her about not being taken to the "dog wash". NA #2 indicated staff had been told by the Director of Nursing (DON) to never use the tubs in the Tub Room or the showers or tubs in resident rooms due to safety concerns. NA #2 further revealed the Administrator, Director of Nursing (DON) and the former Maintenance Supervisor had been told of residents' concerns and there had been no change.

Interview with the DON on 1/29/2022 at 4:20 PM revealed she had told staff not to use the tubs in the Tub Room or the tubs / showers in the resident rooms. The DON stated she and the Administrator determined it was unsafe for residents to use the tubs in the Tub Room or the tubs / showers in the residents' rooms. The DON was concerned residents would attempt to use the Tub Room or in-room tubs / showers without assistance and could sustain injuries. The DON stated she had been told Resident #13 viewed the Tub Room as a "dog washing station". The DON was not aware of any plans to update,

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repair or replace fixtures in the Tub Rooms or in-room tubs / showers on the East Wing.

Interview with the Administrator on 1/28/2022 at 5:35 PM revealed he was aware of some residents' concerns about not getting showers. The Administrator stated he was not aware of any resident concerns regarding dignity. He stated staff received dignity training and he expected them to maintain resident's dignity. The Administrator indicated plans were in the works to replace the fixtures in the Tub Room on the West Wing, but no plans were currently in the works for work in the East Wing Tub Room.

5. Resident #360 was admitted to the facility on 1/11/2022 with diagnoses of renal insufficiency, chronic obstructive pulmonary disease and others.

Review of Resident #360's admission Minimum Data Set dated 1/18/2022 revealed she was cognitively intact for daily decision making. Resident #360 required assistance of one person for bathing.

Observation of Resident #360 on 1/24/2022 at 9:15 AM revealed her lying on her back in bed with a nightgown on. Her hair was greasy and shiny.

Interview with Resident #360 on 1/24/2022 at 9:15 AM revealed she had not had a shower, or her hair washed since admission. Resident #360 stated her normal routine at home was to shower and wash her hair every other day. Resident #360 stated she felt "rank and dirty".

Review of the East Wing Shower Schedule

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revealed Resident #360 was scheduled for a shower on evening shifts on Mondays, Wednesdays, and Fridays.

Review of Resident #360's electronic Activities of Daily Living (ADL) report revealed 29 instances of Nurse Aide (NA) documentation of "activity did not occur" under the bathing task. There was 1 instance recorded of a bed bath with assistance of 1 person.

Interview with NA #2 on 1/26/2022 at 8:35 AM revealed she did not recall ever bathing, showering, or washing the hair of Resident #360. NA #2 stated when she was scheduled to work alone, it was not possible to complete showers. NA #2 stated hair washing was part of the bathing / showering task.

Interview with NA #3 on 1/27/2022 at 11:13 AM revealed she did not recall ever bathing, showering, or washing the hair of Resident #360. NA #3 stated there were not enough staff scheduled most days to allow time to complete showers.

Interview with NA #9 on 1/28/2022 at 3:30 PM revealed she did not recall ever bathing, showering, or washing the hair of Resident #360.

Interview with the Director of Nursing (DON) on 1/28/2022 at 4:04 PM revealed she was not aware Resident #360 had not received a shower or had her hair washed since admission. The DON stated she expected all residents to get at least 2 showers per week or per their preference. The DON indicated the shower schedule was currently on her desk for updating, but she had not had time to complete it as she had been

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F 550	Continued From page 15 providing resident care so much lately. The DON stated she did not want the residents to feel "dirty or rank" and expected staff to provide showers and hair washing as scheduled. Interview with the Administrator on 1/28/2022 at 5:39 PM revealed he was aware residents were not getting their showers. He stated if we have not done what we are supposed to do, it is unacceptable.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social,	F 561		2/28/22

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F 561	Continued From page 16 religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to accommodate a resident's request to be assisted out of bed at their preferred time of day (Resident #9) and provide residents with their preferred number of showers per week (Resident #58) for 2 of 4 residents reviewed for choices. Findings included: 1. Resident #9 admitted to the facility on 07/22/14 with multiple diagnoses that included chronic obstructive pulmonary disease (difficulty breathing), chronic pain, osteoarthritis, and anxiety. The quarterly Minimum Data Set (MDS) dated 10/05/21 indicated Resident #9 was cognitively intact and required limited assistance of 1 staff member for bed mobility and transfers. The MDS noted she displayed no behaviors or refused care during the MDS assessment period. Review of Resident #9's care plans, last reviewed/revised on 11/16/21, revealed a plan of care that addressed a physical functioning deficit related to self-care and mobility impairment. Interventions included she would like to be up in the early morning every day and back to bed late afternoon. During an observation and interview on 01/24/22 at 11:08 AM, Resident #9 was lying in bed and expressed she preferred to get up out of bed	F 561	F561 1. Residents # 9 and #58 were cited. Identified residents were given their choice of shower or bath; given preference along with preference for getting in/out of bed this was completed on 2/18/22. 2. An audit was completed by the Interdisciplinary team to ensure we were honoring all resident preference on: showers vs bed bath including days and shifts desired to the best of our ability. This was concluded on 2/18/22 and implemented by the Director of Nursing on 2/18/22. 3. The Administrator and Director of Nursing began education o with the 100% of the direct care staff including agency staff and the interdisciplinary team on the topic of resident rights to include shower preferences and transfer preferences per plan of care. This education will be completed by 2/25/22. Any newly hired staff or agency staff to enter our facility will be educated on this going forward. Any new agency staff will be educated via their agency orientation packet. 4. The Director of Nursing or Unit Manager will audit: shower/bathing/transfers per their plan of care through interviews with cognitively	

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F 561	Continued From page 17 between 7:00 AM to 7:30 AM; however, the past 3 to 4 months staff had not assisted her out of bed, almost daily, until 11:00 AM, 12:00 PM or sometimes later in the afternoon. Resident #9 added she needed staff assistance to get up out of bed but was always told there wasn't enough staff available to assist her out of bed when requested. Subsequent observations conducted on 01/25/22 at 8:00 AM and 01/26/22 at 8:55 AM, 10:40 AM, and 11:30 AM revealed Resident #9 was still in bed wearing her nightgown. During an interview on 01/26/22 at 10:47 AM, the MDS Coordinator voiced Resident #9 started requesting to get up out of bed and ready "first thing this morning" for her afternoon appointment at 1:15 PM. The MDS Coordinator stated she would talk with Resident #9 to assure her she would be ready in time. During an interview on 01/26/22 at 11:36 AM, Nurse #3 stated she was aware that Resident #9 was wanting to get up out of bed. Nurse #3 explained staff were fixing to get Resident #9 up out of bed for a shower and then ready for her appointment. During an observation and interview on 01/26/22 at 11:50 AM, NA #6 was observed in Resident #9's room getting ready to provide her with care. NA #6 explained she was called in to assist with showers and was asked to assist Resident #9 with getting up out of bed and ready for her appointment. During an interview on 01/26/22 at 11:52 AM, NA #5 explained when she arrived at work, she was	F 561	intact residents about care and dignity needs being met and through observations for residents who are not cognitively intact for 5 residents at 4x week for 4 wks; 5 residents 3xweek for 4wks; and 5 residents 1xweek for 4 wks. The Director of Nursing will bring results to our Quality Assurance and Performance Improvement meeting to present results and take recommendations on any process improvement to maintain compliance with self-determination. Completion date: 2/28/22	

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originally assigned to work on the east unit but then sent to the west unit to assist with resident care. NA #5 confirmed Resident #9 was on her assignment and was aware she had been requesting to get up out of bed. NA #5 stated she had not assisted Resident #9 up out of bed because NA #6 was going to get her up and give her a shower. NA #5 added she was not that familiar with the residents on the west unit and was unaware of Resident #9's preference to be up out of bed at 7:00 AM.

During an interview on 01/28/22 at 4:20 PM, the Director of Nursing (DON) stated she was unaware that Resident #9 had requested to get up out of bed since 7:30 AM on 01/26/22 but did not receive staff assistance until 11:50 AM and would have expected for staff to assist Resident #9 up out of bed when first requested or as soon as possible.

2. Resident #58 was admitted to the facility on 2/16/19 with diagnoses that included cerebral infarction (stroke), Parkinson's disease and hypertension.

Resident #58's care plan revised on 11/16/21 indicated Resident #58 had things he really enjoyed and were important to him. His life's simple pleasures included showers twice a week per resident and family preference.

The quarterly Minimum Data Set (MDS) assessment dated 12/7/21 indicated Resident #58 was cognitively intact, had no rejection of care behaviors and bathing did not occur during the assessment period. He also had impairment

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on both sides of his lower extremities.

A review of the Shower schedule revealed Resident #58 was scheduled for a shower on Monday, Wednesday, and Friday on the 7:00 PM to 7:00 AM shift.

A review of the Bathing Record for Resident #58 from 12/1/21 to 1/27/22 indicated the following information:
Resident #58 received a shower on 12/4/21, a bed bath on 12/22/21, 1/10/22 and 1/11/22. He refused a shower on 1/6/22.

An interview with Resident #58 on 1/24/22 at 10:22 AM revealed he did not get any showers because the facility did not have enough staff. Resident #58 stated he would like to get a shower at least twice a week.

An interview with Nurse Aide (NA) #2 on 1/26/22 at 8:08 AM revealed she worked with Resident #58 on the 7:00 AM to 7:00 PM shift on 12/3/21, 12/6/21, 12/10/21, 12/20/21, 12/27/21, 12/29/21, and 1/5/22. NA #2 stated the last time she had given Resident #58 a shower was when he was on the day shift schedule before 12/1/21. NA #2 reported she often had to work by herself on the West wing during the last 3 weeks and did not have time to do any of the showers. NA #2 also stated she sometimes did not have someone to relieve her when it was time for her to leave at 7:00 PM so she just gave report to the nurses and let them know she was leaving.

An interview with NA #8 on 1/26/22 at 3:47 PM revealed she had taken care of Resident #58 on 1/7/22, 1/12/22, 1/19/22 and 1/26/22 on the day shift from 7:00 AM to 7:00 PM. NA #8 did not

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remember ever giving Resident #58 a shower since she started working at the facility. NA #8 stated she was only able to do morning showers when she had help but did not have time to do any when she had to work by herself on the West wing.

An interview with NA #3 on 1/27/22 at 11:11 AM revealed she worked with Resident #58 on 12/24/21 and 12/31/21 on the evening shift from 3:00 PM and 11:00 PM and did not give him a shower because she didn't have enough time to do it. NA #3 stated she worked by herself on the West wing and did not get any help.

An interview with NA #4 on 1/28/22 at 12:37 PM revealed she was routinely assigned to the West wing from 7:00 AM to 7:00 PM and the facility was often short-staffed. NA #4 stated that there had been a lot of days where there was one nurse aide for the entire building or for each wing. NA #4 stated having only one nurse aide made it difficult to get all showers completed as scheduled because she had to do rounds, provide incontinence care, assist with getting residents dressed and out of bed and assist with meals.

An interview with NA #10 on 1/28/22 at 1:35 PM revealed she usually worked from 7:00 PM to 7:00 AM and was expected to do showers whenever she came in at 7:00 PM. NA #10 stated staffing had been bad. She usually worked three times a week and had worked twice this week by herself. NA #10 stated she was not able to get showers done when she was the only nurse aide in the facility. She was only able to get meals and incontinence care done but it was difficult to assist all the residents with their care.

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F 561	Continued From page 21 A phone interview with NA #7 on 1/28/22 at 2:27 PM revealed she provided care to Resident #58 on 12/1/21, 12/3/21, 12/6/21, 12/13/21, 1/7/22, 1/12/22 and 1/26/22 on the 7:00 PM to 7:00 AM shift. NA #7 stated she had never given Resident #58 a shower. NA #7 reported that she was told not to do showers when they didn't have enough staff because they wouldn't have enough time to complete them, and someone had to stay on the floor to monitor the call lights and the residents if they needed something. NA #7 stated she often had to work by herself on the West wing and sometimes for the whole facility. All she was able to do was answer call lights and provide incontinence care to the residents who needed it. A phone interview with NA #9 on 1/28/22 at 3:20 PM revealed she had taken care of Resident #58 on 12/8/21, 12/20/21, 12/29/21 and 1/14/22 on the evening shift from 3:00 PM to 11:00 PM and had not given him a shower on those days because she was working by herself on the West wing. NA #9 stated she didn't have time to do any showers because she prioritized giving incontinence care and getting the residents fed their supper meal. NA #9 further stated the facility often did not have enough staff to take care of all the residents in the building. An interview with the Director of Nursing (DON) on 1/28/22 at 4:04 PM revealed she had been aware of the staffing issues at the facility, and this was why showers had not been completed as scheduled. The DON stated that Resident #58 should be given showers per his preference.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		2/28/22

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§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide

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F 578	Continued From page 23 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to clarify and update the medical records to reflect the desired advance directives for 2 of 2 residents reviewed for code status (Resident #57 and #41). The findings included: 1. Resident #57 was admitted to the facility on 9/24/21 with diagnoses including stroke and hemiplegia following a cerebral infarction affecting the left non-dominate side. The advance directive Care Plan last reviewed on 10/8/21 revealed Resident #57's advanced directive as a full code status with the goal the resident's wishes would be honored. Interventions included to update code status quarterly and follow full code with any changes. A review of the most recent quarterly Minimum Data Set (MDS) dated 1/4/22 indicated Resident #57 had moderately impaired cognition. A review of the physician orders for Resident #57 revealed 2 separate orders existed for advance directives. An active physician order was in place for full code status indicating Cardiac Pulmonary Resuscitation (CPR) would be initiated. A second active physician's order was in place for Do Not Resuscitate (DNR) indicating CPR would not be initiated. Review of the Medical Doctor progress note dated 1/12/22 revealed code status and CPR	F 578	F578 1. Resident #57 and Resident #41were cited. Advanced directives clarified, orders updated, and advanced directives book updated to reflect accurate advanced directives for residents #57 and #41 on 1/28/22. 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved Director of Nursing to conduct advanced directive audit to ensure advanced directives are accurate per resident preference and reflected accurately in medical record and advanced directives book. This was completed on 2/2/22. 3. Administrator will educate interdisciplinary team and current facility and agency licensed staff related to advanced directive processes and ensuring all documentation is accurate and reflects resident wishes. This will be completed by 2/25/22. Any new staff hired will be educated upon hire date. New agency staff will be educated via their agency orientation packet. 4. Administrator or designee to audit to ensure advanced directives process is followed and accurate 4x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Administrator or designee will bring results to our monthly	

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F 578	Continued From page 24 were discussed, and Resident #57 did not want CPR and expressed she wanted to be an DNR. An interview with the Regional Director of Clinical Services (RDCS) was conducted on 1/28/22 at 10:14 AM. The RDCS reviewed the advance directive book kept at the nurses station on unit where Resident #57 resided and stated she was not sure if the advance directive book at the nurse station was up to date and did not see an advance directive indicating the code status for a DNR. The RDCS revealed there should be only 1 physician's order in a resident's chart indicating advanced directives not 2 conflicting orders 1 for full code and 1 for DNR. An interview with Director of Nursing (DON) was conducted on 1/28/22 at 12:50 PM. The DON revealed the original physician order for full code was not the newest and she expected the nurses to go by the newest advanced directive for the DNR. The DON revealed she had called the Medical Doctor (MD) to clarify Resident #57's code status was DNR and explained the MD wasn't aware he had to discontinue the original order for full code after inputting the newest order for DNR. The DON revealed she expected physician orders to have one advance directive in place and the paperwork was in the MD book for him to sign on his next visit. 2. Resident #41 was admitted to the facility on 8/14/21. A DNR (Do Not Resuscitate) form dated 8/20/21 for Resident #41 was located in the advance directive book at the West wing nurses' station. Resident #41's care plan last revised on 9/20/21	F 578	Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months 5. Completion date 2/28/22	

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indicated Resident #41 had an advance directive of DNR. Interventions included to follow facility protocol for identification of code status and to review code status quarterly.

Further review of Resident #41's electronic medical record revealed a physician order dated 10/20/21 for full code.

The quarterly Minimum Data Set (MDS) assessment dated 11/27/21 indicated Resident #41 was cognitively intact.

An interview was attempted with Resident #41 on 1/26/22 at 8:49 AM but Resident #41 stated to leave him alone and that he was not feeling well.

An interview with Nurse #3 on 1/26/22 at 9:56 AM revealed she noted the DNR form for Resident #41 dated 8/20/21 was in the advance directive book at the nurses' station. Nurse #3 stated that if there was an emergency, she would look at the advance directive book and follow the advance directive from the book. Nurse #3 further stated she had not noticed that Resident #41 had conflicting advance directives in his medical record and that it needed to be clarified.

An interview with the MDS Coordinator on 1/26/22 at 10:14 AM revealed that she had entered the order for full code in Resident #41's electronic medical record when he re-admitted to the facility on 10/20/21. The MDS Coordinator stated she obtained the full code order from the discharge summary from the hospital. She also verified it with Resident #41 who told her that he wanted his advance directive to be changed to a full code. The MDS Coordinator stated the Social Worker was responsible for making sure the

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F 578	Continued From page 26 advance directives were updated but the facility currently didn't have a Social Worker so some of the tasks by the Social Worker were split among the administrative staff. An interview with the Director of Nursing (DON) on 1/28/22 at 4:04 PM revealed the medical records officer had been assigned to handle the advance directives but she didn't catch the change in Resident #41's advance directive after he was re-admitted to the facility. Unfortunately, if something changed after a resident was re-admitted to the facility, the changes didn't get noted. The DON acknowledged that the facility had some work to do, and they didn't follow the entire process with following up on the changes in Resident #41's advance directive.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other	F 583		2/28/22

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F 583	Continued From page 27 materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect the Private Health Information (PHI) for 1 of 1 sampled resident (Resident #9) by leaving confidential medical information unattended in an area visible and accessible to the public on 1 of 2 west unit medication carts. The findings included: Resident #9 admitted to the facility on 07/22/14. A continuous observation was made on 01/26/22 from 6:38 AM through 6:52 AM of an unattended computer on the west unit medication cart. Nurse #2 left the west unit medication cart with the computer screen visible to walk off the unit to the medication storage room. Resident #9's PHI, which included picture, room number and list of medications, was visible to anyone that passed by, including those not authorized to view the confidential information.	F 583	F583 1. Resident #9 cited. Resident # 9 confidential medial information protected when identified. Nurse #2 educated regarding HIPPA and not leaving computer screen visible when not in use on 1/31/22. 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved: Director of Nursing audited all staff to ensure no other HIPPA issues observed. 3. Director of Nursing to educate all current facility and agency licensed nursing staff and Interdisciplinary team staff related to Health Insurance Portability and Accountability Act (HIPAA). This will be completed by 2/25/22. Any new hired licensed nurse staff will be	

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F 583	Continued From page 28 During an interview on 01/26/22 at 6:59 AM, Nurse #2 confirmed he left Resident #9's PHI visible on the computer screen when he left the medication cart to go to the medication storage room with another surveyor. Nurse #2 explained he was nervous and forgot to minimize the computer screen when he left the cart unattended. He acknowledged that it was inappropriate to leave the computer unattended with a resident's PHI visible and confirmed he had received the Health Insurance Portability and Accountability Act (HIPAA) training during orientation and yearly from the facility. During an interview on 01/27/22 at 2:55 PM, the Director of Nursing (DON) stated all nursing staff received HIPPA training which included not leaving computer screens unattended with resident confidential information visible. The DON stated she would have expected Nurse #2 to close the computer or lock the computer screen before leaving the medication cart unattended to protect Resident 9's confidential personal and medical information.	F 583	educated upon hire and any new agency licensed nursing staff will be educated via their orientation packets. 4. Director of Nursing or Unit manager to audit computers to ensure compliance with protecting healthcare information 4x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration to maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA). Completion date 2/28/22.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		2/28/22

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F 584	Continued From page 29 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: Based on record review, observations and staff interviews, the facility: 1) failed to ensure 6 of 21 overbed tables were clean and in good repair in 6 of 28 resident rooms (Rooms #103, #107, #206, #208, #211, and #219) on 3 of 4 resident halls; 2) failed to maintain a clean, sanitary, homelike environment for 10 of 31 resident rooms (#113, #119, #206, #207, #208, #209, #211, #212, #218,	F 584	1) By 2/28/22, maintainence and housekeeping staff completed the following: a)Bedside tables were replaced and cleaned for Rooms #103,#107,#206,#208, #211 and #219; b) room #113 corner of the wall repaired, electric fan was cleaned, the bed was declined, peeling plaster was repaired and	

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and #219) observed to have scraped and cracked walls, peeling paint and plaster, dirty floors, trash not emptied, dirty bed rails, stains on the walls, and electric fan with of dust accumulation on 3 of 4 resident halls; 3) failed to ensure a baseboard was in good repair in 1 of 8 resident rooms (Room #108) on 1 of 4 resident halls; 4) failed to maintain built-in dressers and closets in good repair in 4 of 31 resident rooms (Rooms #112, #208, #212, and #219) on 3 of 4 resident halls; 5) failed to ensure personal care equipment was labeled and covered in 2 of 20 resident bathrooms (Rooms #209 and #218) on 2 of 4 resident halls; 6) failed to repair missing baseboard in the east wing nourishment room for 1 of 2 nourishment rooms; and 7) failed to maintain clean and sanitary tub rooms used for resident bathing for 2 of 2 tub rooms (East and West wings).

Findings included:

1 a. An observation of Room #103 on 01/24/22 at 10:12 AM revealed the overbed table for the A-side of the room was chipped on the corners and the top had peeling laminate. Subsequent observations conducted on 01/26/22 at 8:43 AM and 01/28/22 at 8:43 AM revealed the conditions remained unchanged.

b. An observation of Room #107 on 01/24/22 at 10:19 AM revealed the top of the overbed table for the A-side of the room had chipped and peeling laminate. Subsequent observations conducted on 01/26/22 at 8:03 AM and 01/28/22 at 8:45 AM revealed the conditions remained unchanged.

c. An observation of Room #206 on 01/25/22 at

the gouges and missing paint on the walls repaired; c) Room #207 wall next to the windows cleaned; d) Room #208 was deep cleaned; F. Room #209 trash removed; e) Room #211 gauges repaired and painted; f) Room #212 walls repaired and painted; g) Room #218 deep cleaned, exposed plaster repaired and painted; h) Room #219 A bed and B bed wall repaired and painted; i) Room #108 based board repaired; j) Room #112 bottom door repaired and handle replaced; k)Room #208 drawers painted; l) Room #212 built-in dresser drawer repaired and missing handle replaced and resident clothing and personal belonging stored inside the dresser; m) Room #219 built-in dresser drawer repaired and missing handle replaced; n) Room #209 the seat riser removed; o) Room #218 urinals removed and section of the missing baseboard repaired; p) East wing shower room and tub deep deep cleaned, tub removed, floor replaced and second linen cabinet installed.

2) On 2-17-2022, the Maintenance Director and Housekeeping Director completed an audit of all resident rooms, bathrooms, shower rooms and common areas and made corrections as identified to ensure a safe, clean, comfortable, homelike environment for all residents.

3) The Administrator provided education to current facility and agency staff related to maintaining a Safe/Clean/Comfortable/Homelike Environment. Education included all staff

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F 584	Continued From page 31 3:06 PM revealed the top of the overbed table was cracked and peeling with rusted table supports. A second observation conducted on 01/28/22 at 8:31 AM revealed the conditions remained unchanged. d. An observation of Room #208 on 01/25/22 at 3:03 PM revealed a clear, dried substance that was circular in pattern on the top of the overbed table. A second observation conducted on 01/28/22 at 8:32 AM revealed the conditions remained unchanged. e. An observation of Room #211 on 01/25/22 at 12:03 PM revealed the top of the overbed table for the B-side of the room was covered with a brown substance and brown liquid filled the rim of the border around the surface. A second observation on 01/28/22 conducted on 01/28/22 at 8:35 AM revealed the conditions remained unchanged. f. An observation of Room #219 on 01/24/22 at 3:47 PM revealed the overbed table for the A-side of the room was unclean and had dried paper stuck to the top. Subsequent observations conducted on 01/25/22 at 4:03 PM and 01/28/22 at 8:39 AM revealed the conditions remained unchanged. A walking round and joint interview was conducted with the Administrator, Environmental Services Director (ESD), and Maintenance Director on 01/28/22 at 11:40 AM. The Administrator stated he was unaware of the conditions of the overbed tables, staff should have informed management and they would be replaced. The ESD explained housekeeping staff were expected to clean overbed tables as part of	F 584	responsiblity for reporting any repair needs to Maintenance Director and reporting sanitation needs to the Housekeeping Director and/or logging in Maintenance or Housekeeping Reguest Logs located at each nurses station. Maintenance and Housekeeping Director educated on daily responsibilities including completing requests by staff as logged in the Maintenance/Housekeeping binders. Education completed by 2/28/22. Any newly hired facility or agency staff hired will be educated upon hire. Department heads will complete resident room and facility common area rounds twice a week and will report findings to the Administrator, Maintenance Director and Housekeeping Director. Any concerns identified will also be logged in the Maintenance/Housekeeping binders for communication and follow-up. Facility preventive maintenance and repairs will also be logged into TELS (electronic monitoring system). 4) The Administrator will audit resident rooms and facility common areas for safety, cleanliness, comfort and homelike environment. Maintentance/Housekeeping logs will also be monitored for completion. Monitoring will be completed 2 times weekly for 4 weeks then weekly for eight weeks. The Administrator will bring results to our Quality Assurance and Performance Improvement meeting monthly and make changes to the plan as necessary to maintain compliance with resident right for a safe, clean,	

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F 584	Continued From page 32 their daily procedure and he would be providing reeducation. 2 a. An observation of Room #113 on 01/24/22 at 3:54 PM revealed the corner of the wall near the bathroom door had missing chunks of plaster extending up the wall approximately 2 inches. Subsequent observations on 01/26/22 at 8:09 AM and 01/28/22 at 8:48 AM revealed the conditions remained unchanged. b. An observation of Room #119 on 01/24/22 at 1:26 AM revealed the electric fan on top of the nightstand beside the B-bed was covered with dust on the back of the vented fan cover. The bedrail of the C-bed had brown, dried substance on the inside of the left bedrail and food particles/debris along the inside base of the bedrail. Peeling plaster was noted on the wall of the room next to the sink. Subsequent observations conducted on 01/25/22 at 8:50 AM and 01/28/22 at 8:52 AM revealed the conditions remained unchanged. c. An observation of Room #206 on 01/25/22 at 3:06 PM revealed gouges and missing paint on several areas of the walls. A second observation conducted on 01/28/22 at 8:31 AM revealed the conditions remained unchanged. d. An observation of Room #207 on 01/25/22 at 3:01 PM revealed on the middle of the wall to the left of the window were scattered, black dots resembling mold. A second observation conducted on 01/28/22 at 8:30 AM revealed the conditions remained unchanged. e. An observation of Room #208 on 01/25/22 at 3:03 PM revealed there was crumbled tissue, an	F 584	comfortable, homelike environment. Alleged compliance date: 2/28/22	

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empty medicine cup and a dried red substance on the floor next to the wall between the A and B beds. A second observation conducted on 01/28/22 at 8:32 AM revealed the conditions remained unchanged.

f. An observation of Room #209 on 01/28/22 at 8:34 AM revealed a full, plastic grocery bag of trash attached to an empty toilet paper holder in the resident bathroom.

g. An observation of Room #211 on 01/25/22 at 12:03 PM revealed peeling paint and linear gouges on the wall behind the B-bed. A second observation conducted on 01/28/22 at 8:35 AM revealed the conditions remained the same.

h. An observation of Room #212 on 01/24/22 at 4:37 PM revealed several long, vertical scrapes of damaged plaster with missing paint. Subsequent observations conducted on 01/27/22 at 8:49 AM and 01/28/22 at 8:36 AM revealed the conditions remained unchanged.

i. An observation of Room #218 on 01/25/22 at 9:32 AM revealed brown colored marks on the walls of the resident room. In the resident bathroom there was a brown smear stain on the wall next to the light switch and the wall around the sink had a hole with exposed plaster and stained. Subsequent observations conducted on 01/27/22 at 8:57 AM and 01/28/22 at 8:38 AM revealed the conditions remained unchanged.

j. An observation of Room #219 on 01/24/22 at 3:40 PM revealed the wall behind the head of the A-bed had approximately 5 vertical scrapes with missing paint. The wall behind the B-bed had missing paint and exposed plaster with a

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nickel-sized hole in the wall. Subsequent observations conducted on 01/25/22 at 4:03 PM and 01/28/22 at 8:39 PM revealed the conditions remained unchanged.

A walking round and joint interview was conducted with the Administrator, Environmental Services Director (ESD), and Maintenance Director on 01/28/22 at 11:40 AM. The Maintenance Director revealed he had only been in his position about a month but was out of work for approximately 2 weeks for personal reasons. He stated he was aware of the conditions of the walls observed and plans were to patch and paint as he could but he had not yet had the time due to focusing on emergent repairs that needed completed. The Administrator, ESD and Maintenance Director all stated they had not noticed the scattered black dots on the wall of Room #207 but did not think it was mold. They explained it was likely caused by furniture rubbing up against the wall when moving things around in the room. The ESD stated the trash on the floor and dirty brown substances observed on the walls, the inside of the bedrail, and the unemptied trash was unacceptable and should have been cleaned by housekeeping staff as part of their daily procedure. The ESD was not aware of the dust accumulation on the fan and stated housekeeping staff should have dusted the fan when cleaning the bedside table. The ESD added he would be providing reeducation.

3. An observation of Room #108 on 01/24/22 at 10:17 AM revealed by the entrance of the bathroom door was a section of flexible baseboard, approximately 12 inches in length, detached from the wall. Subsequent observations conducted on 01/26/22 at 8:04 AM

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and 01/28/22 at 8:46 AM revealed the conditions remained unchanged.

A walking round and joint interview was conducted with the Administrator, Environmental Services Director and Maintenance Director on 01/28/22 at 11:40 AM. All three stated they were unaware the baseboard had detached from the wall and needed repaired. The Maintenance Director stated he relied on staff informing him when issues were identified for him to make plans to repair. The Administrator and ESD both stated nursing and/or housekeeping staff should have noticed the condition of the baseboard and notified the Maintenance Director.

4 a. An observation of Room #112 on 01/24/22 at 11:09 AM revealed the bottom drawer of the built-in dresser did not close all the way and was missing a handle. A second observation conducted on 01/28/22 at 8:41 AM revealed the conditions remained unchanged.

b. An observation of Room #208 on 01/25/22 at 3:03 PM revealed the drawers of the built-in dresser were rusted. A second observation conducted on 01/28/22 at 8:32 AM revealed the conditions remained unchanged.

c. An observation of Room #212 on 01/24/22 at 4:37 PM revealed the first drawer of the built-in dresser would not open and the second drawer did not shut all the way and was missing a handle. The resident's clothing and personal belongings were observed stored on top of the built-in dresser. Subsequent observations conducted on 01/27/22 at 8:49 AM and 01/28/22 at 8:36 AM revealed the conditions remained unchanged.

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d. An observation of Room #219 on 01/24/22 at 3:40 PM revealed stains on the closet door, the bottom drawer of the built-in dresser did not close all the way and was missing a drawer handle. Subsequent observations conducted on 01/25/22 at 4:03 PM and 01/28/22 at 8:39 AM revealed the conditions remained unchanged.

A walking round and joint interview was conducted with the Administrator, Environmental Services Director and Maintenance Director on 01/28/22 at 11:40 AM. The Maintenance Director stated he had noticed the rust on some of the built-in dressers and would have to figure out a plan for what could be done. The Maintenance Director was unaware some of the drawers would not open, close all the way or had missing handles and stated the conditions were something that staff should have reported to him.

During an interview on 01/28/22 at 3:45 PM, the Regional Director of Operations explained the corporation had plans to remodel all the skilled nursing facilities buildings and this facility was on the schedule for 2022; however, an exact date for the remodel had not been established.

5 a. An observation of the bathroom in Room #209 revealed a white, plastic toilet seat riser uncovered on the floor of the walk-in shower and leaning up against the shower wall. Subsequent observations conducted on 01/25/22 at 12:03 PM and 01/28/22 at 8:34 PM revealed the conditions remained unchanged.

b. An observation of the shared bathroom in Room #218 on 01/25/22 at 9:32 AM revealed 2 dirty, unlabeled, and uncovered graduated urinal

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cylinders on top the toilet tank. Subsequent observations conducted on 01/27/22 at 8:57 AM and 01/28/22 at 8:38 AM revealed the conditions remained unchanged.

A walking round and joint interview was conducted with the Administrator, Environmental Services Director and Maintenance Director on 01/28/22 at 11:40 AM. The Administrator stated the toilet seat riser and urinals should be clean, labeled and covered. He was unsure who was responsible for labeling and covering personal care equipment and would discuss the issue with the Director of Nursing.

6. An observation of the east wing nourishment room on 01/25/22 at 3:30 PM revealed a section of missing baseboard, approximately 18 inches in length, along the right side of the wall. The exposed structure was discolored and black in appearance.

A walking round and joint interview was conducted with the Administrator, Environmental Services Director and Maintenance Director on 01/28/22 at 11:40 AM. All three stated they were unaware the baseboard was missing from the wall and needed repaired. The Maintenance Director stated he relied on staff informing him when issues were identified for him to make plans to repair. The Administrator stated nursing and/or housekeeping staff should have noticed and notified the Maintenance Director of the missing baseboard.

7 a. An observation of the east wing tub room on 01/24/22 at 10:05 AM and 1:42 PM revealed on the inside and outside of the tub had a brown, dried substance and long, dark hairs stuck to the

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F 584	Continued From page 38 surfaces. Subsequent observations conducted on 01/25/22 at 12:05 PM and 1:42 PM and 01/28/22 at 8:27 AM revealed the conditions remained the same. b. An observation of the west wing tub room on 01/24/22 at 11:45 AM revealed multiple, folded towels and a pink, bath basin containing various hygiene items stored on the inside of the sink. The floor was dirty and there were several wadded balls of dark hair on the floor along the left wall. Inside the tub were 4 bottles of shampoo and conditioner scattered along the seat and bottom of the tub. A second observation on 01/28/22 at 8:55 AM revealed the conditions remained unchanged. A walking round and joint interview was conducted with the Administrator, Environmental Services Director (ESD), and Maintenance Director on 01/28/22 at 11:40 AM. The Administrator stated staff had used the tub room for resident bathing this morning which was why the towels and bathing items were left on the sink and in the tub. The ESD stated the trash and hair left on the floor and dirty tubs were unacceptable and should have been cleaned by housekeeping staff as part of their daily procedure. The ESD added he would be providing reeducation.	F 584		
F 636 SS=E	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.	F 636		2/28/22

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§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive 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

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F 636	Continued From page 40 assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes 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 interviews, the facility failed to complete and transmit comprehensive Minimum Data Set (MDS) assessments within the regulatory timeframes as specified in the Resident Assessment Instrument (RAI) manual for 4 of 30 sampled residents reviewed (Residents #11, #39, #109, and #360). Findings included: 1. Resident #11 was admitted to the facility on 12/09/20. Review of Resident #11's electronic medical record revealed the most recent MDS assessment was coded as an annual with an ARD of 12/17/21. The MDS assessment had a status of "in progress." During interviews on 01/25/22 at 4:55 PM and 01/28/22 at 1:48 PM, the MDS Coordinator explained since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks	F 636	1) Residents #11, #39, #109, and #360 cited. The Minimum Data Set Coordinator provided immediate corrective action for the alleged deficient practice regarding failure to complete and transmit Comprehensive Minimum Data Set (MDS) within regulatory timeframes as specified in the Resident Assessment Instrument (RAI). The MDS is now current as per RAI guidelines. 2) On2-3-2022 MDS schedule has been reviewed for completion timing of MDS assessments. A 100% audit of current facility Residents' open assessments (Admission, Annual, Significant Change and Quarterly Assessments) using the In-Progress report and Assessment History report was completed. Corrective actions were put in place to correct deficient practice to get facility Compliant with Comprehensive Assessment and Timing including Transmission per RAI Manual.	

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F 636	Continued From page 41 of work which put her behind on completing MDS assessments. The MDS Coordinator verified Resident #11's MDS assessment dated 12/17/21 was not completed or transmitted within the regulatory time frames. During an interview on 01/28/22 at 5:35 PM, the Administrator revealed he was aware that MDS assessments were not being completed and/or transmitted within the regulatory timeframes. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues. 2. Resident #39 was admitted to the facility on 11/15/21. Review of Resident #39's electronic medical record revealed an admission MDS assessment with an ARD of 11/23/21. The MDS assessment was marked completed on 12/20/21 and transmitted on 12/22/21. During interviews on 01/25/22 at 4:55 PM and 01/28/22 at 1:48 PM, the MDS Coordinator explained since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks of work which put her behind on completing MDS assessments. The MDS Coordinator verified Resident #39's MDS assessment dated 11/23/21 was not completed or transmitted within the regulatory time frames. During an interview on 01/28/22 at 5:35 PM, the Administrator revealed he was aware that MDS assessments were not being completed and/or transmitted within the regulatory timeframes. He explained due to staffing shortages, resident care	F 636	3) The MDS Consultant educated the Interdisciplinary (IDT) team on 2-3-2022 to review the guidelines set forth in the RAI manual regarding all requirements needed to schedule, data entry, and completed based upon MDS regulations and timeframes. All new hires that include completion of a resident assessment will be educated on the requirements during orientation. 3) The Comprehensive assessments scheduled will be audited 4 times a week for 4 weeks, 2 times a week for 4 weeks, then 1 time a week for 4 weeks by the Administrator or designee to ensuring timely completion and transmittals of assessments on required due dates. The Administrator is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for a minimum of three months. 4) Completed on 2/28/22.	

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came first and their focus was placed on the residents' immediate care issues.

3. Resident #109 was admitted to the facility on 12/03/21.

Review of Resident #109's electronic medical record revealed an admission MDS assessment with an ARD of 12/10/21 and a status of "export ready." The MDS assessment was marked completed on 01/21/22.

During interviews on 01/25/22 at 4:55 PM and 01/28/22 at 1:48 PM, the MDS Coordinator explained since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks of work which put her behind on completing MDS assessments. The MDS Coordinator verified Resident #109's MDS assessment dated 12/10/21 was not completed or transmitted within the regulatory time frames.

During an interview on 01/28/22 at 5:35 PM, the Administrator revealed he was aware that MDS assessments were not being completed within the regulatory timeframe. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues.

4. Resident #360 was admitted to the facility on 1/11/2022.

Review of Resident #360's electronic medical record revealed the admission MDS had not been completed or transmitted in the timeframe outlined in the RAI manual. The record indicated a Medicare 5-day MDS was opened on 1/14/2022

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F 636	Continued From page 43 with a status of "in progress" and an Admission MDS was opened on 1/18/2022 with a status of "in progress". Interview with the facility MDS Coordinator on 1/28/2022 at 2:16 PM revealed she was aware MDS were not being completed or submitted within the timeframes required. MDS Coordinator verified the admission MDS for Resident #360 had not been completed or transmitted within the regulatory schedule. MDS Coordinator revealed due to staffing shortages, she had been working in resident care since June and had not been able to complete the MDS as required. Interview on 1/28/2022 at 5:39 PM with the facility Administrator revealed he was aware completion and submission of MDS were out of compliance. The Administrator indicated the MDS Coordinator #3 had been participating in resident care which was the priority.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced	F 637		2/28/22

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F 637	Continued From page 44 by: Based on record review and staff interviews, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment was completed within 14 days of a resident being admitted into Hospice care for 1 of 1 resident reviewed for Hospice (Resident #7). Findings included: Resident #7 was admitted to the facility on 08/25/13 with multiple diagnoses that included Alzheimer's disease. The Hospice Plan of Care, with an effective date of 12/09/21, indicated Resident #7 was certified to receive hospice services for end-of-life care. Review of Resident #7's electronic medical record on 01/25/22 at 3:17 PM revealed the significant change MDS assessment dated 12/13/21 had a status of "in progress." During an interview on 01/25/22 at 4:55 PM the MDS Coordinator confirmed Resident #7 was admitted to Hospice services on 12/09/21 and a significant change MDS assessment dated 12/13/21 was started but had not been completed. The MDS Coordinator explained since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks of work which put her behind on completing MDS assessments. The MDS Coordinator verified Resident #7's MDS assessment dated 12/13/21 was not completed within the regulatory time frame. During an interview on 01/28/22 at 5:35 PM, the Administrator revealed he was aware that MDS	F 637	F637 1) Residents #7. For resident #7, The Minimum Data Set (MDS) Coordinator completed and transmitted significant change minimum data set assessment on 1/26/22. 2) On 2/3/22, 100% audit of current facility Residents to ensure any identified significant change assessments were completed and transmitted per regulatory assessment instrument (RAI) guidelines, MDS schedule has been reviewed for completion timing of MDS assessments. Any identified findings corrected as indicated to maintain compliance with comprehensive assessment after significant changes. 3) The MDS Consultant educated the MDS coordinator on 2/3/22 to review the guidelines set forth in the RAI manual regarding all requirements related to comprehensive assessment after significant changes. ff All new hires that include completion of a resident assessment will be educated on the requirements during orientation. 3) The Comprehensive assessments after a significant change schedule will be audited 4 times a week for 4 weeks, 2 times a week for 4 weeks, then 1 time a week for 4 weeks by the Administrator or designee to ensuring timely completion and transmittals of Comprehensive significant change assessments per RAI	

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F 637	Continued From page 45 assessments were not being completed within the regulatory timeframe. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues.	F 637	guidelines. The Administrator is responsible for the success of this plan of correction and will discuss the audit results to the Quality Assurance and Performance Improvement Committee meeting for review and revision as necessary to maintain compliance with Comprehensive Assessment after a Significant Change. 4) Completed on 2/28/22	
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 quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD) for 3 of 30 sampled residents reviewed (Residents #12, #9 and #6). Findings included: 1. Resident #12 was admitted to the facility on 10/02/16. Review of Resident #12's electronic medical record revealed the most recent MDS assessment was coded as a quarterly with an ARD of 12/19/21. The MDS assessment was marked completed on 01/24/22 and had a status of "export ready."	F 638	1) Residents #12, #, #9, and #6 cited. The Minimum Data Set Coordinator completed quarterly assessments for residents#12, #, #9, and #6 cited . The MDS is now current as per RAI guidelines. 2) On 2/3/22, 100% audit of current facility Residents MDS schedule based on In-Progress report and Assessment History was completed to ensure identified Incomplete Quarterly assessments were completed and transmitted per regulatory assessment instrument (RAI) guidelines. Any identified Late Quarterly assessments will be corrected to maintain compliance set forth in the RAI Manual by 2/28/22. 3) The MDS Consultant educated the	2/28/22

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F 638	Continued From page 46 During interviews on 01/25/22 at 4:55 PM and 01/28/22 at 1:48 PM, the MDS Coordinator explained since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks of work which put her behind on completing MDS assessments. The MDS Coordinator verified Resident #12's MDS assessment dated 12/19/21 was not completed within the regulatory time frame. During an interview on 01/28/22 at 5:35 PM, the Administrator revealed he was aware that MDS assessments were not being completed within the regulatory timeframe. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues. 2. Resident #9 was admitted to the facility on 07/22/14. Review of Resident #9's electronic medical record revealed the most recent MDS assessment was coded as a quarterly with an ARD of 01/05/22. The MDS assessment was marked completed on 01/24/22. During interviews on 01/25/22 at 4:55 PM and 01/28/22 at 1:48 PM, the MDS Coordinator explained since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks of work which put her behind on completing MDS assessments. The MDS Coordinator verified Resident #9's MDS assessment dated 01/05/22 was not completed within the regulatory time frame.	F 638	MDS coordinator on 2/3/22 to review the guidelines set forth in the RAI manual regarding all requirements needed to schedule, data entry, and completed based upon MDS regulations and timeframes as it relates to quarterly assessments at least every 3 months. All new hires that include completion of a resident assessment will be educated on the requirements during orientation. 4) The Quarterly MDS assessments scheduled will be audited 1 time a week for 6 weeks, then 1 time biweekly for 6 weeks by the Administrator or designee to ensuring timely completion and transmittals of assessments on required due dates. The Administrator is responsible for the success of this plan of correction and will present the audit results in the Quality Assurance and Performance Improvement Committee meeting for review and revision to maintain compliance with Comprehensive Assessments and timing. 5) Completed on 2/28/22.	

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During an interview on 01/28/22 at 5:35 PM, the Administrator revealed he was aware that MDS assessments were not being completed within the regulatory timeframe. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues.

3. Resident #6 was admitted to the facility on 5/15/20.

Review of Resident #6's electronic medical record revealed the most recent Minimum Data Set (MDS) assessment was coded as a quarterly with an ARD of 1/5/22. The MDS assessment was marked completed on 1/24/22 but sections C-Cognitive Patterns and D-Mood were marked "not assessed."

An interview with the MDS Coordinator on 1/28/22 at 1:52 PM revealed sections C and D on Resident #6's quarterly MDS assessment were supposed to have been completed within 7 days of the ARD by a Social Worker. Since the facility did not have a Social Worker, she was supposed to complete sections C and D, but she had been out during the time when the quarterly MDS assessment was due to have been completed. She was not sure if anyone had assumed responsibility for the MDS assessments while she was out.

An interview with the Administrator on 1/28/22 at 5:35 PM revealed he was aware that MDS assessments were not being completed within the regulatory timeframe. He explained due to staffing shortages, resident care came first, and their focus was placed on the residents'

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F 638	Continued From page 48 immediate care issues.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 review and interviews with staff, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 3 residents reviewed for falls (Resident #57). The findings included: 1. a. Resident #57 was admitted to the facility on 9/1/21 and readmitted from the hospital on 9/24/21 with diagnoses including left hip fracture. A review of the incident reports for Resident #57 revealed on 9/10/21 an unwitnessed fall occurred with no injury. On 9/17/21 Resident #57 reported a non-witnessed fall occurred with no injury and on 9/20/21 a witnessed fall occurred in the shower room and Resident #57 was sent to the hospital for further evaluation of hip pain. Review of the discharge MDS dated 9/20/21 indicated only one fall with major injury had occurred since admission or the previous assessment. An interview was conducted with the MDS Coordinator on 1/28/22 at 2:16 PM. The MDS Coordinator stated she must have overlooked to mark falls had occurred on the assessment.	F 641	F641 1) Resident #57 cited. To correct the deficient practice, regarding Accuracy of Assessment for Residents #57. Minimum Data Set (MDS) Assessment with Assessment dated 10/4/2021 has been modified to include fall history. 2) To ensure other residents were not affected by the deficient practice, the MDS coordinator completed a 100 percent audit of all residents MDS section J to ensure accuracy on 2/10/22. 3) On 2/3/22 MDS consultant educated MDS coordinator regarding coding of fall history accurately per Resident Assessment Instrument (RAI) guidelines. All new Minimum Data Set staff will be educated on this process upon hire. 4) Administrator or designee will audit MDS assessments section J one time a week for 6 weeks, then 1 times biweekly for 6 weeks. Administrator will report results of audits in Quality Assurance and Performance Improvement meeting for review and revisions will be made as	2/28/22

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F 641	Continued From page 49 An interview was conducted with the Director of Nursing (DON) on 01/28/22 at 5:10 PM. The DON revealed she expected the MDS to reflect the resident and be coded correctly. 1. b. Resident #57 was admitted to the facility on 9/1/21 and readmitted from the hospital on 9/24/21 with diagnoses including left hip fracture. A review of the incident reports for Resident #57 revealed on 9/10/21 an unwitnessed fall occurred with no injury. On 9/17/21 Resident #57 reported a non-witnessed fall occurred with no injury and on 9/20/21 a witnessed fall occurred in the shower room and Resident #57 was sent to the hospital for further evaluation of hip pain. Review of the Significant Change in Status MDS dated 10/4/21 revealed the Fall History on Admission/Entry or Reentry was not completed. An interview was conducted with the MDS Coordinator on 1/28/22 at 2:16 PM. The MDS Coordinator revealed she had done the Significant Change in Status MDS dated 10/4/21 specifically because of Resident #57's fall on 9/20/21 and stated she must have overlooked to mark falls had occurred on the assessment. An interview was conducted with the Director of Nursing (DON) on 01/28/22 at 5:10 PM. The DON revealed she expected the MDS to reflect the resident and be coded correctly.	F 641	necessary to maintain compliance with accuracy of assessments. 5) Completed on 2/28/22.	
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		2/28/22

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F 655	Continued From page 50 §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 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.	F 655		

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F 655	Continued From page 51 (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to complete baseline care plans in conjunction with resident and/or responsible party and failed to provide the resident or their responsible party with a written summary of the baseline care plan for 5 of 5 sampled residents (Resident #109, #10, #39, #36 and #57). Findings included: 1. Resident #109 was admitted to the facility on 12/03/21 with multiple diagnoses that included disruption of external operation (surgical) wounds, pain, and chronic congestive heart failure. Review of Resident #109's electronic medical record revealed a baseline care plan dated 12/03/21 had a status of "in progress." The admission Minimum Data Set (MDS) dated 12/10/21 assessed Resident #109 with intact cognition. During an interview on 01/24/22 at 10:15 AM, Resident #109 did not recall discussing his baseline care plan with facility staff after his admission or receiving a written summary of his baseline care plan. During an interview on 01/28/22 at 1:48 PM, the MDS Coordinator explained nursing staff were supposed to complete the baseline care plan upon admission, provide the resident with a	F 655	1. Resident # 109 and #10 were discharged . Residents #39, #36, and #57 cited. The MDS coordinator updated care plans for Resident #39, #36, and #57 to ensure all care plan needs are addressed in comprehensive care plan. Minimum Data Set coordinator completed a care plan meeting with Resident #39 on 2/18/22 , #36 on 2/16/22, and #57 on 2/17 and their representative to provide a summary of the care plan. 2. On 2/21/22, the Director of Nursing completed an audit of baseline care plans for residents admitted within the last 21 days. Four residents were identified to not have a baseline care plan completed or reviewed with resident/representative. Director of Nursing developed a baseline care plan and reviewed with resident/representative for all four residents identified. 3. On 2/3/22 the Administrator began education to the Interdisciplinary Team (MDS coordinator, Social Worker, Dietary Manager, Activities) and current facility and agency licensed direct-care nurses and nurse aides on baseline care plan completion and timing a per Resident assessment Instrument (RAI) guidelines. This will be completed by 2/25/22. The Director of Nursing will review baseline care plans for new admissions in clinical	

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F 655	Continued From page 52 written summary and have the resident sign a copy to scan into their medical record. The MDS Coordinator stated the baseline care plan was opened but not completed for Resident #109 and verified no data was entered. The MDS Coordinator stated she tried to follow-up on new admissions but since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks of work which put her behind. During an interview on 01/28/22 at 4:20 PM, the Director of Nursing (DON) explained the admitting nurse was expected to complete the baseline care plan within 48 hours of admission and print off a copy for the resident along with a list of their medications. She added if it was a late admission, the admitting nurse would then hand it off to the oncoming nurse to complete. The DON added she would have expected for nursing staff to provide Resident #109 with a written summary of his baseline care plan. During an interview on 01/28/22 at 5:47 PM, the Administrator revealed he was aware of the issues identified with care plans not being completed within the regulatory timeframes. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues. 2. Resident #10 was admitted to the facility on 07/26/21 with multiple diagnoses that included hemiplegia (paralysis on one side of the body), diabetes, heart disease, and major depressive disorder. Review of Resident #10's electronic medical record revealed a baseline care plan dated	F 655	meeting to ensure completion and resident review. 4. The DON or designee will audit baseline care plans for completion and resident/representative review 4 times a week for 4 weeks, 2 times a week for 4 weeks, then 1 time a week for 4 weeks. The Director of Nursing will report findings during Quality Assurance Performance Improvement meetings for review and will make changes as necessary to maintain compliance with baseline care plan and review. 5. The completion date is 2/28/22.	

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08/24/21 had a status of "in progress."

The admission Minimum Data Set (MDS) assessment dated 08/26/21 assessed Resident #10 with intact cognition.

Resident #10 discharged on 01/24/22 and was unable to be interviewed.

During an interview on 01/28/22 at 1:48 PM, the MDS Coordinator explained nursing staff were supposed to complete the baseline care plan upon admission, provide the resident with a written summary and have the resident sign a copy to scan into their medical record. The MDS Coordinator verified the baseline care plan was opened but not completed for Resident #10. The MDS Coordinator stated she tried to follow-up on new admissions but since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks of work which put her behind.

During an interview on 01/28/22 at 4:20 PM, the Director of Nursing (DON) explained the admitting nurse was expected to complete the baseline care plan within 48 hours of admission and print off a copy for the resident along with a list of their medications. She added if it was a late admission, the admitting nurse would then hand it off to the oncoming nurse to complete. The DON added she would have expected for nursing staff to provide Resident #10 with a written summary of his baseline care plan.

During an interview on 01/28/22 at 5:47 PM, the Administrator revealed he was aware of the issues identified with care plans not being completed within the regulatory timeframes. He

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explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues.

3. Resident #39 was admitted on 11/15/21 with multiple diagnoses that included left foot metatarsal (long bones of the foot) fracture, major depressive disorder, and anxiety.

The admission Minimum Data Set (MDS) dated 11/23/21 coded Resident #39 with intact cognition for daily decision making.

Review of Resident #39's medical record revealed no evidence a written summary of the baseline care plan was given to the resident.

During an interview on 01/24/22 at 10:32 AM, Resident #39 did not recall discussing her baseline care plan with facility staff after her admission or receiving a written summary of her baseline care plan.

During an interview on 01/28/22 at 1:48 PM, the MDS Coordinator explained nursing staff were supposed to complete the baseline care plan within 24 hours of admission, provide the resident with a written summary and have the resident sign a copy to scan into their medical record. The MDS Coordinator stated the baseline care plan was completed for Resident #39; however, there was not a signed copy scanned into her medical record indicating the care plan was discussed with her or she was provided a written summary.

During an interview on 01/28/22 at 4:20 PM, the Director of Nursing (DON) explained the admitting nurse was expected to complete the baseline care plan within 48 hours of admission

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and print off a copy for the resident along with a list of their medications. She added if it was a late admission, the admitting nurse would then hand it off to the oncoming nurse to complete. The DON stated she would believe Resident #39 if she stated she did not receive a copy of her baseline care plan. The DON added she would have expected for nursing staff to provide Resident #39 with a written summary of her baseline care plan.

During an interview on 01/28/22 at 5:47 PM, the Administrator revealed he was aware of the issues identified with care plans not being completed within the regulatory timeframes. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues.

4. Resident #36 was admitted to the facility on 11/5/21 with diagnoses that included a history of cerebrovascular accident and seizure disorder.

The admission Minimum Data Set (MDS) dated 11/12/21 assessed Resident #36's cognition as severely impaired for making daily decisions.

Review of Resident #36's medical records revealed no baseline Care Plan.

An interview was conducted with MDS Coordinator on 1/28/22 at 2:15 PM. The MDS Coordinator revealed the admitting nurse was supposed to complete the baseline care plan. After review of Resident #36's medical records the MDS Coordinator confirmed the baseline care plan was not done.

An interview was conducted with Director of

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Nursing (DON) on 1/28/22 at 5:07 PM. The DON explained Resident #36's admitting nurse was supposed to complete the baseline care plan and if not done upon admission it would continue to carry over. The DON was unsure why the nurses had not completed but it was her expectation baseline care plans were done and included in the resident's medical record.

5. Resident #57 was admitted to the facility on 9/1/21 with diagnoses that included hypertension and history of a cerebrovascular accident.

The admission Minimum Data Set (MDS) dated 9/8/21 assessed Resident #57's cognition as moderately impaired for making daily decisions.

Review of Resident #57's medical records revealed the baseline care plan dated 9/2/21 was still in progress.

An interview was conducted with MDS Coordinator on 1/28/22 at 2:15 PM. The MDS Coordinator revealed the admitting nurse was supposed to complete the baseline care plan. The MDS Coordinator reviewed the medical records of Resident #57 and confirmed the baseline care plan was not completed.

An interview was conducted with Director of Nursing (DON) on 1/28/22 at 5:07 PM. The DON explained Resident #57's admitting nurse was supposed to complete the baseline care plans and if not done upon admission it would continue to carry over. The DON was unsure why the nurses had not completed but it was her expectation baseline care plans were done and included in the resident's medical record.

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		2/28/22

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate

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F 656	Continued From page 58 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with staff the facility failed to implement care plan interventions for 1 of 3 residents reviewed for falls (Resident #57) and 1 of 10 residents reviewed for activities of daily living (Resident #9); the facility also failed to develop a comprehensive care plan for 1 of 1 resident reviewed for hospice (Resident #7) and for 1 of 1 resident reviewed for smoking (Resident #41). The findings included: 1. Resident #57 was admitted to the facility on 9/1/21 with diagnoses that included a history of cerebrovascular accident (compromised blood flow to a part of the brain) and hemiplegia (severe or complete loss of strength) affecting the left non-dominate side. Review of the Care Plan (CP) revised on 10/8/21 identified Resident #57 had 3 actual falls with no injury and included the intervention to place a fall mat to the right side of the bed to protect from injury. On 9/24/21 the CP identified Resident #57 fell and sustained a left hip fracture with interventions to continue with the floor mat on the right side of the bed, ensure the call light was within reach and encourage the resident to use for assistance as needed and provide prompt response to request. Review of the most recent quarterly Minimum	F 656	1) Residents #57, #9, and #7. To correct the deficient practice, the Minimum Data Set (MDS) coordinator reviewed and corrected the following: Resident #57 care planned fall interventions implemented on 1/28/22; Resident # 9 care plan was updated to reflect current preferences and preferences honored 2/21/22 ; Resident #7 care plan was updated to reflect hospice services and end of life care on 2/2/22. Resident #41 care plan updated to reflect smoking on 2/18/22. 2) To ensure other residents were not affected by the deficient practice, the MDS Coordinator and completed a 100 percent care plan audit on 2/18/22 pertaining to: Activities of Daily living, Hospice, residents who smoke or use tobacco products and fall interventions to ensure all care plan and interventions are in place both in the care plan itself and in their environment. Any issues identified were corrected at the time of audit. The MDS nurse / Social Service Director / Dietary Manager / Activities Director or designee will be responsible in updating residents' careplans for new interventions that were developed or when current interventions need to be updated. 3) The MDS consultant educated the	

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F 656	Continued From page 59 Data Set (MDS) dated 1/4/22 assessed the cognitive status of Resident #57 was moderately impaired and functional status for activities of daily living was extensive assistance needed for bed mobility, transfers, and toilet use. The MDS indicated no falls occurred since admission, entry or reentry or prior assessment. An observation of Resident #57 resting in bed was made on 1/24/22 at 1:24 PM. The call light was within reach and functioning but there was no fall mat in place. An observation of Resident #57 resting in bed was made on 1/25/22 at 8:37 AM with no fall mat in place. An interview was conducted with Nurse Aide (NA) #2 on 1/25/22 at 8:08 AM. NA #2 revealed she was assigned to provide care for Resident #57 and when she arrived for her shift today there was only 1 NA in building. NA #2 revealed she was the only NA on the unit where Resident #57 resided, and her focus was incontinence care and breakfast trays and was difficult to ensure resident safety. An interview was conducted with the Director of Nursing (DON) on 1/27/22 at 9:43 AM. The DON revealed she expected CP interventions to be in place and explained when Resident #57 changed rooms staff may have forgot it, but she would ensure a fall mat was in place. 2. Resident #9 was admitted to the facility on 07/22/14 with multiple diagnoses that included chronic obstructive pulmonary disease (difficulty breathing), chronic pain, osteoarthritis, and anxiety.	F 656	MDS coordinator on 2/3/22 regarding the expectation that they ensure that care plans are developed for residents who elected Hospice services, Interventions for falls, residents who smoke or use tobacco products and activities of daily living. Administrator educated interdisciplinary team and all direct current facility and agency direct care staff to ensure residents that have care plan interventions followed and placed in their environment as per care plan on 2/21/22. All new staff will be educated upon hire. New agency staff will be educated per their agency orientation packet. 4) Administrator or designee will audit care plans for Fall Interventions, Activities of Daily living, and hospice goals/interventions 4 times a week for 4 weeks; 3 times a week for 4 weeks; and 1 time a week for 4 weeks. In addition, the DON or designee will monitor the halls/residents' rooms for fall interventions activities of daily living interventions to be in place per the care plan for 5 residents 4 times a week for 4 weeks; 3 times a week for 4 weeks; and once a week for 4 weeks. Results of audits will be brought to Quality Assurance and Performance Improvement meeting for Review and revisions will be made as necessary to maintain compliance with Developing and implementing comprehensive care plan. 5) Completed on 2/28/22.	

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The quarterly Minimum Data Set (MDS) dated 10/05/21 indicated Resident #9 was cognitively intact and required limited assistance of 1 staff member for bed mobility and transfers.

Review of Resident #9's care plans, last reviewed/revised on 11/16/21, revealed a plan of care that addressed a physical functioning deficit related to self-care and mobility impairment. Interventions included she would like to be up in the early morning every day and back to bed late afternoon.

During an observation and interview on 01/24/22 at 11:08 AM, Resident #9 was lying in bed and expressed she preferred to get up out of bed between 7:00 AM to 7:30 AM; however, the past 3 to 4 months staff had not assisted her out of bed, almost daily, until 11:00 AM, 12:00 PM or sometimes later in the afternoon. Resident #9 added she needed staff assistance to get up out of bed but was always told there wasn't enough staff available to assist her out of bed when requested.

Subsequent observations conducted on 01/25/22 at 8:00 AM and 01/26/22 at 8:55 AM, 10:40 AM, and 11:30 AM revealed Resident #9 was still in bed wearing her nightgown.

During an interview on 01/25/22 at 10:29 AM, Nurse Aide (NA) #1 explained she was the only NA for the entire building for 59 residents and had not gotten the chance to get Resident #9 up out of bed this morning. NA #1 added for the last 2 to 3 months, she had worked by herself on a unit or for the entire building, which made it take longer for her to get rounds completed.

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During an interview on 01/26/22 at 11:52 AM, NA #5 explained when she arrived at work, she was originally assigned to work on the east unit but then was sent to the west unit to assist with resident care. NA #5 confirmed Resident #9 was on her assignment and was aware she had been requesting to get up out of bed. NA #5 stated she had not assisted Resident #9 up out of bed because NA #6 was going to get her up and give her a shower. NA #5 added she was not that familiar with the residents on the west unit and was unaware of Resident #9's preference to be up out of bed at 7:00 AM.

During an interview on 01/28/22 at 12:37 PM, NA #4 confirmed Resident #9 liked to get up out of bed every morning around 7:00 AM but it wasn't always possible. NA #4 explained a lot of days there was only one NA for the entire building or 2 NAs, one on each unit, which caused it to take longer for them to complete rounds and provide resident care.

During an interview on 01/28/22 at 4:20 PM, the Director of Nursing (DON) stated she expected staff to follow care plan interventions and should assist Resident #9 out of bed at her preferred time of day when possible. The DON explained when there was only one NA on the unit, it was difficult for them to get rounds completed and provide resident care.

3. Resident #7 was admitted to the facility on 08/25/13 with multiple diagnoses that included Alzheimer's disease.

The hospice certification and plan of care, with an effective date of 12/09/21, indicated Resident #7

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was certified to receive hospice services for end-of-life care.

Review of Resident #7's electronic medical record on 01/25/22 at 3:17 PM revealed the significant change MDS assessment dated 12/13/21 had a status of "in progress."

Review of Resident #7's comprehensive care plans on 01/25/22 at 3:17 PM revealed no care plan for hospice services.

During an interview on 01/25/22 at 4:55 PM the MDS Coordinator confirmed Resident #7 was admitted to Hospice services on 12/09/21. The MDS Coordinator explained since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks of work which put her behind. The MDS Coordinator stated she was currently working on completing Resident #7's significant change MDS dated 12/13/21 which would include developing a care plan for hospice services.

During an interview on 01/28/22 at 5:35 PM, the Administrator revealed he was aware that care plans were not being developed and/or revised within the regulatory timeframe. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues.

4. Resident #41 was admitted to the facility on 8/14/21 with diagnoses that included chronic obstructive pulmonary disease and hypertension.

The admission Minimum Data Set (MDS) assessment dated 8/27/21 indicated Resident #41 was cognitively intact, had shortness of

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breath or trouble breathing with exertion and was on oxygen therapy but used tobacco.

The most recent quarterly MDS dated 11/27/21 indicated Resident #41 was cognitively intact, required extensive physical assistance with activities of daily living and continued with oxygen therapy.

Resident #41's care plan last revised on 9/20/21 indicated no care plan for smoking.

A review of Resident #41's Safe Smoking Screening dated 12/23/21 indicated Resident #41 currently smoked more than 10 times per day and did not wish to quit smoking. Resident #41 used supplemental oxygen, but he could safely be without it during smoking times. Due to this, he required supervision while smoking. At the end of the screening form was a statement that Resident #41's care plan was going to be updated to reflect smoking status.

An interview with Resident #41 on 1/24/22 at 3:24 PM revealed he smoked at the facility and had tried to quit smoking but always failed to do so. He stated he always left his oxygen tank inside the facility and set it at the door before he went out to the courtyard to smoke and was always assisted by a staff member when smoking.

An interview with the MDS Coordinator on 1/26/22 at 10:14 AM revealed that she did not find a care plan for smoking for Resident #41 on his medical record. The MDS Coordinator stated she was responsible for initiating and updating the care plans, but it had been a hit and miss lately due to not having much time to do them. The MDS Coordinator stated she had been asked to

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F 656	Continued From page 64 do several other tasks and had a lot more responsibility since June of 2021 brought on by the turn-over in administrative nurses. An interview with the Director of Nursing (DON) on 1/28/22 at 4:04 PM revealed she did not know why Resident #41 did not have a care plan for smoking but stated that he should have had one. Resident #41's smoking-related privileges, restrictions and concerns should have been noted on his care plan.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		2/28/22

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F 657	Continued From page 65 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to invite residents and/or their representative to participate and provide input in care planning for 3 of 5 sampled residents (Residents #9, #39 and #13) and failed to update the care plan to reflect the current advance directive for 1 of 2 residents (Resident #41) reviewed. This practice had the potential to affect other residents. Findings included: 1. Resident #9 admitted to the facility on 07/22/14 with multiple diagnoses that included chronic obstructive pulmonary disease (difficulty breathing), chronic pain, osteoarthritis, and anxiety. The quarterly Minimum Data Set (MDS) dated 10/05/21 indicated Resident #9 was cognitively intact for daily decision making. Review of Resident #9's electronic medical record revealed the last documented care plan meeting was held on 04/28/21 with Resident #9 in attendance. Further review revealed no evidence she was invited to attend a care plan meeting to discuss and provide input regarding her plan of care following the completion of the quarterly MDS assessment dated 10/05/21. During an interview on 01/24/22 at 11:06 AM, Resident #9 was unable to recall the last time she was invited to participate in a care plan meeting.	F 657	1) Residents #39, #9, #41 and #13. For all residents affected Minimum Data Set Coordinator (MDS)For resident #41 care plan updated to reflect current advanced directives on 1/28/22. Care plan meeting held for resident #39 on 2/18/22. Care plan meeting held for resident #9 on 2/18/22. Care plan meeting held for resident #13 on 2/18/22. 2) To ensure other residents were not affected by the deficient practice, on 2/2/22 The Director of Nursing and the MDS Coordinator and completed a 100 percent care plan audit on care plans to include advanced directives and care plan meetings to ensure accurate timing and revisions as well as care plan meetings held. All issues identified corrected to ensure compliance. All identified areas corrected by 2/18/22. 3) The MDS consultant educated the interdisciplinary team on 2/3/22 regarding the expectation that they ensure that Advanced Directive care plans are reviewed and revised with interdisciplinary team and care plan meetings are held per regulatory timeframe guidelines. All new staff involved with care planning will be educated upon hire. 4) Administrator or designee will audit Advanced Directive care plans for	

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F 657	Continued From page 66 Resident #9 stated she used to be invited regularly but not "in quite a while." During interviews on 01/25/22 at 4:55 PM and 01/28/22 at 1:48 PM, the MDS Coordinator stated either she or the Social Worker (SW) would send the care plan invites to the resident and/or representative and then scan a copy into the resident's electronic medical record. The MDS Coordinator confirmed there had been no recent care plan meeting held for Resident #9 and stated one should have been scheduled after the completion of her quarterly MDS dated 10/05/21. The MDS Coordinator explained since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks of work which put her behind and she just couldn't to get caught up. During an interview on 01/28/22 at 5:35 PM, the Administrator revealed he was aware care plan meetings were not being held on a routine basis. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues. 2. Resident #39 was admitted to the facility on 11/15/21 with multiple diagnoses that included left foot metatarsal (long bones of the foot) fracture, major depressive disorder, and anxiety. The admission Minimum Data Set (MDS) dated 11/23/21 indicated Resident #39 was cognitively intact for daily decision making. Review of Resident #39's electronic medical record revealed no evidence she was invited to attend a care plan meeting or provide input in the development of her comprehensive care plan.	F 657	accurate timing and revisions as well as care plan meetings 1 time a week for 6 weeks, then 1 time biweekly for 6 weeks, then 1 time monthly for 4 weeks. 5) Completed on 2/28/22.	

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During an interview on 01/24/22 at 10:32 AM, Resident #39 revealed she had not been invited or participated in a care plan meeting since her admission.

During interviews on 01/25/22 at 4:55 PM and 01/28/22 at 1:48 PM, the MDS Coordinator stated either she or the Social Worker (SW) would send the care plan invites to the resident and/or representative and then scan a copy into the resident's electronic medical record. The MDS Coordinator confirmed Resident #39 had not been invited or had a care plan meeting held since her admission and stated one should have been scheduled after the completion of her admission MDS dated 11/23/21. The MDS Coordinator explained since June 2021, due to staffing shortages, she had been pulled to help on the floor when needed and had also missed 4 weeks of work which put her behind and she just couldn't to get caught up.

During an interview on 01/28/22 at 5:35 PM, the Administrator revealed he was aware care plan meetings were not being held on a routine basis. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues.

3. Resident #13 was admitted to the facility on 2/25/2021. His quarterly Minimum Data Set (MDS) dated 1/8/2022 revealed he was cognitively intact.

Review of Resident #13's medical record revealed no indication the resident had been invited to a care plan meeting. A care plan participation form dated 6/15/2021 was present in

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the medical record. The form was signed by the MDS Coordinator, the Director of Therapy, the Dietary Manager, and the Social Services Director. The form was not signed by the resident.

An interview on 1/24/2022 at 2:17 PM with Resident #13 revealed he had not been invited to a care plan meeting since his admission.

Interview with the facility MDS Coordinator on 1/28/2022 at 2:25 PM revealed she was responsible for updating care plans and scheduling care plan meetings. The MDS Coordinator stated she had not scheduled or invited the resident to a care plan meeting "in a long time". The MDS Coordinator revealed she had been out of the facility for a month and prior to that she had been working in resident care due to staffing shortages.

Interview with the Director of Nursing (DON) on 1/28/2022 at 4:33 PM revealed she was not aware the resident had not been invited to a care plan meeting since admission or that care plan meetings had not been scheduled or completed. The DON stated she expected all residents (or their families / health care power of attorneys or guardians) to be invited to discuss care plans.

Interview with the facility Administrator on 1/28/2022 at 5:39 PM revealed he was aware of the lack of care plan meetings. He stated the MDS Coordinator had been working as a Nurse Aide on the units because resident care was the priority. The Administrator further revealed staff knew to conduct care plan meetings and if it was not done; it was unacceptable.

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4. Resident #41 was admitted to the facility on 8/14/21.

A DNR (Do Not Resuscitate) form dated 8/20/21 for Resident #41 was located in the advance directive book at the West wing nurses' station.

Resident #41's care plan last revised on 9/20/21 indicated Resident #41 had an advance directive of DNR (Do Not Resuscitate). Interventions included to follow facility protocol for identification of code status and to review code status quarterly.

Further review of Resident #41's electronic medical record revealed a physician order dated 10/20/21 for full code.

An interview with the MDS Coordinator on 1/26/22 at 10:14 AM revealed that she had entered the order for full code in Resident #41's electronic medical record when he re-admitted to the facility on 10/20/21. The MDS Coordinator stated she obtained the full code order from the discharge summary from the hospital. She also verified it with Resident #41 who told her that he wanted his advance directive to be changed to a full code. The MDS Coordinator further stated she should have updated Resident #41's care plan to reflect his current advance directive of being a full code. The MDS Coordinator stated she was responsible for initiating and updating the care plans, but it had been a hit and miss lately due to not having much time to do them. The MDS Coordinator stated she had been asked to do several other tasks and had a lot more responsibility since June of 2021 brought on by the turn-over in administrative nurses.

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F 657	Continued From page 70 An interview was conducted with the Director of Nursing (DON) on 1/28/22 at 4:04 PM. The DON stated Resident #41's care plan should have been updated to reflect his current advance directive.	F 657		
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by:	F 661		2/28/22

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F 661	Continued From page 71 Based on record review and staff interviews, the facility failed to complete a recapitulation of stay for 1 of 1 resident reviewed for a planned discharge to the community (Resident #10). This practice had the potential to affect other residents who discharged from the facility. Findings included: Resident #10 was admitted to the facility on 07/26/21 and discharged to another facility on 01/24/22. The quarterly Minimum Data Set (MDS) dated 09/20/21 coded Resident #10 with intact cognition. Review of Resident #10's electronic medical record revealed no discharge summary that included all the components of the recapitulation of stay and a final summary of the resident's status at discharge. During interviews on 01/28/22 at 10:27 AM and 1:48 PM, the MDS Coordinator stated a recapitulation of resident stay was documented as a discharge assessment in the resident's electronic medical record and confirmed there was no discharge assessment started or completed for Resident #10 when he discharged from the facility on 01/24/22. The MDS Coordinator explained she had been trying to fill in with some of the Social Worker's (SW) duties until the position was filled but there was only so much she could do. During an interview on 01/28/22 at 4:20 PM, the Director of Nursing (DON) explained, typically, the SW opened the discharge assessment for a	F 661	F661 1) Resident #10 cited. Resident #10 no longer in facility. 2) On 2/21/22 Administrator educated interdisciplinary team related to completion of discharge summary for all residents with planned discharges. Director of Nursing to initiate discharge summary for Interdisciplinary team to complete. 3) Administrator or designee will audit discharged residents for completed discharge summary one time a week for 6 weeks, then 1 times biweekly for 6 weeks. Administrator will report results of audits in Quality Assurance and Performance Improvement meeting for review and revisions will be made as necessary to maintain compliance with discharge summary. 4) Completed on 2/28/22.	

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F 661	Continued From page 72 planned discharge, each discipline completed their section and a copy was provided to the resident upon their discharge from the facility. The DON added they were currently without a SW and was not sure who was assigned the responsibility for ensuring discharge assessments were completed until the SW position could be filled.	F 661		
F 677 SS=E	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, observations, interviews with residents and staff the facility failed to provide a shower or a complete bed bath for residents' dependent on staff for 3 of 10 residents reviewed for activities of daily living care (Resident #28, Resident #9, and Resident #39). The findings included: 1. Resident #28 was admitted to the facility on 7/1/21. Review of the most recent quarterly Minimum Data Set (MDS) dated 11/5/21 assessed cognition was intact for Resident #28 and needs for activities of daily living as total assistance required for bed mobility, transfer, toilet use, personal hygiene, and bathing. There had not been any refusal of care behaviors during the lookback period.	F 677	1. Resident #28, Resident #9, and Resident #39 were cited. Residents interviewed to obtain preferences for shower/bathing. All residents provided with shower/bathing per their preference and plan of care on 1/28/22. 2. On 2/18/22 the Director of Nursing conducted audit to ensure shower/bathing preferences are being honored. Care plans and point of care tasks updated accordingly to reflect preferences. This will be completed by 2/18/22. 3. DON or designee to educate current facility and agency direct care staff on importance of ADL care as well as honoring resident preferences. This will be completed by 2/25/22. All newly hired staff will be educated upon hire and new agency staff will be educated via	2/28/22

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F 677	Continued From page 73 Review of Resident #28's bathing records from December 2021 through January 2022 revealed 2 showers were given one on 12/3/21 and one on 1/11/22. On 1/13/22 Resident #28 had refused a shower and on the following days received bed baths: 12/8/21, 12/10/21, 12/14/21, 12/18/21, 12/27/21, and 1/22/22. Review of nurse progress notes revealed Resident #28 was out of the facility in December from 12/19/21 through 12/23/21 and returned on 12/24/21. Resident #28 also was out of the facility from 1/16/22 through 1/21/21 and returned on 1/22/22. The Care Plan in place for activities of daily living revised on 1/27/22 identified Resident #28 as having a self-care performance deficit with interventions in place for bathing and showering that include check nail length and trim and clean on bath day and as necessary. An interview was conducted with Resident #28 on 1/24/22 at 2:05 PM. Resident #28 explained she required total assistance with transfer using a mechanical lift and stated there was not enough staff to get her out of bed upon request and not enough staff to give her showers consistently each week. Resident #28 revealed she had gone 3 to 4 weeks without a shower and stated there have been times she could smell her own body odor. Resident #28 revealed it had been approximately 3 weeks since her last shower and she only gets one whenever there's enough staff and her shower days were inconsistent. An observation was made of Resident #28 on 1/24/22 at 2:05 PM. Resident #28's hair appeared greasy, tangled, and tied up in a ponytail.	F 677	orientation packet. 4. DON or Unit Manager to audit 5 residents to ensure ADL care/bathing/grooming/nail care is being provided per plan of care: 4x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months to maintain compliance with ADL care for dependent residents. 5. Completed on 2/28/22.	

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An interview was conducted with NA #1 on 1/25/22 at 10:29 AM. NA #1 revealed she was assigned to provide care for Resident #28 and currently the only NA on unit. NA #1 revealed there had been one NA in the facility for the previous night shift and her focus this morning was on providing incontinence care, delivering water, and meal trays. NA #1 revealed when she was assigned as the only NA on the unit residents did miss their scheduled showers.

An observation was made of Resident #28 on 1/25/22 at 4:16 PM. Resident #28's appearance had not changed, and her hair continued to appear dirty, tangled and pulled up in a ponytail.

An interview was conducted with Resident #28 on 1/25/22 at 4:16 PM. Resident #28 revealed she hadn't had her scheduled shower yet and when she mentioned it to NA #1 was told bear with her as she was the only NA on the unit. Resident #28 stated since she returned from the hospital on 1/22/22 her hair hadn't been washed, she hadn't had a bed bath or shower and the last sponge bath her peri-area was cleaned, and lotion applied to her body.

A follow-up interview was conducted with Resident #28 on 1/28/22 at 3:45 PM. Resident #28 revealed she had received her shower yesterday, 1/27/22 and was assisted by NA #1.

An interview was conducted with the Director of Nursing (DON) on 1/28/22 at 4:57 PM. The DON revealed she heard complaints from residents not getting showers and had begun an audit. The DON revealed when one NA was on the unit it would be difficult to complete care and provide

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residents their scheduled showers.

An interview was conducted on 1/28/22 at 5:47 PM with the Administrator. The Administrator revealed he was aware resident showers weren't given as scheduled due to staffing shortages. The Administrator revealed due to staffing shortages the focus was on resident care and their immediate care issues.

2. Resident #9 admitted to the facility on 07/22/14 with multiple diagnoses that included chronic obstructive pulmonary disease (difficulty breathing), chronic pain, osteoarthritis, and anxiety.

The quarterly Minimum Data Set (MDS) dated 10/05/21 indicated Resident #9 was cognitively intact and required extensive to total assistance of 1 staff member for bathing and personal hygiene.

Review of Resident #9's care plans, last reviewed/revised on 11/16/21, revealed plans of care that addressed the following care areas: Activities of Daily Living (ADL) self-care performance deficit related to activity intolerance, impaired balance, left foot fracture, and non-weight bearing status on left lower extremity. Interventions included encourage the resident to participate to the fullest extent possible with each interaction, encourage use of call bell for assistance, and monitor, document, report as needed any changes, potential for improvement and declines in function.
I have things I really enjoy and are important to me. My Life's Simple Pleasures include showers three times per week.

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Review of the west unit shower schedule revealed Resident #9 was to receive showers on Tuesday, Thursday and Saturday during the day shift.

Review of the Nurse Aide (NA) bathing documentation for Resident #9 for the months of December 2021 and January 2022 revealed the following:
Showers were documented as provided on 12/04/21 and 12/18/21. Bed baths were documented as provided on 12/07/21, 12/09/21, 12/11/21, and 12/14/21.
Showers were documented as provided on 01/01/22, 01/06/22, 01/08/22, 01/11/22, 01/13/22, 01/17/22, 01/20/22, and 01/22/22.

Review of the staff progress notes for the months of December 2021 and January 2022 revealed no entries related to Resident #9 refusing bathing assistance.

During an interview on 01/24/22 at 11:06 AM, Resident #9 stated she was supposed to receive 3 showers per week but was lucky if she got one per week. She added there had been several weeks she was not provided with a shower or bed bath.

During a second interview on 01/26/22 at 08:55 AM, Resident #9 revealed she did not receive her scheduled shower yesterday and was told by staff they would "wipe her down really good" before her appointment today at 1:00 PM. Resident #9 added when she didn't get her scheduled showers, it made her "feel bad and angry. I don't like not being clean."

During an interview on 01/26/22 at 8:09 AM, NA

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#2 revealed she frequently worked during the hours of 7:00 AM and 7:00 PM and had provided Resident #9's care. NA #2 stated Resident #9 was scheduled for showers on Tuesday, Thursday, and Saturday and did not refuse when offered. NA #2 explained during the past 3 weeks, she was the only NA assigned to the west unit and was not able to provide resident showers but did try to give Resident #9 a partial bed bath when able. NA #2 added when she worked by herself, the best she could do was keep the residents clean, dry and fed.

During an interview on 01/28/22 at 12:37 PM, NA #4 revealed she frequently worked during the hours of 7:00 AM and 7:00 PM and routinely provided Resident #9's care. NA #4 stated residents had voiced complaints about missing their scheduled showers but when there was one NA for the entire building or one NA on each unit, it was difficult to get resident showers completed because it left no one on the hall to answer call lights and/or provide care.

During an interview on 01/28/22 at 4:20 PM, the Director of Nursing (DON) revealed she had received complaints from a lot of residents regarding them not getting their scheduled showers. The DON explained she would like for all residents to get at least 2 showers per week or per their preference; however, when there was only one NA on the unit, it was difficult for them to get showers completed and provide resident care.

During an interview on 01/28/22 at 5:47 PM, the Administrator revealed he was aware that residents' showers were not being completed as scheduled due to staffing. The Administrator

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explained when they had sufficient staff, showers were completed but when there was only one NA for the unit, it was difficult for them to provide showers. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues.

3. Resident #39 was admitted to the facility on 11/15/21 with multiple diagnoses that included left foot metatarsal (long bones of the foot) fracture, major depressive disorder, and anxiety.

The admission Minimum Data Set (MDS) dated 11/23/21 indicated Resident #39 was cognitively intact and required extensive assistance of 1 to 2 staff members for bathing and transfers.

Review of Resident #39's care plans, last reviewed/revised on 12/19/21, revealed a plan of care that addressed an Activities of Daily Living (ADL) self-care performance deficit related to activity intolerance, impaired balance, left foot fracture, and non-weight bearing status on left lower extremity. Interventions included encourage the resident to participate to the fullest extent possible with each interaction, encourage use of call bell for assistance, and monitor, document, report as needed any changes, potential for improvement and declines in function.

Review of the west unit shower schedule revealed Resident #39 was to receive showers on Tuesday, Thursday and Saturday on the evening shift.

Review of the Nurse Aide (NA) bathing documentation for Resident #39 for the months of December 2021 and January 2022 revealed the

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following:
Showers were documented as provided on 12/03/21 and 12/06/21. A partial bed bath was documented as provided on 12/18/21.
Showers were documented as provided on 01/14/22 and 01/25/22. Bed baths were documented as provided on 01/01/22 and 01/24/22.

Review of the staff progress notes for the months of December 2021 and January 2022 revealed no entries related to Resident #39 refusing bathing assistance.

An observation and interview were conducted with Resident #39 on 01/24/22 at 10:23 AM. Resident #39's hair appeared oily and she stated she had not had a shower or her hair washed. Resident #39 stated she received a shower approximately a week ago but prior to that, she went without a shower for over a month. Resident #39 added she had asked staff "every day" for a shower but was told there wasn't enough staff available to give one. Resident #39 added, during the time she went without a shower, she went out for an appointment with her hair "beyond greasy" which made her feel terrible and embarrassed.

A second interview was conducted with Resident #39 on 01/26/22 at 11:50 AM. Resident #39 stated she did not receive a shower on 01/25/22 and added "I wasn't even offered one."

During an interview on 01/28/22 at 10:48 AM, Nurse #4 stated she would occasionally provide a resident with a shower but it didn't happen often. Nurse #4 stated it was an error that she initialed the bathing documentation report as providing

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Resident #39 a shower on 01/25/22 and confirmed she had not given her one on that date. Nurse #4 added she had not given any showers to residents in the past month.

During an interview on 01/26/22 at 8:09 AM, NA #2 revealed she frequently worked during the hours of 7:00 AM and 7:00 PM and had provided Resident #39's care. NA #2 stated Resident #39 had voiced concerns about not receiving her scheduled showers. NA #2 explained during the past 3 weeks, she was the only NA assigned to the west unit and was not able to provide resident showers or bed baths. NA #2 added when she worked by herself, the best she could do was keep the residents clean, dry and fed.

During an interview on 01/28/22 at 12:37 PM, NA #4 revealed she frequently worked during the hours of 7:00 AM and 7:00 PM and routinely provided Resident #39's care. NA #4 stated residents had voiced complaints about missing their scheduled showers but when there was one NA for the entire building or one NA on each unit, it was difficult to get resident showers completed because it left no one on the hall to answer call lights and/or provide care.

During an interview on 01/28/22 at 4:20 PM, the Director of Nursing (DON) revealed she had received complaints from a lot of residents regarding them not getting their scheduled showers. The DON stated she would never want a resident to feel dirty or embarrassed because of not receiving a shower. The DON added she would like for all residents to get at least 2 showers per week or per their preference; however, when there was only one NA on the unit, it was difficult for them to get showers

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F 677	Continued From page 81 completed and provide resident care. During an interview on 01/28/22 at 5:47 PM, the Administrator revealed he was aware that residents' showers were not being completed as scheduled due to staffing. The Administrator explained when they had sufficient staff, showers were completed but when there was only one NA for the unit, it was difficult for them to provide showers. He explained due to staffing shortages, resident care came first and their focus was placed on the residents' immediate care issues.	F 677		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with residents, staff and the Nurse Practitioner, the facility failed to administer oxygen as prescribed by the physician for 3 of 3 residents (Resident #53, Resident #32, and Resident #47) reviewed for oxygen therapy. The findings included: 1. Resident #53 was admitted to the facility on 2/25/20 with diagnoses that included chronic obstructive pulmonary disease and chronic	F 695	F695 1. Residents # 53, #47 and #32 were cited. Residents #32 and #47orders were clarified and corrected as well as observation to ensure accurate oxygen amount being administered per POC on 1/28/22. Resident #53 no longer in facility. 2. An audit was completed by the Director of Nursing to ensure all oxygen orders are accurate in medical record and the correct amount of oxygen is being administered.	2/28/22

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F 695	Continued From page 82 respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions). Resident #53's care plan revised on 9/20/21 indicated Resident #53 had alteration in respiratory status due to chronic obstructive pulmonary disease with potential for shortness of breath with lying flat. Interventions included to administer oxygen as needed per physician order, monitor oxygen saturation on room air and/or oxygen and monitor oxygen flow rate and response. The quarterly Minimum Data Set (MDS) assessment dated 12/5/21 indicated Resident #53 was cognitively intact, required limited assistance with activities of daily living and did not use oxygen while at the facility. A physician order dated 1/22/22 for Resident #53 indicated continuous oxygen via nasal cannula every shift for shortness of breath and hypoxia, may titrate to 10 liters per minute to keep oxygen saturation between 88% to 92%. Call the physician if difficulties keeping above 88%. An observation and interview with Resident #53 on 1/24/22 at 9:55 AM revealed her wearing an oxygen cannula to her nose. Resident #53 stated she had been vomiting on the morning of 1/24/22 and was waiting for the nurse to check her. No sound was heard coming from the oxygen concentrator to which Resident #53's nasal cannula had been plugged into. Further inspection of the oxygen concentrator revealed a red warning indicator light was on and the dial was set to 0 (zero).	F 695	This was completed on. This will be completed by 2/25/22. 3. The Director of Nursing to provide education to all current facility and agency direct care staff on oxygen administration. Education was completed by 2/25/22. Any newly hired staff or agency staff to enter our facility will be educated on this going forward. Any new agency staff will be educated via their agency orientation packet. 4. The Director of Nursing or Unit Manager will audit: Oxygen administration to ensure accuracy of orders and amount being administered per their plan of care through medical record review and observation for 5 residents at 4x week for 4 weeks; 5 residents 3xweek for 4wks; and 5 residents 1xweek for 4 wks. The Director of Nursing will bring results to our Quality Assurance and Performance Improvement meeting to present results and take recommendations on any process to maintain compliance with Respiratory care. Completion date: 2/28/22	

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An observation and interview with Nurse #4 of Resident #53 on 1/24/22 at 10:01 AM revealed Resident #53's oxygen concentrator had been off, and Nurse #4 stated that it probably shut off automatically when it got backed up against the bed and it overheated. Nurse #4 turned on Resident #53's oxygen concentrator and set the dial to 2 liters per minute. Nurse #4 further stated that the concentrator had been on when she gave Resident #53's medications around 8:00 AM. After being requested to check Resident #53's oxygen saturation, Nurse #4 checked it and obtained an 87% reading on the pulse oximeter. Nurse #4 stated that the reading of 87% was normal for Resident #53.

Further interview with Resident #53 on 1/24/22 at 10:06 AM revealed the oxygen saturation reading of 87% was a little low for her but was expected since she was currently sick. Resident #53 stated her oxygen saturation usually ran in the low 90% and did not remember when her oxygen concentrator had cut off.

An interview with the Nurse Practitioner on 1/27/22 at 11:49 AM revealed Resident #53's oxygen saturation of 87% was too low for the parameters that were set on her oxygen order and Nurse #4 should have followed the order and titrated it until her oxygen saturation was within 88% to 92%.

An interview with the Director of Nursing (DON) on 1/28/22 at 4:04 PM revealed the oxygen concentrator that Resident #53 used automatically cut off when it got pushed up against boxes in her room, but she was not sure if this was what happened to Resident #53's oxygen concentrator. The DON did not know why

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Resident #53's oxygen concentrator had been turned off and was not sure how long it had been off. She stated Nurse #4 should have made sure Resident #53 was receiving oxygen as ordered by the physician and she should have titrated it within the range that was prescribed by the physician.

2. Resident #32 was admitted to the facility on 12/22/20 and re-admitted on 9/23/21 with diagnoses that included cerebral infarction (stroke) and congestive heart failure.

A physician order dated 9/23/21 for Resident #32 indicated continuous oxygen at 2 liters in and out of bed.

The quarterly Minimum Data Set (MDS) assessment dated 11/8/21 indicated Resident #32 was rarely or never understood and had severe impairment with making decisions regarding tasks of daily life. He was totally dependent on staff with all activities of daily living and had impairment on both sides of both upper and lower extremities. The MDS further indicated that Resident #32 used oxygen while a resident at the facility.

Resident #32's care plan revised on 11/16/21 indicated he had a history of pneumonia, was at risk for aspiration pneumonia due to tube feeding and excessive oral secretions and was oxygen dependent. Interventions included to administer oxygen per physician order, monitor oxygen saturation on room air and/or oxygen and monitor oxygen flow rate and response.

An observation of Resident #32 on 1/24/22 at 10:16 AM revealed him wearing a nasal cannula

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which was connected to an oxygen concentrator that was running at 4 liters per minute. Resident #32 was sleeping in bed with his head elevated.

A second observation was made of Resident #32 on 1/24/22 at 12:34 PM still wearing a nasal cannula with the oxygen concentrator set at 4 liters per minute. Nurse #4 was observed at the bedside preparing to flush Resident #32's gastrostomy tube.

A third observation of Resident #32 on 1/24/22 at 3:09 PM revealed him lying in bed with head elevated with an oxygen cannula to his nose and his oxygen concentrator set at 4 liters per minute.

A fourth observation of Resident #32 on 1/25/22 at 3:03 PM revealed him continuing to receive 4 liters of oxygen via nasal cannula through his concentrator.

An observation with Nurse #4 of Resident #32 on 1/25/22 at 3:45 PM revealed that his oxygen concentrator had been set to 4 liters per minute via nasal cannula.

An interview with Nurse #4 on 1/25/22 at 3:49 PM revealed that Resident #32's oxygen should have been set at 2 liters per minute instead of 4 liters. Nurse #4 stated she didn't pay attention to the setting of the oxygen concentrator and had not noticed that it had been set on 4 liters per minute.

An interview with the Nurse Practitioner on 1/27/22 at 11:49 AM revealed Resident #32 had been on long-term use of oxygen for congestive heart failure and that she expected the nurses to deliver his oxygen at the rate it was ordered.

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An interview with the Director of Nursing (DON) on 1/28/22 at 4:11 PM revealed Nurse #4 should have set Resident #32's oxygen according to the orders made by the physician.

3. Resident #47 was admitted to the facility on 7/6/2020 with re-entry to the facility on 6/22/2021.

The quarterly Minimum Data Set (MDS) dated 10/17/2021 included diagnoses of chronic obstructive pulmonary disease (COPD) with the use of oxygen.

Review of Resident #47's care plan dated 12/7/2021 focused on potential for COVID - 19 infection. Interventions included administer oxygen per Physician order.

Review of Physician's orders were as follows: 12/19/2021 - Oxygen per nasal cannula to maintain oxygen saturations greater than 92% due to COVID - 19 for 14 days.

Observation of Resident #47 on 1/24/2022 at 2:34 PM revealed her lying in bed with oxygen via nasal cannula (NC). The oxygen concentrator was set at a rate of 5 liters per minute (l/m).

Observation of Resident #47 on 1/25/2022 at 10:14 AM revealed her standing in the hallway without oxygen via NC beside the medication cart, talking with the nurse. Resident #47 was observed to converse with ease and demonstrated no shortness of breath and no signs of cyanosis (blue or gray coloration of the skin or mucous membranes in the absence of oxygenated blood).

Observation of Resident #47 on 1/27/2022 at

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9:39 AM revealed her lying in bed with oxygen via NC in place. The concentrator was set on 5 L/m.

Observation and interview with Resident #47 on 1/28/2022 at 1:15 PM revealed her lying on her left side on her bed with oxygen via NC donned correctly. The oxygen concentrator was set on 3 L/m. There were no signs of respiratory distress. Resident #47 stated she was aware the oxygen dosage was at 3 L/m. The resident stated "I just put it where I want it. I don't need oxygen. I just like to wear it."

Interview with NA #1 on 1/25/2022 at 10:29 AM revealed Resident #47 walked the halls of the facility and outside in the courtyard daily without wearing oxygen. NA #1 stated Resident #47 took her oxygen off and put it on frequently throughout the day. NA #1 indicated she had only seen Resident #47 experience shortness of breath when she was lying down on her back in bed.

Interview with Nurse #1 on 01/25/22 03:30 PM revealed she was an agency nurse. Nurse #1 stated she had not witnessed shortness of breath or respiratory distress from Resident #47. Nurse #1 indicated she had witnessed Resident #47 taking her oxygen off and putting it on herself. Nurse #1 stated she did not notice the oxygen order had a stop date.

Interview with the facility Nurse Practitioner (NP) on 1/27/2022 at 12:28 PM revealed the oxygen order should have included a dosage rate. The NP further stated Resident #47 should have had the oxygen discontinued after 14 days as stated in the order. The NP disclosed she had seen Resident #47 walking around the facility without oxygen and having no respiratory distress.

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F 695	Continued From page 88 Interview with the Director of Nursing (DON) on 1/28/2022 at 4:33 PM revealed she was not previously aware the oxygen order was without a dosage or that oxygen had not been stopped according to the order. The DON stated the orders should have been checked and she expected orders to be followed as written by the provider.	F 695		
F 725 SS=H	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725		2/28/22

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F 725	Continued From page 89 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews with residents and staff, the facility failed to maintain sufficient staff to assure preferred choices were honored for bathing and requests for transfer in and out of bed; failed to assure consistent showers were provided for residents dependent on staff and as a result of these failures residents expressed feeling that included being helpless and forgotten about. The facility also failed to implement, develop and/or complete baseline and comprehensive care plans and invite residents and their representative to care plan meetings. The facility failed to timely complete and/or transmit comprehensive, quarterly, and significant change Minimum Data Set assessments. These failures affected 15 of 29 residents sampled in the areas of dignity, choices, self-determination, care planning, assessments, and activities of daily living (Resident #6, #7, #9, #10, #11, #12, #13, #28, #36, #39, #41, #57, #58, #109, and #360). The findings included: This tag was cross-referred to: F 550: Based on record review, observations, resident and staff interviews, the facility failed to maintain residents' dignity by not providing showers, bathing, transfers, and incontinence care resulting in residents feeling helpless, dirty, and embarrassed, angry, and "forgotten about." This affected 5 of 5 (Residents #9, #39, #28, #13, and #360) sampled residents.	F 725	1. Resident #7, #8, #9,#13, #23, #26, #27, #45,#50, #54, #81 provided with care per their preference and POC. Resident #82 no longer in facility. 2. On 2/21/22, the Administrator completed an audit of current staffing levels to determine sufficient staffing needed to ensure resident care is provided to assure preferred choices are honored for bathing and requests for transfer in and out of bed; and to assure consistent showers are provided for residents dependent on staff; and assure completion of baseline and comprehensive care plans and invition for residents and their representative to care plan meetings; and to assure timely completion and/or transmission of resident comprehensive, quarterly, and significant change Minimum Data Set assessments. As a result of this review, the facility has posted additional job openings for multiple licensed nurses and nurse aides. Recruitment and retention will remain a priority. 3. DON or designee to educate staffing coordinator on staffing based on ratios/PPD level and resident acuity. Education completed on 2-21-2022. The Administrator and DON will review resident acuity and census to determine staffing levels and will share this information with the staffing coordinator for appropriate staffing each shift/day.	

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F 725	Continued From page 90 F 561: Based on record review, observations, resident and staff interviews, the facility failed to accommodate a resident's request to be assisted out of bed at their preferred time of day (Resident #9) and provide residents with their preferred number of showers per week (Resident #58) for 2 of 4 residents reviewed for choices. F 636: Based on record review and staff interviews, the facility failed to complete and transmit comprehensive Minimum Data Set (MDS) assessments within the regulatory timeframes as specified in the Resident Assessment Instrument (RAI) manual for 4 of 30 sampled residents reviewed (Residents #11, #39, #109, and #360). F: 637: Based on record review and staff interviews, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment was completed within 14 days of a resident being admitted into Hospice care for 1 of 1 resident reviewed for Hospice (Resident #7). F: 638: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD) for 3 of 30 sampled residents reviewed (Residents #12, #9 and #6). F: 655: Based on record review, resident and staff interviews, the facility failed to complete baseline care plans in conjunction with resident and/or responsible party and failed to provide the	F 725	Staffing needs will be reviewed in daily morning meeting and determined staffing needs reported to staffing coordinator to ensure sufficient staffing is provided to ensure resident care is provided to assure preferred choices are honored for bathing and requests for transfer in and out of bed; and to assure consistent showers are provided for residents dependent on staff; and assure completion of baseline and comprehensive care plans and invition for residents and their representative to care plan meetings; and to assure timely completion and/or transmission of resident comprehensive, quarterly, and significant change Minimum Data Set assessments. 4. Administrator or designee to audit schedules, daily staffing sheets, daily labor reports, actual employees presence in the building along with callout to adjust the schedule appropriately to ensure adequate staffing to meet resident care needs areas of dignity, choices, self-determination, care planning, assessments, and activities of daily living. Monitoring will be comleted at a frequency of 5x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Administrator or designee will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement and makes changes to the plan as necessary to maintain compliance with sufficient staffing.	

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F 725	Continued From page 91 resident or their responsible party with a written summary of the baseline care plan for 5 of 5 sampled residents (Resident #109, #10, #39, #36 and #57). F: 656: Based on record review, observations, and interviews with staff the facility failed to implement care plan interventions for 1 of 3 residents reviewed for falls (Resident #57) and 1 of 10 residents reviewed for activities of daily living (Resident #9); the facility also failed to develop a comprehensive care plan for 1 of 1 resident reviewed for hospice (Resident #7) and for 1 of 1 resident reviewed for smoking (Resident #41). F 657: Based on observations, record review and staff interviews, the facility failed to invite residents and/or their representative to participate and provide input in care planning for 3 of 5 sampled residents (Residents #9, #39 and #13) and failed to update the care plan to reflect the current advance directive for 1 of 2 residents (Resident #41) reviewed. This practice had the potential to affect other residents. F 677: Based on record review, observations, interviews with residents and staff the facility failed to provide a shower or a complete bed bath for residents' dependent on staff for activities of daily living care (Resident #28, Resident #9, and Resident #39). An interview was conducted on 1/24/22 at 10:26 AM with Nurse #6. Nurse #6 revealed she had	F 725	5.POC completion date is _2-28-2022_.	

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worked at the facility since June 2021, and it was normal for one nurse to be scheduled on the unit. Nurse #6 revealed when she arrived this morning there was one Nurse Aide (NA) for the entire building. Nurse #6 was not sure if facility had found someone to come in but stated it was not unusual to come in and only one NA be in the building. Nurse #6 revealed typically one nurse was assigned to each unit or one Med Aide. Nurse #6 stated residents missed their showers and staff try to get the residents who complain done but sometimes there's not enough time. Nurse #6 stated staffing wasn't getting better, but she was not called in or asked to cover shifts and when she comes in to work finds out the facility was short staffed.

During an interview on 1/24/22 at 12:15 PM Nurse Aide (NA) #2 explained she had worked at the facility for two years and normally three NA staff were assigned on each side or at least five NA staff but for the past 6 months she had worked shifts as the only NA in the building. NA #2 stated when she was the only NA resident showers were missed and incontinence care was late and the ability to ensure resident safety was difficult.

An interview was conducted with NA #1 on 1/25/22 at 8:42 AM. NA #1 revealed when she arrived this morning only one NA was in the building from night shift.

An interview was conducted on 1/25/22 at 5:05 PM with NA #6. NA #6 stated on night shift she had worked as the only NA for the east and west

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unit. NA #6 revealed on 1/24/22 she worked from 10 AM through 4 AM.

During an interview on 1/27/22 at 11:13 AM, NA #3 revealed she worked during the hours of 7:00 AM to 7:00 PM and often worked short-staffed with only one NA for the entire building or 2 NAs, one on each unit. NA #3 verified residents had complained about not getting their scheduled showers and stated when there was only one or 2 NA staff to provide care, resident showers could not be done. NA #3 stated when working day shift, by the time she completed her first resident round breakfast was ready to be served, then there residents who must be supervised for smoking, then it was lunch time and basically all she has time to do is make sure the residents were clean, dry and fed.

During an interview on 1/28/22 at 10:48 AM Nurse #4 revealed the facility was often short staffed and there were a lot of days only one NA for entire building and/or for each hall and having one NA made it difficult to get resident showers completed as scheduled.

An interview was conducted on 1/28/22 at 2:28 PM with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator explained she did the daily schedule for nursing staff and tried to have two nurses and two Med Aides and four NA staff on first shift. For second shift she tried to have two nurses and three to four NA staff and for night shift 1 nurse and 2 Med Aides. The MDS Coordinator revealed she based the needs of nursing staff on acuity of residents and the facility

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F 725	Continued From page 94 census and at times there were call outs and currently she didn't have as needed (prn) staff. The MDS Coordinator revealed she used four to five staffing agencies to cover shifts and had heard residents state there's not enough staff and they didn't get a shower. The MDS Coordinator explained she had worked on floor as an NA when someone didn't show up, and when staff called out, she tried to find coverage and if unable either she or the DON came in. The MDS Coordinator revealed management staff were on-call 24 hours a day 7 days a week and due to staffing needs and being pulled to the floor she didn't have much time to complete her job duties as the MDS Coordinator. An interview was conducted with DON on 1/28/22 at 4:14 PM. The DON revealed with the weather and staffing issues she had been pulled to the floor to provide resident care and her regular duties had been put off. During an interview on 1/28/22 at 5:35 PM the Administrator revealed he was aware of issues correlating to staffing including residents missing showers. The Administrator explained resident care came first and when they have all staff showers were done but if there was only one NA it would be difficult for residents to get their showers. The Administrator stated if the facility hadn't done what was supposed to be done that was unacceptable.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732		2/28/22

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F 732	Continued From page 95 §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observations, interviews with staff the facility failed to complete and post	F 732	F732 1. No residents cited. Nurse staffing	

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F 732	Continued From page 96 daily nursing staff information for 5 of 5 days reviewed for staffing. The findings included: Observations for the daily nursing staff hours revealed the following: -01/24/22 at 1:16 PM no posting of nursing hours or current census of residents, -01/25/22 at 8:54 AM no posting of nursing hours or current census of residents, -01/26/22 at 7:29 AM no posting of nursing hours or current census of residents, -01/27/22 at 9:19 AM no posting of nursing hours or current census of residents, -01/28/22 at 3:02 PM no posting of nursing hours or current census of residents. An interview was conducted on 01/28/22 03:02 PM with the Receptionist/Assistant Business Office Manager (ABOM). The ABOM revealed she was the person responsible for posting the daily nursing staff hours but had been out of work. The ABOM revealed she didn't have daily posting sheets from 01/24/22 through 01/28/22. An interview was conducted on 01/28/22 at 5:44 PM with the Administrator. The Administrator revealed nursing staff hours should be done daily and posted but were not during the time the ABOM was out of work.	F 732	information posted 1/29/22. 2. Administrator provided education to interdisciplinary team and licensed staff related to Nurse staff posting and the process to follow for coverage to ensure posting is out daily. This will be completed by 2/25/22. Any newly hired staff or agency staff to enter our facility will be educated on this going forward. Any new agency staff will be educated via their agency orientation packet. 3. The Administrator will audit to ensure Nurse staffing is posted 4x week for 4 wks; 3xweek for 4wks; and 1xweek for 4 wks. The Administrator will bring results to our monthly Quality Assurance and Performance Improvement meeting to present results and take recommendations on any process improvement to maintain compliance with Posted Nursing staffing Information. Completion date: 2/28/22	
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental	F 745		2/28/22

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F 745	Continued From page 97 and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews with resident, staff and the Nurse Practitioner, the facility failed to schedule two surgical referrals as ordered by the physician for 1 of 1 resident (Resident #41) reviewed for quality of care. The findings included: Resident #41 was admitted to the facility on 8/14/21 with diagnoses that included liver cirrhosis with ascites (excess abdominal fluid) and chronic obstructive pulmonary disease. The most recent quarterly Minimum Data Set (MDS) assessment dated 11/27/21 indicated Resident #41 was cognitively intact. A review of Resident #41's medical record revealed the following information: *A progress note dated 11/23/21 by the Nurse Practitioner (NP) revealed she had seen Resident #41 who was requesting to have his nephrostomy tube removed. The NP left a referral with the visit to remove the catheter. *A physician order dated 11/23/21 indicated a referral to general surgery due to his desire to have nephrostomy tube removed due to pain. *A progress note dated 12/3/21 by the Medical Director revealed Resident #41's peritoneal catheter was not being used and increased the risk for infection. Referral placed to general surgery to have it removed. *A physician order dated 12/13/21 indicated a referral to general surgery for removal of peritoneal catheter that was no longer needed.	F 745	For all residents directly affected by this alleged deficient practice: 1. Resident #41 cited. Resident #41 attended surgical referral on 2/3/22. 2. On 2/21/22, the Director of Nursing completed an audit of current facility residents to identify and ensure resident medical referrals have been scheduled as indicated. Facility physician orders and outside medical provider visit summaries from 1/21/22-2/21/22 were reviewed to identify resident medical referral needs to ensure appointments scheduled as indicated. All referral appointments scheduled as indicated. 3. Director of Nursing or designee to educate licensed staff to include agency staff to ensure referral needs are identified and communicated to Director of Nursing and appointment scheduler to ensure referral is made and service needs are obtained timely. Education will be completed by 2/25/22. Any newly hired staff or agency staff to enter our facility will be educated on this going forward. Any new agency staff will be educated via their agency orientation packet. 4. Director of Nursing or designee to audit physician orders and outside provider visit summaries for referrals and corresponding scheduling by the facility	

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F 745	Continued From page 98 An observation and interview with Resident #41 on 1/24/22 at 3:12 PM revealed him pointing to a small plastic tube that was implanted under his skin on his abdomen. Resident #41 stated that he had a peritoneal catheter that needed to come out and the facility had not made any arrangements for him to see a surgeon. Resident #41 stated he had had the peritoneal catheter since he had been admitted to the facility, but he hadn't been using it and he wanted it out because it was causing him discomfort. The tube often got caught on things. An interview with Nurse #3 on 1/26/22 at 9:53 AM revealed Resident #41 had a peritoneal catheter when he was admitted to the facility which was left in case he needed it, but he had not used it since he was at the facility. Nurse #3 stated she received a verbal order from the Nurse Practitioner on 11/23/21 about referring him to a surgeon to have the peritoneal catheter removed and she remembered telling the MDS Coordinator about it because she was responsible for scheduling outside consults. An interview with the MDS Coordinator on 1/26/22 at 10:14 AM revealed she was never responsible for scheduling any medical appointments. She stated she had only helped with doing transportation for residents who went out for their medical appointments. The Social Worker was assigned to schedule medical appointments but since the facility had not had a Social Worker, she wasn't sure who should be doing them. She could not remember receiving an order for surgical referral for Resident #41 but knew that the Director of Nursing (DON) had been trying to get him an appointment with a	F 745	for 5 residents 4x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. DON or designee will report the results being reviewed during QA meetings 5. Completed on 2/28/22.	

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F 745	Continued From page 99	F 745		

surgeon.

A phone interview with Nurse #4 on 1/28/22 at 10:56 AM revealed she received an order on 12/13/21 for a surgical referral for Resident #41 and she gave the order to the receptionist because she was responsible for scheduling medical appointments.

An interview with the Receptionist on 1/28/22 at 11:41 AM revealed she was responsible for scheduling medical appointments but had only started doing them at the end of November 2021 and she had just come back from being out for 2 weeks. She couldn't remember setting up a surgical appointment for Resident #41 and she could not find anything in her calendar or referral forms about it. She stated that she had only been working at the facility for a few months and was not really sure what needed to be done when setting up medical appointments for the residents.

An interview with the Nurse Practitioner (NP) on 1/27/22 at 11:49 AM revealed Resident #41 had a peritoneal catheter because he went through paracentesis (procedure used to remove fluid from the peritoneal cavity) when he was at the hospital, and it had been left in place in case he needed it. The NP stated he had not had ascites while he was at the facility, and she had ordered for the catheter to be removed. The NP further stated she thought the facility had tried multiple times to get a surgical referral scheduled and she thought that they refused to operate on him due to his respiratory status.

An interview with the Director of Nursing (DON) on 1/28/22 at 4:04 PM revealed she had not been

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F 745	Continued From page 100 aware of any of the orders for Resident #41 for a surgical referral to have his peritoneal catheter removed. The DON stated she was not sure what had happened, but the referrals might have gotten lost during the transition when the receptionist assumed the responsibility of scheduling medical appointments. The DON stated she had scheduled some appointments while the receptionist had been out but none of them were for Resident #41. An interview with the Administrator on 1/28/22 at 5:35 PM revealed the orders for surgical referral for Resident #41 had been overlooked because the facility did not have a staff member designated to keep up with the appointments. The MDS Coordinator had helped and the receptionist was also doing some scheduling, but both had been out and when they had been out, nobody was available to schedule the outside medical appointments.	F 745		
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	F 761		2/28/22

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F 761	Continued From page 101 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired intravenous fluids in accordance with the manufacturer's expiration date for 1 of 1 medication storage rooms observed for medication storage. The findings included: Observation of the medication storage room was conducted on 1/27/2022 at 8:33 AM in the presence of the Director of Nursing (DON). The observation revealed a bag of intravenous (IV) normal saline with an expiration date of 11/2021. The DON was asked to view the bag of normal saline and verbalize the expiration date stamped on the bag. The DON looked at the bag and stated the manufacturer's expiration date was 11/2021. Interview with the DON at the time of the observation revealed the Supply Manager was responsible for checking expiration dates in the medication storage room and the bag of saline must have been overlooked. The DON verbalized her expectation that expiration dates be checked daily with delivery of medications.	F 761	F761 1. No residents cited. IV normal saline removed from med room and discarded. 2. The Director of Nursing to audit all items in med rooms to ensure items are within manufacturers use date. This was completed on 2/1/22. 3. The Director of Nursing to provide education to all licensed care staff including agency staff, as well as central supply clerk related to medication storage and dates. This will be completed by 2/25/22. Any newly hired staff or agency staff to enter our facility will be educated on this going forward. Any new agency staff will be educated via their agency orientation packet. 4. The Director of Nursing or designee will audit med room items to ensure all items are within manufacturers use date 4x week for 4 wks; 3xweek for 4wks; and 1xweek for 4 wks. The Director of Nursing will bring results to our Quality Assurance	

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F 761	Continued From page 102 The DON expected the bag to have been discarded in November 2021. Interview with the Supply Manager on 1/28/2022 at 10:11 AM revealed she was responsible to stock and verify expiration dates of over-the-counter medications in the cabinet of the medication storage room. The Supply Manager indicated she did not check expiration dates of intravenous fluids as she had been told intravenous fluids expiration dates were checked by the pharmacy staff who delivered the fluids. Interview with the Pharmacist on 1/28/2022 at 10:26 AM revealed pharmacy staff did not participate in checking expiration dates of any fluids or medications in the facility medication storage room. The Pharmacist indicated pharmacy staff were only responsible for checking expiration dates of medications they delivered. Subsequent interview with the DON on 1/29/2022 at 4:20 PM revealed she was not aware of the confusion of responsibilities to check expiration dates of IV fluids. The DON stated she had corrective work to do with staff.	F 761	and Performance Improvement meeting monthly to present results and take recommendations on any process improvement to maintain compliance with Label/storage Drugs and biologicals. Completion date: 2/28/22	
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment	F 802		2/28/22

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F 802	Continued From page 103 required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to have sufficient dietary staff to carry out meal preparation and service for 59 of 59 residents who received meals at the facility. Findings included: The dietary time sheets for the period 01/01/22 through 01/25/22 revealed: No dietary staff worked on 01/16/22. One dietary staff worked on 01/17/22. Two dietary staff worked on 01/02/22, 01/03/22, 01/04/22, 01/06/22, 01/09/22, 01/15/22, and 01/18/22. During an interview on 01/25/22 at 9:45 AM, Dietary Aide (DA) #1 revealed there were staffing challenges within the dietary department with several open positions that included a Dietary Manager, cook and dietary aides for the weekends. She added they currently had only 4 dietary staff to fill the daily schedule which made it difficult to ensure there was adequate coverage. DA #1 disclosed she had not been trained as the Dietary Manager (DM) or had certification but was	F 802	Deficiency: Based on observations, record reviews, and interviews with residents and staff, the facility failed to have sufficient dietary staff to carry out meal preparation and service for 59 of 59 residents who received meals at the facility. 1. Prior to 1/28/2022 the Administrator asked the Regional Food service Director to keep him informed of dietary staffing and hiring plans to insure sufficient Dietary staff. On 1/28/22, Administrator ensured dietary was staffed sufficiently with support staff to safely and effectively carry out the functions of meal preparation and service to all residents. Sufficient dietary staff hired as reported by the Regional Food Service Director. The minimum dietary staff per shift/ meal service is one cook and one dietary aide. In case of the minimum dietary staff need not met the Dietary Manager will assume position needed and call other dietary staff in.	

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F 802	Continued From page 104 trying to fill-in as best she knew how until the DM position could be filled. During an interview on 01/26/22 at 10:01 AM, the Resident Council President (RCP) reported there wasn't enough dietary staff and at times, meals were served late to the residents. The RCP added group activities were not being held at this time due to the facility's COVID outbreak, so the Activity Director often helped out in the kitchen due to the dietary staff shortages. During an interview on 01/25/22 at 8:08 AM, Nurse Aide (NA) #1 revealed on several occasions, most recently 2 days ago, she was pulled of the floor to assist in the kitchen during a meal service due to dietary staff shortages which left only one NA on the halls to answer call lights and provide resident care. NA #1 added when working short-staffed, the nurses helped pass meal trays, assist dependent residents with their meals and made sure all residents were fed. During an interview on 01/25/22 at 5:05 PM, NA #6 revealed on 01/16/22 through 01/17/22 during the snowstorm, she and another NA remained at the facility and worked 48 hours straight, with only 4 hours of sleep, providing resident care. NA #6 added since there was no dietary staff in the kitchen, the Administrator and Director of Nursing (DON) both came into the facility to prepare and serve meals while she and the other NA remained on the floor providing resident care. As a result, she stated residents were not served breakfast until approximately 11:00 AM and lunch until approximately 3:00 PM. During an interview on 01/26/22 at 10:23 AM, the Administrator explained they had a contract with	F 802	2. Administrator and Dietary manager to conduct audit to solidify dietary staffing needs to ensure sufficient dietary staffing to maintain compliance with dietary staffing needs based on resident assessments, acuity, and diagnosis of resident population in accordance with facility assessment. This was completed on 2/16/22 3. Administrator to educate Dietary Manager on adequate staffing level requirements as determined by resident assessments, acuity, and diagnosis of resident population in accordance with facility assessment on 2/16/22. Newly hired dietary managers to be educated during orientation. Effective 2/28/22, a new Dietary Manager and three new full-time dietary support staff were hired to provide additional staff support and back-up coverage when needed. The Dietary Manager and Administrator will review daily scheduling coverage to ensure adequate staffing levels are met with additional staff available to provide back-up support if necessary. The Dietary Manager will be responsible for ensuring adequate staffing levels each shift and for ensuring back-up support is available to meet resident care needs. 4. Administrator or designee to audit to ensure sufficient dietary staffing as evidenced by resident care needs are	

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F 802	Continued From page 105 an outside agency who employed all dietary staff for the facility which currently consisted of 4 dietary aides. He added the Dietary Manager resigned last month and the position had not yet been filled. The Administrator confirmed during the snowstorm on 01/16/22, dietary staff were unable to make into the building and he came to the facility to prepare resident meals and assisted the DA in the kitchen with meals on 01/17/22. During an interview on 01/26/22 at 2:13 PM, the Activity Director (AD) stated since December 2022 due to the COVID outbreak they had not been having group activities and she was pulled to assist in the kitchen every other day during at least one meal service due to dietary staff shortages. The AD explained she didn't cook or plate the food, just reviewed the meal ticket to determine what additional items needed to be placed on the meal tray, such as drinks or supplements, placed the items along with the plate of food onto the tray and put the tray into the meal cart for delivery to the residents. An observation of the supper meal service on 01/26/22 at 4:25 PM revealed DA #4 plating meals from the food steam table. The Maintenance Director and Activity Director were both observed in the kitchen assisting DA #4 by putting the plated meals on the trays and loading them into the meal cart for delivery to the residents. There were no other staff observed assisting in the kitchen. During an interview on 01/28/22 at 1:48 PM, the Minimum Data Set (MDS) Coordinator revealed on 01/16/22, the day of the snowstorm, the Administrator picked her up and they both came into the facility to assist staff. The MDS	F 802	maintained 4x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Administrator will bring results to our monthly Quality Assurance and Performance Improvement meeting to present results and take recommendations on any process improvement to maintain compliance with sufficient dietary staffing. 5. POC completion date 2/28/22	

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ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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F 802	Continued From page 106	F 802		

Coordinator stated once at the facility, "she hit the floor running" and then went into the kitchen to help the Administrator prepare and serve meals for the residents.

During an interview on 01/26/22 at 5:16 PM, DA #4 revealed dietary staff had worked short since November 2021 and there were currently only 4 dietary staff to cover the schedule, two DA who usually only worked the day shift which left DA #1 and herself to work it out amongst themselves how to cover the evening shift. In addition, she stated they were currently without a full-time Dietary Manager and DA #1 was now out on medical leave. DA #4 stated she was the only dietary aide in the kitchen this evening which meant she had to prepare, cook, serve, and clean the kitchen by herself. She added while she plated the food, the Maintenance Director and Activity Director assisted with preparing the meal trays which helped get the meals delivered to the residents on time. DA #4 indicated they needed at least 3 dietary staff for each meal service; however, it was not uncommon for them to only have two DA scheduled which made it difficult to get everything done on time and resident meals were often served late.

During an interview on 01/28/22 at 12:37 PM, NA #4 revealed she frequently worked during the hours of 7:00 AM and 7:00 PM and on a lot of days, there was only one NA assigned for the entire building or each unit. NA #4 added due to dietary staff shortages, resident meals were often served late and some days the breakfast trays came out early while other times, they would be one to two hours late. She added when both NA and dietary staff worked short, it was difficult to plan rounds for resident care because staff never

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F 802	Continued From page 107 knew what time resident meal trays would be delivered to the halls. During an interview on 01/28/22 at 3:15 PM, the Regional Dietary Manager (RDM) revealed he was responsible for overseeing the dietary department at 11 different facilities and staffing was a challenge. He explained dietary staff were trained upon hire and as needed but was not sure how non-dietary staff were trained if they assisted in the kitchen. The RDM explained for meal service to run efficiently, there needed to be at least 3 dietary staff for each meal service/shift. He confirmed there were only 4 dietary staff currently employed at the facility and while they were actively recruiting more dietary staff via word of mouth and advertising, the hiring process had been difficult. During an interview on 01/28/22 at 5:47 PM, the Administrator stated he was aware of the dietary staffing challenges and explained the contracted agency was advertising for various dietary positions and he felt the agency was doing all they could to get them more dietary staff. The Administrator added despite the staffing challenges, residents did not go without prepared meals. He stated while there had been complaints related to food being cold when delivered, he had heard no complaints from residents that meals were served late.	F 802		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		2/28/22

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F 812	Continued From page 108 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard bags of shredded lettuce with visible signs of spoilage in 1 of 2 reach-in coolers and failed to ensure 2 of 3 dietary staff had all hair covered during 2 separate meal services which had the potential for cross-contamination of food served to residents. Findings included: 1. An observation of the kitchen and subsequent interview was conducted with Dietary Aide (DA) #1 on 01/24/22 at 9:45 AM. Stored in the first reach-in cooler were 2 clear bags of shredded lettuce dated 01/15/22 with approximately ¼ of each bag containing lettuce that had turned brown and slimy. DA #1 confirmed both bags of lettuce had signs of spoilage and stated they should have been removed from the reach-in cooler and discarded. DA #1 explained they had staffing challenges within the dietary department, were without a Dietary Manager and she was	F 812	1. No residents cited. Immediate labeling of all food containers in refrigerators/freezers completed and disposal of spoiled food items. Administrator ensured immediately that all dietary staff had all hair covered to maintain compliance with food procurement, Store/Prepare/Serve-sanitary. Completed on 1/29/21. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved: 2. Dietary Manager (DM)/Registered Dietician (RD) or designee to audit all food storage areas for accurate label and dating of all food items and appropriate disposal of spoiled food items. DM/RD to audit all dietary staff for appropriate hair	

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F 812	Continued From page 109 trying to cover the position the best she knew how. During an interview on 01/28/22 at 5:47 PM, the Administrator stated all dietary staff were responsible for checking the reach-in coolers daily to make sure all items were labeled, dated and discarded if expired. 2. During an observation and interview on 01/25/22 at 4:50 PM, Cook #1 was observed at the food steam table, plating resident meals. Cook #1's hair was pulled into a ponytail and she was wearing a cap that covered the top and sides of her head with the loose ends of the ponytail uncovered and hanging down the back of her neck. Cook #1 was unaware that all parts of the hair should be covered when preparing/serving food. She added she was told as long as her hair was pulled back and covered with a cap, it was ok if the ponytail hung loose. During an observation and interview on 01/25/22 at 4:50 PM, DA #2 was observed at the food steam table putting the plated meals onto trays and loading them into the meal cart for delivery to the residents. DA #2 was not wearing a hairnet and her braided hair was fashioned into bun on the top of her head with loose braids hanging down the length of her back past her waist. DA #2 explained her hair was too long to put inside a hairnet and if she put the back of her hair into the hairnet, the top of her hair would not stay covered. During a continuous observation of meal service on 01/27/22 from 7:00 AM to 9:05 AM, both DA #2 and DA #3 were observed at the food steam table putting plated meals and drinks onto the	F 812	covering. Audit completed on 2/16/21 with no concerns identified during observation. 3. DM/RD or designee to educate all dietary staff on accurate dating and labeling of food items and wearing hair covering at all times as it relates to food procurement, Store/Prepare/Serve-sanitary . Any food items not labeled, dating/or with signs of spoilage will be discarded immediately. Education completed on 2/16/21. All newly hired staff will be educated at time of hire. 4. Dietary Manager or designee to audit all food storage areas for proper dating and labeling and for spoiled or out of date foods; and dietary staff for wearing appropriate hair covering 4x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. 5. The Dietary Manager or designee will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for a duration of three months 6. POC completion date is 2/28/22.	

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F 812	Continued From page 110 trays and loading them into the meal cart for delivery to residents. DA #2 was observed not wearing a hairnet and her braided hair was fashioned into bun on the top of her head with loose braids hanging down the length of her back past her waist. DA #3 was wearing a hairnet on the top of her head with long loose braids handing down her back uncovered. During an interview on 01/27/22 at 9:05 AM, DA #3 stated she was supposed to have her hair covered when working in the kitchen and explained she only covered the top portion of her hair because the rest was too long fit in the hairnet. During an interview on 01/28/22 at 3:15 PM, the Regional Dietary Manager stated dietary staff should have all parts of their hair covered when preparing and serving food. During an interview on 01/28/22 at 5:47 PM, the Administrator stated he was aware of the issues identified and dietary staff were expected to have all parts of their hair covered when preparing and serving food.	F 812		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		2/28/22

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F 842	Continued From page 111	F 842		

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

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F 842	Continued From page 112 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to maintain an accurate Treatment Administration Record (TAR) for the administration of oxygen for 1 of 3 residents (Resident #32) reviewed for oxygen therapy. The findings included: Resident #32 was admitted to the facility on 12/22/20 and re-admitted on 9/23/21 with diagnoses that included cerebral infarction (stroke) and congestive heart failure. A physician order dated 9/23/21 for Resident #32 indicated continuous oxygen at 2 liters in and out of bed. A review of the Treatment Administration Records (TAR) for Resident #32 from 9/23/21 to 1/24/22 indicated no documentation of oxygen received	F 842	F842 POC For all residents directly affected by this alleged deficient practice 1. Resident #32 cited. Resident #32 oxygen orders clarified and transcribed accurately to treatment administration record to enable proper documentation on 1/28/22. 2. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved: Director of Nursing to audit all residents using oxygen to ensure orders are transcribed accurately to treatment administration record to enable proper documentation of	

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F 842	Continued From page 113 by Resident #32. An observation of Resident #32 on 1/24/22 at 10:16 AM revealed him wearing a nasal cannula which was connected to an oxygen concentrator that was running at 4 liters per minute. Resident #32 was sleeping in bed with his head elevated. An interview with Nurse #4 on 1/25/22 at 3:49 PM revealed that Resident #32's oxygen should have been set at 2 liters per minute instead of 4 liters. Nurse #4 stated the nurses had been recording Resident #32's oxygen saturation on the TAR but she could not find any documentation about the amount of oxygen that Resident #32 had been receiving each shift. Nurse #4 further stated that they should have been documenting the administration of oxygen to Resident #32 and she didn't notice that they hadn't been. An interview with the Minimum Data Set (MDS) Coordinator on 1/26/22 at 10:14 AM revealed she had carried out the oxygen order for Resident #32 but could not remember entering it into the electronic medical record. The MDS Coordinator acknowledged that she failed to enter a scheduled time for the oxygen to be administered and this was why the order didn't get carried over to the TAR for the nurses to document the administration of oxygen to Resident #32. The MDS Coordinator stated she was just helping the nurses out by putting orders in the computer and forgot to schedule Resident #32's oxygen order. An interview with the Director of Nursing (DON) on 1/28/22 at 4:11 PM revealed that all orders should be transcribed correctly and the administration of oxygen to Resident #32 should have been documented every shift. The DON	F 842	oxygen administration. This will be completed by 2/25/22. 3. Director of Nursing to educate all current facility and agency licensed nursing staff related to accurate order transcription of orders to ensure proper documentation of treatments. This will be completed by 2/25/22. Any new hired licensed nurse staff will be educated upon hire and any new agency licensed nursing staff will be educated via their orientation packets. 4. Director of Nursing or Unit manager to audit 5 resident medical records to ensure orders are transcribed accurately and proper documentation of oxygen administration 4x/week for 4 weeks, then 3x/week for 4 weeks, then 1x/week for 4 weeks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting to present results and take recommendations on any process improvement to maintain compliance with resident records. 5. Completion date 2/28/22	

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F 842	Continued From page 114 stated she was supposed to audit all physician orders daily, but she had been getting pulled to help with patient care frequently and had been unable to complete her audits.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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		2/28/22

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F 880	Continued From page 115 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 record reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 by not	F 880	Per 2567&.facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 by not requiring 4	

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F 880	Continued From page 116 requiring 4 of 4 staff members (Therapy staff member #1, Nurse Aide #2, Nurse Aide #1 and Nurse Aide #8) to wear all recommended PPE (Personal Protective Equipment) when caring for 3 of 3 newly admitted unvaccinated residents (Resident #360, Resident #359 and Resident #361) and for 2 of 2 unvaccinated residents (Resident #16 and Resident #42) while the facility was on COVID-19 outbreak. In addition, 4 of 4 staff members (Nurse Aide #7, Nurse #5, Nurse Aide #2 and Nurse #2) failed to wear eye protective gear while providing care to residents and 1 of 2 staff members (Nurse #1) failed to perform hand hygiene during wound care on 1 of 3 residents (Resident #36) reviewed. These failures occurred during a COVID-19 pandemic. The findings included: 1. The CDC guideline entitled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," updated on 9/10/21 indicated the following statements: *In general, all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission. *Unvaccinated residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP (healthcare personnel) using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. *If no additional cases are identified during the broad-based testing, room restriction and full PPE use by HCP caring for unvaccinated residents can be discontinued after 14 days.	F 880	of 4 staff members (Therapy staff member #1, Nurse Aide #2, Nurse Aide #1 and Nurse Aide #8) to wear all recommended PPE (Personal Protective Equipment) when caring for 3 of 3 newly admitted unvaccinated residents (Resident #360, Resident #359 and Resident #361) and for 2 of 2 unvaccinated residents (Resident #16 and Resident #42) while the facility was on COVID-19 outbreak. In addition, 4 of 4 staff members (Nurse Aide #7, Nurse #5, Nurse Aide #2 and Nurse #2) failed to wear eye protective gear while providing care to residents and 1 of 2 staff members (Nurse #1) failed to perform hand hygiene during wound care on 1 of 3 residents (Resident #36) reviewed. These failures occurred during a COVID-19 pandemic. F880 POC 1. A QAPI meeting was conducted by the IDT on 2/21/22 to determine root cause analysis of the facilities failure to 1) ensure proper personal protective equipment use by staff while providing care to unvaccinated residents during a COVID-19 pandemic and to 2) ensure staff wear eye protective gear while providing care to residents and 3) ensure infection prevention practices of hand hygiene during wound care. The facility determined that 1) signage was not posted to indicate isolation precautions and PPE use for unvaccinated residents and 2) staff were knowledgeable on PPE use and protective eyewear however, the facility did not effectively monitor staff on following guidance and 3) nurse was	

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F 880	Continued From page 117 *If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days. A review of the facility's COVID-19 policy entitled, "Novel Coronavirus Prevention and Response," revised on 9/15/21 indicated the following statements: *All unvaccinated residents who are new admissions or readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission. * Unvaccinated residents who have had close contact with someone with COVID-19 infection should be placed in quarantine for 14 days after exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). During the entrance conference with the Administrator on 1/24/22 at 9:39 AM, he reported that the facility had been on a COVID-19 outbreak when a resident tested positive for COVID-19 on 12/1/21. The facility implemented a broad-based approach and conducted facility-wide testing of all residents and staff members. Additional cases of residents and staff members were subsequently identified as having been positive for COVID-19. The last COVID-19 positive resident was identified on 1/3/22 but the staff members continued to test positive for COVID-19 with the last one identified on 1/18/22. A review of the list of unvaccinated residents from the medical records included the following residents:	F 880	knowledgeable on infection prevention and control related to hand hygiene during wound care however, she did not follow this practice on date cited. 2. On 2/1/22, the Director of Nursing posted isolation signage on residents room door for Resident #361, #360, #359, #16, #42 and staff will continue to don appropriate PPE per Infection Control Policy and CDC guidance. On 1/28/22, Regional Director of Clinical Services educated Director of Nursing related to isolation standards and PPE use to maintain effective infection control and prevention for unvaccinated residents. On 1/28/22 NA #1, NA #8, NA # 7, NA #2, Nurse #2, Nurse #5, and therapy #1 were educated on appropriate PPE practices by Director of Nursing. Nurse #1 completed no longer working in facility. 3. For all residents with potential to be affected by the alleged deficit practice, the following has been achieved: On 2/17/22 the Director of Nursing completed an audit by visual observation of 1) unvaccinated residents to ensure isolation signage posted and 2) appropriate use of PPE and protective eyewear during resident care and 3) proper hand hygiene during wound care to per Infection Control Policy and CDC guidance. No additional concerns were identified during this observation. 4. Director of Nursing to educate all current facility and agency direct-care staff	

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F 880	Continued From page 118 Resident # 360 was admitted to the facility on 1/11/22. Resident #359 was admitted to the facility on 1/11/22. Resident #361 was admitted to the facility on 1/11/22. Resident #16 was admitted to the facility on 10/1/21. Resident #42 was admitted to the facility on 12/1/21. a. Observations made on 1/24/22 at 11:51 AM, 1/25/22 at 2:30 PM and 1/26/22 at 8:30 AM of the East wing revealed no residents were on transmission-based precautions and there were no PPE supplies available for use outside any resident door. Additional observations on the East wing revealed the following: Therapy staff member #1 was observed on 1/24/22 at 12:13 PM wearing an N-95 mask and goggles while walking Resident #361 to the therapy room. Nurse Aide (NA) #2 was observed entering Resident #16's room while wearing an N-95 mask and goggles. NA #1 was observed on 1/25/22 at 2:44 PM wearing an N-95 mask and goggles while helping Resident #359 to get dressed. She was further observed on 1/26/22 at 8:58 AM wearing an N-95 mask and goggles while providing care to Resident #360. An interview with Therapy staff member #1 on 1/28/22 at 9:06 AM revealed Resident #361 had been in the same room since he was admitted which was right outside the COVID-19 unit, but he wasn't placed on any transmission-based precautions. He didn't have any sign or PPE outside his door and she never wore full PPE when she worked with Resident #361.	F 880	related to proper hand hygiene during wound care and infection control policies and procedures related to isolation precautions and posting appropriate signage, personal protective equipment including eyewear and hand hygiene per Infection Control Policy and CDC guidance. This will be completed by 2/25/22. Any newly hired direct care staff will be educated upon hire. Any new agency direct care staff will be educated via orientation packet prior to working. The designated Infection Preventionist will be responsible for maintaining a master list of unvaccinated/vaccinated residents and routine monitoring of staff for proper use of PPE and infection prevention practices. The licensed nurse will be responsible for posting isolation signage as ordered. 5. Director of Nursing/Infection Preventionist to monitor 5 direct-care staff by visual observation of hand hygiene during wound care and personal protective equipment use and eyewear during patient care for 5 direct care staff and monitoring isolation signage for unvaccinated residents weekly x 4 weeks then, 3 direct care staff weekly x 4 weeks then, 1 direct care staff weekly for 4 weeks. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement meeting monthly to present results and make changes to the plan as necessary to maintain compliance with infection prevention and control practices during incontinence care.	

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F 880	Continued From page 119 An interview with NA #2 on 1/28/22 at 1:34 PM revealed she took care of all the residents on the East wing on 1/24/22 and did not remember any of the residents being on transmission-based precautions. She did not see any signs on the door or PPE, so she did not wear a gown or full PPE to take care of Resident #16, Resident #359, Resident #360, or Resident #361. NA #2 also reported that she worked at the facility on the East wing since December 2021 and the only residents who were placed on transmission-based precautions were the residents in the COVID-19 unit. An interview with NA #1 on 1/27/22 at 9:15 AM revealed she came back to work on 1/10/22 after being out and had worked with Resident #359, Resident #360, and Resident #361 since they were admitted to the facility. NA #1 did not remember any of the newly admitted residents being placed on transmission-based precautions. The only residents who were on transmission-based precautions were the residents who tested positive for COVID-19. NA #1 stated she never wore a gown or full PPE to take care of any of the unvaccinated newly admitted residents. b. Observations made on 1/24/22 at 10:00 AM, 1/25/22 at 9:30 AM and 1/26/22 at 6:30 AM of the West wing revealed no residents were on transmission-based precautions and there were no PPE supplies available for use outside any resident door. NA #8 was observed on 1/24/22 at 11:30 AM entering Resident #42's room while wearing an N-95 mask and goggles. An interview with NA #8 on 1/28/22 at 10:07 AM revealed she had taken care of Resident #42 on	F 880	6. Alleged date of compliance 2/28/22. 7. Root Cause Analysis using 5-Whys Tool 8. Timeline of Events (see attachment) 9. Attestation of Infection Control education (see attachment)	

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1/24/22 and in January 2022 and she did not notice any signs about transmission-based precautions or PPE on her door. NA #8 stated she only wore an N-95 mask and goggles but did not know she was supposed to wear full PPE including a gown.

An interview with the Director of Nursing (DON) who acted as the facility's Infection Preventionist on 1/27/22 at 2:24 PM revealed the facility started facility-wide testing after a resident tested positive for COVID-19 on 12/1/21 because they were unable to determine who had been exposed to the resident because she walked around the facility before being tested. They tested all residents and staff members and presumed everyone had possible exposure to COVID-19. They monitored the unvaccinated residents for signs and symptoms of COVID-19 based on guidance given to her from their corporate office. The DON stated she had been told it was not necessary to place the unvaccinated residents under transmission-based precautions when the facility was on outbreak status. She also stated she did notice that their facility policy had directions otherwise. The DON further stated she did not know why the unvaccinated newly admitted residents were not placed on transmission-based precautions until there were no new cases of COVID-19 for 14 days. She was responsible for putting up signage for transmission-based precautions but failed to do so when she was directed by corporate that it was not necessary, and was told that they only needed to monitor the residents for signs and symptoms of COVID-19.

An interview with the Administrator on 1/28/22 at 5:35 PM revealed it was an oversight that they

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failed to place the unvaccinated newly admitted residents and unvaccinated residents on transmission-based precautions while the facility was on a COVID-19 outbreak. He stated they had focused more on placing the COVID-19 positive residents on transmission-based precautions.

2. A review of the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker on 1/26/22 indicated that the county where the facility was located had a high level of community transmission for COVID-19.

The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 9/10/21 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for HCP (Healthcare Personnel):
*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 including: 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.

A review of the facility policy entitled, "Novel Coronavirus Prevention and Response," revised on 9/15/21 indicated:
f. Implement standard, contact, and droplet precautions. Wear gloves, gowns, goggles/face

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shields, and a NIOSH-approved N95 or equivalent or higher-level respirator upon entering room and when caring for the resident.

a. During an observation at the East wing on 1/26/22 from 6:24 AM to 6:33 AM, Nurse Aide (NA) #7 was observed wearing a surgical mask with no eye protective gear when she reached into the linen cart, obtained a towel and entered Resident #56's room. At 6:31 AM, NA #7 exited Resident #56's room and answered Resident #360's call light. NA #7 was still wearing a surgical mask with no eye protection. She came out of Resident #360's room holding an empty drinking cup, filled the cup with ice and went back into Resident #360's room.

An interview with NA #7 on 1/26/22 at 6:34 AM revealed she had worked with all residents at the facility on the night shift while wearing a surgical mask with no eye protective gear. NA #7 stated no one had told her that eye protection was needed while providing care to the residents.

b. Nurse #5 was observed on 1/26/22 at 6:28 AM talking to Resident #47 at the East wing nurses' station while wearing an N-95 mask and no eye protective gear.

An interview with Nurse #5 on 1/26/22 at 6:54 AM revealed she had not been told that eye protection was needed to be used when interacting or providing care to residents. Nurse #5 stated the last time she had used eye protective gear was at the COVID-19 unit while working with residents who were positive for COVID-19.

c. NA #2 was observed on 1/26/22 at 7:20 AM

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assisting a phlebotomist while drawing blood from Resident #33. NA #2 was wearing an N-95 mask with no eye protective gear on.

An interview with NA #2 on 1/26/22 at 8:08 AM revealed that she had not been wearing eye protection while providing care to residents because she didn't know she was supposed to.

d. An interview with Nurse #2 on 1/26/22 at 7:22 AM revealed he had been working with all the residents on the night shift while wearing an N-95 mask and no eye protective gear. Nurse #2 stated he thought he only needed to wear eye protection when working with a COVID-19 positive resident and didn't think he had to wear one now.

An interview with the Director of Nursing (DON) on 1/27/22 at 2:24 PM revealed all staff members had been trained to wear eye protective gear at all times while providing care to the residents because the level of transmission for COVID-19 at the county was still high. The DON stated she did not know why the night shift staff did not wear eye protection.

An interview with the Administrator on 1/28/22 at 5:35 PM revealed education had been provided to all staff regarding use of protective eye gear when interacting and providing care to all the residents. He stated that it was not acceptable that some staff members did not do what they were supposed to do.

3. Review of the document titled, "Hand Hygiene" reviewed and/or revised on 10/29/20 read in part:

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"Policy: all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors." The policy included a hand hygiene table for types of conditions staff were to use soap and water or an alcohol-based hand rub that included before and after handling clean or soiled dressings, after handling items potentially contaminated with blood and body fluids, and during resident care when moving from a contaminated body site.

An observation on 1/26/22 at 11:16 AM was made of Nurse #1 providing wound care for 3 separate pressure ulcers located on the buttocks and the left and right foot of Resident #36. Nurse #1 performed hand hygiene using an alcohol-based hand rub and donned a pair of clean gloves to reposition Resident #36 on his side. Nurse #1 then removed a soiled dressing from the resident's buttocks and begun to clean the wound using gauze damped with normal saline then measured the size of the wound. While wearing the same gloves Nurse #1 applied a small piece of silver infused material directly on the wound bed then applied a new bandage to cover the pressure ulcer. Nurse #1 removed her gloves and performed hand hygiene using an alcohol-based hand rub and donned a pair of clean gloves. No dressing was in place on the left foot pressure ulcer. Nurse #1 begun to clean the pressure ulcer with gauze damped with normal saline and while wearing the same gloves used a cotton-tipped applicator to apply medication to the wound bed then covered the pressure ulcer with a clean bandage. Without removing her gloves or performing hand hygiene Nurse #1 removed a soiled dressing from Resident #36's right foot and begun to clean the wound bed with gauze damped with normal saline. Without removing her

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F 880	Continued From page 125 gloves or performing hand hygiene Nurse #1 used a wooden applicator to apply a powder infused with medication then applied a small piece of silver infused material and covered the pressure ulcer with a new bandage. An interview was conducted on 01/26/22 at 11:38 AM after Nurse #1 completed Resident #36's wound care. When asked about infection control and hand hygiene practices during wound care Nurse #1 confirmed she hadn't changed gloves or performed hand hygiene after a soiled dressing was removed or between wound care provided to the left and right foot pressure ulcers. Nurse #1 stated for infection control practice she should remove her gloves and perform hand hygiene after a soiled procedure and before treatment was provided to a separate wound. An interview was conducted with Director of Nursing (DON) on 1/27/22 at 1:01 PM to share the observation of wound care for Resident #36. The DON revealed after the nurse performed a dirty process like wound care, she expected the nurse would remove her gloves and perform hand hygiene and would also expect the nurse to remove her gloves and perform hand hygiene when moving from one wound site to another to prevent the spread of infection.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 921		2/28/22

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F 921	Continued From page 126 Based on record review, observations and staff interviews, the facility failed to maintain a safe environment as evidenced by exposed wires and metal water pipes protruding out of the wall in 2 of 28 resident rooms/bathrooms observed on the 200 unit (Rooms #207 and #209), exposed metal pipes protruding from the wall of a resident's room in 1 of 30 resident rooms observed on the 100 unit (Resident #12), and an electrical outlet cover sticking out from the wall of 1 of 2 resident hallways on the 200 unit. Findings included: 1 a. An observation of Room #207 on 01/25/22 at 3:01 PM revealed exposed wires hanging out of the top part of the wall, approximately 7 feet from the floor, on the A-bed side of the room. Room #207 was currently unoccupied. A second observation conducted on 01/28/22 at 8:30 AM revealed the exposed wires remained unchanged. b. An observation of the walk-in shower in the bathroom of Room #209 on 01/24/22 at 2:18 PM revealed a metal pipe protruding out from the wall approximately 7 feet from the floor with no cap on the end of the pipe. Subsequent observations on 01/25/22 at 12:03 PM and 01/28/22 at 8:34 AM revealed the conditions remained unchanged. c. An observation of Resident #12's room on 01/24/22 at 11:09 AM revealed the sink was removed from the wall of the room with the tips of the metal pipes protruding from the wall approximately 1 to 2 inches and no cover or cap on the ends of the pipes. A second observation conducted on 01/28/22 at 8:41 AM revealed the exposed tips of the pipes remained unchanged.	F 921	1. a. Room #207 exposed wires a overhead light fixture was installed on the A-bed. b. Room #209 Administrator, maintenance director and regional director observed the room. The pipe is caped. c. Resident #12's room the sink was reinstalled and all pipes reconnected. The plastic cover was reattached to the electric socket flushed to the wall without any gap. Resident in the facility have the potential of being affected by this deficient practice. 2. An audit was completed by the Maintenance director to ensure no other exposed wires, missing sinks, protruding pipes, plastic electrical socket cover. This was concluded on 1-28-2022. 3. The Administrator educated maintenance Director on 2/21/22related to maintenance inspection and repairs. Administrator and Maintenance Director began education on 1/28/2022 of all current and agency staff from all departments to report any repairs to the maintenance director. This education will be completed by 2/28/22. Any newly hired staff will be educated on hire. Agency staff will be educated via their agency orientation packet. 4. The Administrator will audit work order request 4x week for 4 wks; 3xweek for 4wks; and 1xweek for 4 wks. The Administrator will bring results to our Quality Assurance and Performance Improvement meeting to present results and take recommendations on any process improvement to maintain compliance with	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 127 d. An observation conducted on 01/28/22 at 8:35 AM of the hallway on the 200 unit revealed underneath the handrail, just above the baseboard, the plastic cover of an electrical socket was pulled out from the wall approximately ½ of an inch causing a slight gap which was only visible when observed closely from the right side. The handrail in the middle of the wall protruded out further than the electrical outlet, preventing someone from scraping their leg as they walked or wheeled by in the wheelchair. A walking round and joint interview was conducted with the Administrator, Environmental Services Director, and the Maintenance Director on 01/28/22 at 11:40 AM. The Maintenance Director revealed he had only been in his position about a month but was out of work for approximately 2 weeks for personal reasons. He stated he was aware of the exposed pipes in the resident bathrooms and had planned on placing a cap on the end of the pipes but had not yet had the time due to focusing on emergent repairs that needed completed. The Administrator explained the sink in Resident #12's room was removed previously when occupied by another resident and the plans were to place the sink back on the wall; however, no timeframe had been established for it to be done. He added Resident #12 was non-ambulatory. The Maintenance Director and Administrator were unaware of the exposed wires and electrical outlet cover on the walls and both stated the Maintenance Director should have been informed when noticed by staff so the issues could be repaired.	F 921	safe/functional/sanitary/and comfortable environment. 5. Completion date: 2/28/22	