STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 02/27/22 through 03/02/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# UGWG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/27/22 to 03/02/22. Event ID #UGWG11. 28 out of 55 complaint allegations were subtantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		3/28/22

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

Electronically Signed | 03/26/2022

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F 550	Continued From page 1 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, resident and staff interview the facility failed to treat 1 of 6 residents in a dignified manner by not ensuring there was enough linen for incontinence care which made the resident feel like she was being treated like a dog and the facility didn't care about her (Resident #75). The findings included: Resident #75 was admitted to the facility on 6/15/21 with diagnoses that included hypertension, and anxiety. A review of the quarterly Minimum Data Set (MDS) dated 1/31/22 indicated Resident #75 was cognitively intact and required extensive assistance with majority of activities of daily living (ADL). The MDS revealed Resident #75 was	F 550	1. The corrective action will be accomplished for the residents found to have been affected by the deficient practice. Linen was provided and CNA was able to provide incontinence care for resident #75 on 2/27/2022. The Housekeeping Director ordered more linen on 3/1/2022. 2. All residents are currently at risk of deficient practice. The Interdisciplinary Team (IDT) conducted a community wide linen audit to obtain a par level of linen for the facility on 3/8/2022. 3. Education: The Administrator and Director of Nursing initiated education to all nursing and housekeeping staff on 2/28/2022. Education to include:	

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F 550	Continued From page 2 coded for always being incontinent. Review of progress note dated 6/3/21 revealed Reside #75 stated to a Nurse "please make a note in my chart that I do not want to be bathed using pillowcases to wash and dry my body." The note further revealed Nurse would speak to administration about this issue. An interview conducted with Resident #75 on 2/27/22 at 11:05 AM revealed that morning she had to wait for incontinence care because the nurse aide had to wait on washcloths. Resident #75 revealed there had been a shortage of linens for several months and nursing staff frequently had trouble finding towels and washcloths to clean residents. Resident #75 indicated nursing staff would use pillowcases and cut up towels to clean her. Resident #75 started to cry and stated she felt like she was being treated like a dog and the facility did not care for her wellbeing. An interview conducted with Nurse Aide (NA) #10 on 3/1/22 at 10:11 AM revealed she had taken care of Resident #75 on 2/27/22 and was unable to complete Resident #75's care when the resident requested because she did not have enough washcloths to clean Resident #75. NA #10 stated Resident #75 had to wait for over an hour without a brief until washcloths could be found. NA #10 indicated this happened often with multiple residents over the last seven months. It was further revealed Resident #75 expressed to NA #10 that she was upset and frustrated and felt the facility did not care. An interview conducted with the Housekeeping Director on 3/1/22 at 9:50 am revealed she had been working in the facility for about three weeks	F 550	" Schedules for laundering linen " Linen distribution, to assure ample supply for the teams & residents " Proper usage of linen, (i.e., do not use pillowcases for washcloths, towels as a substitute for pillowcases, etc.) " Timely incontinent care and proper use of linen " Use if incontinence care products -> i.e. wipes, chuck pads. All education to be completed by March 28,2022. All new hires will be educated upon hire. 4. Monitoring: Administrator or/and or housekeeping will audit linen to verify the facility is maintaining enough clean linen to provide incontinence care and other activities of daily living 5x per week x 4 weeks; 3x per week x 4 weeks, and then weekly to ensure appropriate standards have been met. Additionally, said results will be reviewed and discussed in quarterly Quality Assurance and Performance Improvement meetings by Housekeeping Director to audit processes x 3 months. Revisions made as necessary. 5. Completion date 3/28/22	

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F 550	Continued From page 3	F 550		

and the facility had been very short on linens such as wash cloths and sheets since she had started. The Housekeeping Director further revealed nursing staff complained of not having enough linens and she would be ordering more.

An interview conducted with the Unit Manager on 3/1/22 at 3:40 PM revealed there had been a shortage of linens for residents, and this was an ongoing issue for several months. The Unit Manager further revealed Resident #75 had complained about not having enough washcloths when receiving care. The Unit Manager indicated she had gone to the housekeeping department when there was a shortage of linens to make them aware more linens were needed on the floor.

An interview conducted with the interim Director of Nursing (DON) on 3/2/22 at 5:50 PM revealed she had been in the facility for one week and was aware there was a shortage of linens. The DON stated an order of linens were made on 3/1/22. The DON further revealed she expected for residents to be changed and not have to wait on linens to be cleaned.

An interview with the Administrator on 3/2/22 at 6:55 PM revealed she had a conversation with Resident #72 recently and assured the Resident that the facility was working together to fix the linen shortage. The Administrator further revealed nursing staff had issues finding linens the last few months due to residents taking linens off the linen cart. The Administrator stated she expected for nursing staff to have all supplies in hand before giving care and for residents to feel comfortable and safe in the facility.

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F 583	Continued From page 4	F 583		
F 583 SS=E	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 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 observations and resident and staff	F 583	1. The corrective action will be	3/28/22

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F 583	Continued From page 5 interviews, the facility failed to ensure reisdent privacy by not having a privacy curtain for 1 of 5 residents reviewed for privacy (Resident #83). The findings included: Resident #83 was admitted to the facility on 02/03/21 and readmitted on 06/09/21 with diagnoses which included progressive nervous system disease, heart failure, diabetes mellitus type II and cerebral vascular accident (CVA) or stroke. Review of the annual Minimum Data Set (MDS) assessment dated 02/07/22 revealed Resident #83 was cognitively intact and required total assistance of 1 staff with bathing and extensive assistance of 1 staff with transfers and personal hygiene. Observation and interview on 02/28/22 at 11:20 AM revealed Resident #83 had no privacy curtain around her bed. The resident stated it had been that way since she had been moved into the room in December of 2021 (could not remember the exact date). She stated she received bed baths in her room instead of showers and there was no way to provide her privacy while getting her bed baths. In an observation and interview on 03/01/22 at 9:49 AM with the Housekeeping Director revealed that the Housekeeping Director was a new employee to the facility and had only been there for three weeks. She stated that she worked closely with the Maintenance Director, but it had been a week and a half since the Maintenance director left the facility. She stated that she expected all rooms to have the proper curtains on	F 583	accomplished for residents found to have been affected by the deficient practice. Housekeeping Director had privacy curtain placed in 106B ON 3/2/22. 2. All residents are currently at risk for deficient practice. The Housekeeping Director completed a 100% audit of all rooms on 3/4/2022 ensuring all rooms had curtains suspended from the ceiling that extend around the bed to provide total privacy. All rooms have been checked for curtains both window and privacy curtains. Curtains have been replaced as needed. 3. Education: Administrator and Housekeeping Director initiated education on 3/2/2022 all staff to report if privacy curtains are not present. Education to include reporting torn and/or stained curtains needing replacement, also included privacy and dignity must be maintained for all residents. Housekeeping staff was educated by Housekeeping Supervisor on following facility checklist for servicing a room and for rendering it ready for a new admission, to include privacy curtains and window treatments/drapery is present and operational. All education was completed by March 28,2022. New hires will be educated in this process upon hire. 4. Monitoring: Housekeeping Director will audit 5 rooms 5x weeks for 4 weeks, then 3x week x 4 weeks, then weekly x 4 weeks to ensure privacy curtains, window curtains and draperies are present. Housekeeping Director will discuss deficits and solutions at monthly Quality Assurance and Performance Improvement meetings x 3 months for	

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F 583	Continued From page 6 the window and privacy curtains. She stated that she depends on the housekeeper and all other staff to make her aware of any rooms needing privacy curtains. She further stated that it was unacceptable for residents not to have privacy curtains. On 03/02/22 at 2:53 PM an interview was conducted with the Administrator. The Administrator stated she would expect all residents to have privacy curtains. She indicated housekeeping staff should have reported the curtains were missing.	F 583	review and revision as needed. 5. Completion date 3/28/22	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		3/28/22

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F 584	Continued From page 7 §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 observations and staff interviews, the facility failed to maintain the walls in residents' rooms in good repair for 6 of 29 resident rooms (Rooms 108, 112, 119, 120, 122, and 130); failed to maintain a clean, sanitary, homelike environment for 15 of 32 resident rooms (Rooms 106, 108,109, 112, 113, 114, 119, 120, 122, 129, 130,212, 214, 216, and 222) observed to have scraped and cracked walls, peeling paint and plaster, dirty floors, stains on the walls, stained privacy curtains, exposed wires and cables, exposed nails, and missing outlet covers; failed to replace metal shoe molding with sharp exposed edge and screws for 1 of 1 resident rooms (Room 212); failed to clean dirt and debris from the heating and air conditioning unit and failed to properly fasten the covers to the heating and air conditioning units for 2 of 2 resident rooms (Room 113 and 222) ; and failed to maintain a proper working toilet in 1 of 1 rooms (Room 114);	F 584	1. To correct deficient practice of homelike environment, The Maintenance Team has addressed the concerns in sampled rooms, making the necessary repairs, to include foundational repairs, caulking holes in walls, cracked & or peeling paint and plaster, dirty floors, stained walls, exposed wires & nails, missing outlet covers, improperly working room furnishings and bathroom hardware. Missing shower curtains have been hung in shower rooms. Cable box has been checked for attachment and functionality, Commode in room 114 has been fixed to stop leakage. Hole in wall in room 122has been repaired, outlet over in 216 has been replaced, metal shoe molding at door of room 212 has been removed and replaced, tables with buckled laminate have been removed, shower stall tile	

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F 584	Continued From page 8 failed to maintain clean and sanitary tub rooms used for resident bathing in the west wing for 1 of 2 tub rooms (East and West wings); failed to have two curtains on window for privacy in 1 of 1 Residents room (Room 222); failed to replace the laminate on main dining room tables which had laminate buckled up on the edges with approximately 2 - 4 inche space between the top layer of laminate and top of table for 2 of 5 dining room tables observed; failed to ensure residents had clean linen in their rooms (Room 109) ; and failed to ensure residents had clean linen for 1 of 3 residents reviewed for a safe, clean, and homelike environment (Resident #77). The findings included: 1.a. Observations in room #112 on 02/27/22 at 11:01 AM revealed the no sheet rock on wall beside bathroom door approximately 12 inches x 28 inches , residue noted on the walls, curtain over heater stained approximately 3" x 2", privacy curtain stained across the bottom approximately one - third of the way up the curtain from the bottom, putty noted on wall across from bed not painted, hole in wall beside the sink approximately 1" x 1", exposed sheet rock noted beside the mirror 4 1/2" x 8", dust buildup on curtain located over the heating unit, scuff marks noted on bathroom door, hole in corner of plastic located at the corner of the bathroom door, and floors dirty. Subsequent observations on 02/28/22 at 9:55 AM and 03/1/22 at 1:12 PM of room #112 revealed the conditions remained unchanged. b. Observation in room #109 02/27/22 at 10:35	F 584	repaired. Repairs to be completed by 3/28/22 2. To ensure others will not be affected by deficient practice of failing to maintain walls in good repair as with rooms 108,112, 119, 120, 122and 130 ,and failure to maintain a clean sanitary environment as in rooms 106,108,109,112,113,114,119,120,122,129,130,212,214,216,and 222. All residents with the potential to be affected by the alleged deficit practice, the following has been achieved: The Maintenance Team has completed room to room rounding documenting areas that need to be corrected/cleaned/fixed and completing a projected repair schedule. 3. Interdisciplinary Team has conducted an in-service with the staff on using TELS to report improperly working items, items in disrepair, linen & maintenance concerns of the residents & staff. Direct Care Staff will get training on usage of the tub (West Hall), model # AFXXXXXX-XX, as the door to the tub slides under the tub for safety, appearing to be broken. All clinical staff with be educated by DON on sanitation and infection control as it relates to shower rooms and cleanliness. The Environmental Services Director will in-service the staff on company policy & protocols on cleanliness of the shower room; further, education will be provided to the maintenance department on the expectation of safety, orderly interior of the showers and community wide spaces. All education will be completed for all staff by March 28,2022. Those staff who do not attend will be removed from schedule	

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F 584	Continued From page 9 AM revealed a resident lying in bed with two pillows at the head of her bed. Both pillows were observed without pillowcases and the pillow behind the resident's head had a bath towel covering the top of the pillow underneath the resident's head. c. An observation conducted on 02/27/22 at 10:45 AM revealed a Nurse Aide trying to find linen on the linen cart located on the east wing. No linen was observed on the 3-shelf linen cart. d. Observations in room #114 on 02/27/22 at 11:06 AM revealed a toilet leaking in bathroom with large puddle of water noted to bathroom floor. Subsequent observations on 02/28/22 at 9:59 AM revealed the conditions remained unchanged. e. On 02/27/22 at 11:20 AM an observation was conducted of the laundry room. One staff member was in the laundry room washing clothes. The washer and dryer were running, and the laundry staff member was observed folding linen. Three pillowcases were observed lying on the folding table in which NA obtained to take to a resident. f. Observations in room # 222 on 02/27/22 at 11:30 AM revealed scuff marks noted to the bathroom door, floors were dirty, cable box hanging from the wall, and the heating and air conditioning unit noted with dirt and debris and cover not properly attached, and only one curtain on the window which provided no privacy from the outside. Subsequent observations on 02/28/22 at 10:02 AM and 03/01/22 at 9:07 AM revealed the conditions remained unchanged.	F 584	pending completion of mandatory education. 4. The Maintenance Director or designee will round 5x per week x 4 weeks; 3x per week x 4 weeks, and then weekly, paying special attention to the community concerns, repairs, and the timeliness of repairs. Administrator will check TELS weekly for the completion of work orders for a total of 3 months or until processes improve. Results of audits will be presented to Quality Assurance Performance Improvement Committee at monthly QAPI meeting by the Administrator until substantial compliance is met. 5. Completion date 3/28/22	

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g. Observations in room #113 on 02/27/22 at 12:15 PM revealed cable box not attached to the wall, and heating and air conditioning unit had dirt and debris inside the unit. Heat on the unit not working properly. Subsequent observations on 02/28/22 at 11:22 AM and 03/01/22 at 1:23 PM revealed the conditions remained unchanged.

h. On 02/27/22 at 12:35 PM an observation was conducted of the linen cart for 100/200 halls. No linen was observed on the cart for staff to obtain for residents.

i. Observations in room #122 on 02/27/22 at 3:12 PM revealed large hole at the bottom of the wall near the bathroom. Subsequent observations on 02/28/22 at 11:20 AM and 03/01/22 at 1:28 PM revealed the conditions remained unchanged.

j. Observations in room #216 on 02/27/22 at 3:49 PM revealed exposed wires with missing outlet cover on wall behind the bed. Subsequent observations on at 03/02/22 at 1:25 PM revealed the conditions remained unchanged.

k. Observations in room #212 on 3/1/22 at 3:00 PM revealed metal shoe molding with sharp edges and screws exposed.

l. Observations conducted on 02/27/22 through 03/01/22 revealed no extra linens were observed in sampled resident rooms.

An interview with the Housekeeping Director on 03/01/22 at 9:49 AM revealed she had been working at the facility for 3 weeks. She was unaware that Resident room #222 did not have two window curtains. She stated that was unacceptable and all resident rooms should have

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privacy curtains and two window coverings to provide privacy. In addition, she stated that she will have Maintenance Director to add the curtains to room #222. She stated the facility was very short on linen and it needed it be replaced. The Housekeeping Director stated she put in an order for linen on 02/27/22. The interview revealed when she came into the building in the mornings staff would come to her and tell her they didn't have enough linen on the halls to take care of the residents. The Housekeeping Director stated the previous Housekeeping Director did not keep up with linen orders and that was the reason the facility was short. The interview revealed each Nurse Aide was only provided with 2 wash cloths per resident so first shift was often having to use second shift NA's linens leaving second shift with no clean linen. She stated it was unacceptable for Resident's to have to sleep without a pillowcase.

Review of the facilities linen order form revealed an order was placed on 03/01/22 for additional linen for the facility. No order for linen had been placed on 02/27/22.

An interview and environmental tour on 03/01/22 at 12:07 PM with the Maintenance Director (MD) revealed today was his second day working at the facility. He stated that he would make repairs as he noticed them but also relied on notification from staff when repairs were need. He explained that he is aware the building is an older building and in much need of some repairs.

An interview conducted on 03/02/22 at 5:53 PM with the Director of Nursing revealed a linen shortage had been discussed last week and she felt like it was from residents hoarding linens in their room. The interview revealed she had

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conducted rounding last Thursday and saw extra linen in an ambulatory resident's room. The DON stated residents shouldn't have to lay in their beds without pillowcases.

An interview conducted on 03/02/22 at 6:25 PM with the Administrator revealed she had received calls on the weekends from staff telling her they didn't have any clean linen. She stated she had conducted rounding at night a few nights ago and a staff member stated to her they had no clean sheets. The Administrator stated she felt like they had no clean linen because the residents would hoard the linen in their rooms because they felt like they were not going to have enough. She further stated that was the mind set of some of the residents in the facility that they needed to stock up on items so they would not come up short. She stated moving forward the facility was going to fill the linen carts daily and put them behind a locked door. The Administrator also revealed facility wide improvements were being done and explained facility staff completed weekly compliance rounds to identify any potential issues. The Administrator stated she would have expected for staff to notify the Maintenance Director when repairs were needed, and the new Maintenance Director is trying very hard to get all the repairs done in a timely manner. She further stated that it is unacceptable for any Resident rooms not to have two curtains on the windows to provide privacy.

2. a. Observations of the shower room located on the west wing on 02/28/22 at 4:05 PM revealed one of the tubs was missing a door, had a hairbrush, comb, wash basin and black debris in the bottom of the tub. A used stained N95 mask, a surgical mask, black curly hairs, a can labeled

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"Blue Mist", a box labeled "Dove for Men", a plastic bottle without a lid, a clothes hanger, and a razor was noted under the shower stretcher with blue netting. A corner of tiled shower stall was chipped and broken, grout in the shower stall is missing in places.

Subsequent observations of the west wing shower room on 03/2/22 at 12:53 PM revealed the conditions remained unchanged.

3. a. Observations of the main dining room on 03/02/22 at 1:00 PM revealed two dining tables had laminate bucked up on the edges with approximately 2 - 4 inches space between the top layer of laminate and top of table.

Interview with the Administrator on 03/02/22 at 2:50 PM revealed the facility recently started using the dining room again since COVID. She stated that the facility had new tables in the storage building and would replace the old tables as soon as possible.

A walking round and joint interview was conducted with the Administrator, the assistant maintenance director and Maintenance Director on 03/02/22 at 2:30 PM. The Maintenance Director revealed he had only been in his position about three days. 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, and Maintenance Director stated that they were aware of the dirty walls, which were related to the housekeeper's spraying sanitizer onto the walls. The administrator stated that housekeeping had been informed not to spray the walls. The

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Administrator further stated that the chemicals housekeeping was using caused the floors to be sticky. She stated housekeeping had since changed their chemicals. The Maintenance Director stated the scraped and cracked walls, peeling paint and plaster, dirty floors, stains on the walls, stained privacy curtains, exposed wires and cables, exposed nails, missing outlet covers, sharp exposed edge of metal shoe molding, dirty heating and air conditioning units, exposed wires, loose outlet covers, missing outlet covers, and laminates on the dining room tables were unacceptable and should have been fixed when found. The Administrator further added that all staff will be re- educated on how to notify the maintenance department with any repair issues. The Administrator and Maintenance Director both stated nursing and /or housekeeping staff should have noticed the condition of the shower rooms and notified the Maintenance Director.

During an interview on 03/02/22 at 4:00 PM, the Regional Director of Operations explained the corporation had a Maintenance Performance Plan in place. She stated the facility had been without a Maintenance Director until recently and the Assistant Maintenance Director was doing the best that he could.

Review of the Maintenance Performance Plan with the Regional Director of Operations revealed that the facility currently had a maintenance checklist which included patching holes, painting, checking al sinks and toilets for leaking. The plan included checking three rooms a day starting 11/8/2021. The Director of Operations further stated that the facility had been without a Maintenance Director therefore these findings had not been corrected.

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2. Resident #77 was admitted into the facility on 02/24/21.

Resident #77's quarterly Minimum Data Set (MDS) dated 12/10/21 revealed she was alert and oriented requiring limited assistance of one staff member for most activities of daily living (ADL).

An observation conducted on 02/27/22 at 10:35 AM revealed Resident #77 lying in bed with two pillows at the head of her bed. Both pillows were observed without pillowcases and the pillow behind the resident ' s head had a bath towel covering the top of the pillow underneath the resident ' s head.

An interview conducted with Resident #77 on 02/27/22 at 10:37 AM revealed she had asked for a pillowcase 3 days prior but was told the facility did not have any clean linens and did not have any pillowcases. She stated she had laid on a towel on her pillow for the last 3 days. Resident #77 stated that wasn't the first time the facility hadn't had clean linens that it occurred frequently.

An observation conducted on 02/27/22 at 10:45 AM revealed Nurse Aide (NA) #8 standing at the linen cart going through a clear bag half full of linen. No other linen was observed on the 3-shelf linen cart.

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An interview was conducted on 02/27/22 at 11:13 AM with NA #8. She stated she was at the linen cart trying to find a pillowcase for a resident but was unable to find one. NA #8 stated there was one half full bag of mixed linen on the linen cart including a fitted sheet, top bed sheet and a few towels. The interview revealed that linen was sometimes short in the facility and had become a problem.

On 02/27/22 at 11:20 AM an observation was conducted of the laundry room. One staff member was in the laundry room washing clothes. The washer and dryer were running, and the laundry staff member was observed folding linen. Three pillowcases were observed laying on the folding table in which NA #8 obtained to take to Resident #77. The laundry staff member told NA #8 when the linens were clean, she would bring out more to the NA's.

On 02/27/22 at 12:35 PM an observation was conducted of the linen cart for 100/200 halls. No linen was observed on the cart for staff to obtain for residents.

Observations conducted on 02/27/22 through 03/01/22 revealed no extra linens were observed in sampled resident rooms.

An interview conducted on 03/01/22 at 9:49 AM with the Housekeeping Director revealed she had been working in the facility for 3 weeks. She stated the facility was very short on linen and it needed it be replaced. The Housekeeping Director stated she put in an order for linen on 02/27/22. The interview revealed when she came into the building in the mornings staff would come

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to her and tell her they didn't have enough linen on the halls to take care of the residents. The Housekeeping Director stated the previous Housekeeping Director did not keep up with linen orders and that was the reason the facility was short. The interview revealed each Nurse Aide was only provided with 2 wash cloths per resident so first shift was often having to use second shift NA ' s linens leaving second shift with no clean linen. She stated it was unacceptable for Resident #77 to have to sleep without a pillowcase.

Review of the facilities linen order form revealed an order was placed on 03/01/22 for additional linen for the facility. No order for linen had been placed on 02/27/22.

An interview conducted on 03/01/22 at 3:04 PM with NA#5 revealed she worked first shift coming into the building around 6:30 AM. She stated there were no clean linens when she came on shift in the mornings because the laundry staff member did not come in until 8:00 AM and she would have to wash the linens before supplying the NAs with them. NA #5 stated she usually didn't have clean linen until around 10:00 AM and they were only given a small amount for the residents until 3:00 PM. She stated the 3:00 PM linen was for second shift, but first shift was having to use them because they didn't have enough. The interview revealed third shift often had no clean linen.

An interview conducted on 03/01/22 at 4:06 PM with NA #8 revealed she worked second shift and sometimes stayed over to third shift. She stated they had sometimes run out of linen on second shift and on third shift there were times where

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F 584	Continued From page 18 they had no linen at all. The interview revealed linen being short in the facility happened often. An interview conducted on 03/02/22 at 5:53 PM with the Director of Nursing revealed a linen shortage had been discussed last week and she felt like it was from residents hoarding linens in their room. The interview revealed she had conducted rounding last Thursday and saw extra linen in an ambulatory resident's room. The DON stated residents shouldn't have to lay in their beds without pillowcases. An interview conducted on 03/02/22 at 6:25 PM with the Administrator revealed she had received calls on the weekends from staff telling her they didn't have any clean linen. She stated she had conducted rounding at night a few nights ago and a staff member stated to her they had no clean sheets. The Administrator stated she felt like they had no clean linen because the residents would hoard the linen in their rooms because they felt like they were not going to have enough. She further stated that was the mind set of some of the residents in the facility that they needed to stock up on items so they would not come up short. She stated moving forward the facility was going to fill the linen carts daily and put them behind a locked door. Observations conducted on 02/27/22 through 03/01/22 revealed no extra linens were observed in sampled resident rooms.	F 584		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		3/30/22

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F 655	Continued From page 19 §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 20 (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 interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission for 2 of 2 residents (Resident #339 and #390) reviewed for activities of daily living (ADL). The findings included: 1. Resident #339 was admitted to the facility on 2/10/2022. Admission diagnoses included respiratory failure and chronic obstructive pulmonary disease (COPD). Resident #339 was reliant on oxygen. Review of the electronic medical record revealed a care plan dated 2/15/2022 that included code status, a discharge plan and adjustment to facility. The admission Minimum Data Set dated 2/17/2022 revealed Resident #339 was cognitively intact and totally dependent on one person for bathing and required supervision of one person for personal hygiene. Resident #339's care plan was updated on 2/23/2022 to include COPD and the use of oxygen. Interview with the interim Director of Nursing (DON) on 3/2/2022 at 5:54 PM revealed she was an agency DON. The DON stated she expected the admitting nurse to complete a 48-hour care plan. The DON further expected the care plan to be reviewed and discussed at the next morning's	F 655	1. The corrective action will be accomplished for the residents found to have been affected by deficient practice, resident #339 and resident #390 have comprehensive care plans in place as of 3/28/22 completed by the Minimum Data Set Nurse. 2. All residents are currently at risk for deficient practice. An audit was conducted by The Director of Nursing on 3/2/2022 on residents admitted over the last 21 days (about 3 weeks) to verify baseline care plan was initiated within 48 hours of admission. No other residents were identified to be affected. 3. Education: Director of Nursing provided education to licensed nursing staff on policy of completing baseline within 48 hours of admission. All new admissions will be reviewed daily during clinical meetings by Nurse Management to verify completion. This education was completed by March 30,2022. New hires will be educated in this process upon hire. 4. Monitoring: The Director of Nursing and/or Unit Manager will audit all new admissions 5x week x 4 weeks, 3x week x 4 week, and weekly x 4 weeks to verify completion of baseline care plans within 48 hours of admission. Director of Nursing will bring audits to monthly Quality Assurance and Performance Improvement meetings monthly x 3 months. Review and revision as needed.	

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F 655	Continued From page 21 clinical meeting. Interview with the facility Administrator on 3/2/2022 at 6:25 PM revealed she expected baseline care plans to be completed within 48 hours. 2 .Resident #390 was admitted to the facility on 2/16/22 with diagnoses that included cerebrovascular accident with right sided hemiplegia with right hand contractor, heart failure, and Alzheimer's disease. The admission/5-day Minimum Data Set (MDS) dated 2/25/22 had not been completed at the time of the survey. Resident #390 was cognitively intact and required extensive assistance with bed mobility, dressing, hygiene, transfer, and bathing. Review of Resident #390's electronic medical record revealed a base line care plan dated 2/21/22 for resident willing to remain at the facility. Further review of Resident #390's electronic medical record revealed no care plan, focus, goals, or interventions for cerebrovascular accident with right sided hemiplegia with right hand contractor. An interview with Resident #390 on 2/27/21 at 10:45 AM revealed Resident to be lying in bed with a hand roll in right hand. During the interview Resident #390 stated that she wanted to get out of bed but required assistance to get up. Resident stated that she cannot move her right side without assistance from staff.	F 655	5. Completion date 3/30/22	

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F 655	Continued From page 22 An interview with the Minimum Data Set Nurse on 3/2/22 at 9:26 AM revealed that the Admission's Nurse was responsible for initiating the baseline care plan within forty-eight hours of admission. She further stated that the Admissions Nurse no longer worked at the facility, and that The Director of Nursing could initiate the care plan in the absence of the admission nurse. The Admissions Nurse was unavailable for an interview on 3/1/22 at 11:55 AM. On 03/02/22 at 10:30 AM an interview with the Director of Nursing (DON) revealed that her expectation was that the baseline care plan would have been in Point Click Care (PCC) and completed within the designated timeframe.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		3/30/22

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F 656	Continued From page 23 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 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 observations, interviews, and record reviews the facility failed to implement a comprehensive care plan for 1 of 11 residents (Resident #389) reviewed for care plans. The findings included: Resident #389 was admitted to the facility on 12/1/2021 with diagnoses of diabetes. His admission Minimum Data Set dated 12/13/2021 revealed was cognitively intact and required extensive assistance of 1 person for personal hygiene. Review of Resident #389's care plan dated	F 656	1. The corrective action will be accomplished for the residents found to have been affected by deficient practice. MDS audited plan of care to ensure that plan reflects patient center goals for resident #339. Resident # 389 toenails were trimmed by the Registered Nurse Director of Nursing on 3/3/ 22. Resident has an appointment scheduled for 3/30/22 with the Podiatrist. 2. All residents are currently at risk for deficient practice. 100% audit conducted on care plans with interventions for podiatry visits. Any residents identified	

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F 656	Continued From page 24 12/13/2021 revealed a care plan focus included diabetes. Interventions included refer to podiatrist / foot care nurse to monitor / document foot care needs and to cut long nails. Observation of Resident #389 on 3/1/2022 at 10:57 AM revealed both feet were bare. Observation of Resident #389's feet revealed a thickened right great toenail, tan in color with a craggy surface. The right great toenail protruded approximately ½ inch above the surface of the nail bed. Observation of the left great toenail revealed it was thickened, tan / brown in color and extended off the nail base at a 90-degree angle at a length of approximately 1 inch. Interview with Resident #389 on 3/1/2022 at 10:59 AM revealed he really wanted someone to cut his toenails. He further indicated the length of his toenails made wearing socks and shoes difficult. Interview with the Director of Nursing (DON) on 3/2/2022 at 5:54 PM revealed she expected Nursing staff to follow care plans as written. The DON expected residents whose nails required special equipment to be seen by podiatry services. The DON could not explain why Resident #389 was not on the list of residents to be seen by the podiatrist. Interview with the Facility Administrator on 3/2/2022 at 6:25 PM revealed she expected Nurses to provide care according to care planned interventions. The Facility Administrator stated she did not know why the resident was not on the podiatrist list.	F 656	needing podiatrist placed on upcoming podiatry list. Audit completed 3/22/2022 by Director of Nursing and Minimum Data Set nurse. 3. Education: The Minimum Data set Nurse and the Director of Nursing provided education for licensed nursing staff on implementing the comprehensive care plan related to podiatry services and Unit Managers educated to inform the Social Worker of residents needing podiatry services completed 3/30/2022. All new hires will be trained in this process at time of hire. 4. Monitoring: The Director of Nursing and/or Unit Managers to verify interventions are implemented for podiatry services. Will audit 5 residents 5 x week x 4 weeks, then 3 x week x 4 weeks, then weekly accuracy x 4 weeks. Director of Nursing will bring findings of audits to monthly Quality Assurance and Performance Improvement meetings monthly x 3 to discuss necessary interventions/recommendations and make changes as needed. 5. Date of compliance 3/30/22	
F 677 SS=E	ADL Care Provided for Dependent Residents	F 677		3/30/22

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F 677	Continued From page 25 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 observation, interview and record review the facility failed to provide hair washing and nail care for 3 of 11 residents (Resident #339 - hair washing, Resident #83 - hair washing, and Resident #144 - hair washing and nail care) reviewed for assistance with activities of daily living (ADL). The findings included: 1. Resident #339 was admitted to the facility on 11/19/2021 with re-entry on 2/10/2022. Admission diagnoses included respiratory failure and chronic obstructive pulmonary disease. The admission Minimum Data Set dated 2/17/2022 revealed Resident #339 was cognitively intact and totally dependent on one person for bathing and required supervision of one person for personal hygiene. Observation and interview with Resident #339 on 2/27/2022 at 2:55 PM revealed hair that was stringy and was shiny and greasy. Resident #339 stated she had not had her hair washed since she had come to the facility. Resident #339 reached up to touch her hair and it all moved in one piece as if stuck together. Resident #339 stated she preferred her hair be washed 2 times weekly, but no one had offered to	F 677	1. The corrective action will be accomplished for residents found to have deficient practice residents #83 and #339 had hair washed on 3/3/2022 in beauty shop. Resident #144 had hair washed and nail care provided on 3/3/2022. Resident #144 scheduled to have toenails cut by podiatry on next visit 4/28/2022. Resident #89 hair washed in beauty shop weekly by nursing staff. Resident #339 will have hair shampooed during showers 2 x week and PRN in shower. Resident #144 will have hair washed in the shower twice a week and PRN. 2. For all residents with the potential to be affected by the alleged deficient practice, the following has been achieved: Activity Department to conduct audit with cognitively intact residents and interviews with responsible parties for cognitively impaired residents to ensure bathing/grooming references are being honored. Audit was completed by 3/39/22 3. Education: Director of Nursing educated licensed and certified staff on the facility□s ADL policy related to grooming, personal and oral hygiene as well as honoring preferences related to showers and hair washing. Education was completed on 3/29/22. All new staff will be	

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F 677	Continued From page 26 wash her hair. Interview with Nurse Aides (NA) #2 and #3 on 3/1/2022 at 8:51 AM revealed they provided showers for residents based on a shower schedule. NAs #2 and #3 stated hair washing was part of the shower task. Interview with Resident #339 on 3/1/2022 at 3:01 PM revealed she received a good bed bath that day and therapy staff helped her comb her hair. Observation of Resident #339 at the time of the interview revealed her hair in a bun but remained stringy and greasy. Subsequent interview with Nurse Aide (NA) #2 on 3/1/2022 at 3:15 PM revealed she was familiar with Resident #339. NA #2 stated residents go to the shower on their scheduled days and receive bed baths or partial bed baths on all other days. NA #2 stated residents received hair washing as part of their shower unless they refuse. NA #2 could not explain why Resident #339 had not had her hair washed since admission. Subsequent interview with NA #3 on 3/1/2022 at 3:36 PM revealed she was regularly assigned to Resident #339. NA #3 stated Resident #339 was offered a shower on 2/28/2022, but the resident refused. NA #3 indicated the facility stocked a bath soap for providing hair washing while a resident was in the bed. NA #3 could not explain why Resident #339 had not been provided with hair washing since admission. Interview with the Director of Nursing (DON) on 3/2/2022 at 5:54 PM revealed she expected staff to provide hair washing according to the schedule and as requested by the residents.	F 677	trained on hire. System put in place: the Unit managers will verify showers and resident□s hair washed as scheduled and as needed. Findings will be reported daily during clinical meeting. 4. Monitoring: The Unit manager will audit five random residents for showers and hair washing 5x per week for 4 weeks, 3 x per week for 4 weeks and 3xper week for 2 weeks. The Director of Nursing will bring results of audits to Quality Assurance and Performance Improvement meetings monthly for review and recommendations for a duration of 3 months or until process improvements. Changes will be made as needed. 5. Completion date 3/30/22	

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Interview with the facility Administrator on 3/2/2022 at 6:25 PM revealed she expected residents to receive hair washing on schedule or as needed or requested by the resident.
2. Resident #83 was admitted to the facility on 02/03/21 and readmitted on 06/09/21 with diagnoses which included progressive nervous system disease, heart failure, diabetes mellitus type II, and cerebral vascular accident (CVA) or stroke.

Resident #83 ' s annual Minimum Data Set (MDS) assessment dated 02/07/22 revealed she was cognitively intact with no behaviors and required total assistance of 1 staff with bathing and extensive assistance of 1 staff with transfers and personal hygiene.

Resident #83 ' s care plan dated 02/15/22 revealed a plan of care for progressive loss of functioning with no long-term negative outcome through the next review date of 05/15/22. The interventions included allowing resident to continue to complete tasks at her own pace as long as possible, assist with activities of daily living (ADL) as needed, bathing requires total assist with 1 staff, bed mobility requires limited to extensive assistance of 1 staff, call bell within reach, rehab services as ordered, and transfer assistance requires extensive assist with 1 staff.

Observation and interview on 02/28/22 at 11:20 AM of Resident #83 revealed her up in her wheelchair and dressed for the day. The resident stated she was receiving bed baths because she did not like getting in the shower but stated she had not had her hair washed in about 6 months. Her hair was pulled back in a small ponytail and appeared to be dry. She further stated her scalp

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was dry and itchy and she would like to have her hair washed to return the oil in her hair so it would not be so dry and flakey. Resident #83 indicated she had her bed bath on Saturday 02/26/22 but did not get her hair washed. She further indicated there had been a Nurse Aide (NA) who had worked at the facility but quit about 6 months ago and she had taken the resident into the beauty salon and washed her hair and braided it for her but said since she had left, the resident had not had her hair washed.

According to the shower schedule Resident #83 was scheduled for showers/bed baths on 2nd shift on Wednesday and Saturday.

Interview on 03/01/22 at 11:32 AM with NA #4 revealed she had cared for Resident #83 from 7:00 AM to 7:00 PM on several occasions. NA #4 stated she had not washed Resident #83's hair and said she was not aware she could have taken the resident in the beauty shop to wash her hair in the sink.

Interview on 03/01/22 at 2:56 PM with Nurse Aide (NA) #1 revealed she had cared for Resident #83 from 7:00 AM to 7:00 PM on several occasions. NA #1 stated the resident did not like to get showers because she didn ' t like going in the shower room and getting cold. NA #1 stated she preferred bed baths and stated she had not given her bed baths a lot but stated when she had she had not washed her hair. NA #1 stated she was not aware she could have taken the resident in the beauty shop to wash her hair in the sink.

Interview on 03/01/22 at 3:07 PM with NA #6 revealed she had cared for Resident #83 from 7:00 AM to 7:00 PM or 11:00 PM on numerous

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occasions. NA #6 stated the resident preferred bed baths over showers and stated she had not washed her hair during her bed baths. NA #6 further stated she had not thought about washing her hair in the beauty shop but could have if the resident had requested.

Interview on 03/02/22 at 5:54 PM with the interim Director of Nursing (DON) revealed she would have expected staff to wash Resident #83 ' s hair even if they had to do it in the bed. The DON stated washing resident ' s hair, shaving them, and changing their bed linens was all a part of their bath or shower. The DON further stated no one should go for six (6) months without having their hair washed and that was unacceptable.

Interview of 03/02/22 at 6:26 PM with the Administrator revealed she expected all residents to get their hair washed. She stated she was surprised Resident #83 had not mentioned it to her because she was very vocal and talked with the Administrator frequently. The Administrator indicated she would have washed her hair for her in the beauty shop if she had known Resident #83 had not had her hair washed in 6 months.

3. Resident # 144 was admitted to the facility on 02/15/22 with diagnoses which included neurological condition, diabetes mellitus type II, renal insufficiency, and hypoglycemia. The resident was admitted for rehabilitation services.

Resident #144's admission Minimum Data Set (MDS) assessment that was export ready dated 03/01/22 revealed she was cognitively intact with no behaviors and required extensive assistance of 1 staff with bathing and limited assistance of 1 staff with transfers and set up assistance of 1

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staff with personal hygiene.

Resident #144's care plan dated 03/01/22 revealed a plan of care for activities of daily living (ADL) self-care performance deficit related to generalized weakness. The interventions included check nail length and trim and clean on bath day and as necessary, provide sponge bath when full bath or shower cannot be tolerated, the resident requires hands on assistance of one staff to bathe and shower, the resident requires hands on assistance of 1 staff to move between surfaces, encourage the resident to use bell to call for assistance, praise all efforts at self-care and PT/OT evaluation and treatment as per MD orders.

Observation and interview on 02/27/22 at 2:56 PM of Resident #144 revealed her lying in bed on top of her covers with her clothes on. The resident ' s hair appeared greasy, and her nails were ¼ to ½ inch beyond the end of her fingers. Resident #144 stated she had been receiving bed baths and had not had a shower or had her hair washed for 2 weeks. She further stated she would like for her fingernails to be trimmed. She indicated she was getting bed baths twice a week but would like to get a shower and ger her hair washed.

According to the shower schedule Resident #144 gets showers/bed baths on 2nd shift on Wednesday and Saturday.

Observation and interview of Resident #144 on 02/28/22 at 3:00 PM revealed her up in her wheelchair sitting in her room and dressed for the day. Her hair still appeared greasy, and she stated it had not been washed and said her

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fingernails had not been clipped.

Observation and interview with Resident #144 on 03/01/22 at 11:28 AM revealed her resting in bed and stated she had been up today but had not had her hair washed or her nails trimmed. She stated she had not been in the shower room yet for a shower and to get her hair washed.

Interview on 03/01/22 at 11:32 AM with NA #4 revealed she had taken care of Resident #144 on several days. NA #4 stated she had not given Resident #144 a shower but had given her a bed bath. NA #4 stated she had not noticed the resident's fingernails needed clipping or that her hair needed to be washed. NA #4 further stated she would not be able to clip the resident's nails because she was diabetic but could request the nurse trim her nails. NA #4 indicated she was not sure why she had not given the resident a shower but said she had not.

Interview on 03/01/22 at 3:07 PM with NA #6 revealed she had taken care of Resident #144 on several occasions from 3:00 PM to 11:00 PM and from 7:00 PM to 7:00 AM on occasion. NA #6 stated she had given Resident #144 a bed bath but had not given her a shower. NA #6 further stated she had not noticed the resident's fingernails needing clipped and stated if she had she would have notified the nurse to trim them. NA #6 explained the resident was diabetic and she could not trim her fingernails. NA #6 further explained she had not noticed Resident #144's hair being greasy and said the resident had not mentioned it to her. NA #6 indicated she would make sure the resident received a shower on her next shower day and had her hair washed.

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F 677	Continued From page 32 Interview on 03/01/22 at 4:06 PM with NA #5 revealed she had taken care of Resident #144 on several occasions from 3:00 PM to 11:00 PM. NA #5 stated she had given Resident #144 a bed bath but had not given her a shower and washed her hair. NA #5 further stated she had not noticed the resident's fingernails needed clipping but stated she would not be able to clip them because she was diabetic. NA #5 stated if the resident had requested her nails be clipped, she would have notified the nurse so she could clip them. NA #6 indicated she could take the resident to the shower and wash her hair on her next scheduled shower day. Interview on 03/02/22 at 6:02 PM with the interim Director of Nursing (DON) revealed she expected residents to get showers or bed baths on their scheduled shower days and expected residents ' hair to be washed, residents who requested to be shaved and she expected fingernails to be trimmed by the NAs or the nurses if they were diabetic. Interview on 03/02/22 at 6:34 PM with the Administrator revealed Resident #144 was afraid to come out of her room when she was first admitted to the facility but stated that was not reason to not wash her hair for 2 weeks. The Administrator said she expected the resident to be showered and her hair washed as she wanted. She also indicated the nurses should trim her nails as requested and needed.	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment	F 687		3/30/22

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F 687	Continued From page 33 and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide nail care for 1 of 2 residents (Resident #389) reviewed for foot care. The findings included: Resident #389 was admitted to the facility on 12/1/2021 with diagnoses of diabetes. His admission Minimum Data Set dated 12/13/2021 revealed he required extensive assistance of 1 person for personal hygiene. Review of Resident #389's care plan dated 12/13/2021 revealed a focus on ADL self-care performance deficit. Interventions included check nail length and trim and clean on bath day. A second care plan focus included diabetes. Interventions included refer to podiatrist / foot care nurse to monitor / document foot care needs and to cut long nails. Review of the facility list of residents scheduled to see the podiatrist revealed Resident #389 was not on the list. The podiatrist had been in the facility on 2/17/2022.	F 687	1. The corrective action will be accomplished or the deficient practice. Resident # 389 toenails were trimmed by the Registered Nurse Director of Nursing on 3/3/ 22. Resident has an appointment scheduled for 3/30/22 with the Podiatrist. 2. The corrective action will be accomplished or the deficient practice. To ensure that residents receive proper treatment and care to maintain mobility, the facility will do a 100% audit of all residents present in facility by 3/28/2022. Nonemergent issues will be placed on inhouse podiatry list. Emergent cases will have appointments made with outside provider. This will be completed by March 30,2022. RCA revealed the resident was not added on the podiatry list due to social worker, who manages the podiatry appointments, was on leave and the facility did not efficiently identify new admissions who required podiatry services in the absence of the social worker. 3. Education: DON and Nursing Management will provide leadership	

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F 687	Continued From page 34 Observation of Resident #389 on 3/1/2022 at 10:57 AM revealed a thickened right great toenail, tan in color with a craggy surface. Observation of the left great toenail revealed it was thickened, tan / brown in color and extended off the nail base at a 90-degree angle at a length of approximately 1 inch. Interview with Resident #389 on 3/1/2022 at 10:59 AM revealed he really wanted someone to cut his toenails. He further indicated the length of his toenails made wearing socks and shoes difficult. Interview with the Director of Nursing (DON) on 3/2/2022 at 5:54 PM revealed she expected Nursing staff to perform nail care for diabetic residents unless special equipment was needed. The DON expected residents whose nails required special equipment to be seen by podiatry services. The DON could not explain why Resident #389 was not on the list of residents to be seen by the podiatrist. Interview with the Facility Administrator on 3/2/2022 at 6:25 PM revealed she expected Nurses to cut resident nails as needed or obtain referral to podiatry. The Facility Administrator stated she did not know why the resident was not on the podiatrist list.	F 687	regarding 100% audit. Nursing Management will provide education on personal hygiene, podiatric care, diabetic foot care, ADLs, hair washing, bathing/showering and proper completion of weekly skin assessments. Nurse Managers will notify Social Worker of any urgent podiatric needs. Appointments will be scheduled with outside provider and transportation arranged to get to appointment. 4. Monitoring: Nurse Managers will monitor ADL documentation, shower sheets and skin assessments 5x week for 4 weeks and bring findings to stand up meeting each morning. Nurse Managers will also review new admissions to determine if podiatry care is needed and have scheduled accordingly to ensure the deficient practice does not recur. Nurse Managers will then review 3x week for 4 weeks, then weekly x 4 weeks or until process is in place. DON will bring results of each audit/documentation to QAPI monthly, and recommendations discussed and revised accordingly. 5. Completion date 3/30/22	
F 691 SS=E	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with	F 691		3/28/22

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F 691	Continued From page 35 professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to seek an effective resolution to a leaking ostomy one of one resident (Resident #3). Findings Included: Resident #38 was admitted to the facility on 01/13/2021 with diagnosis which included Ileostomy status, diabetes, and hypertension. A review of the quarterly Minimum Data Set (MDS) dated 1/25/21 indicated Resident #38 was cognitively intact and required moderate assistance with majority of activities of daily living (ADL). The MDS revealed Resident #38 was occasionally incontinent of urine and had an ostomy for bowel. Review of care plan dated 10/26/2021 revealed the resident had an alteration in gastrointestinal status related to her ileostomy/ colostomy with interventions to include ensuring the ileostomy/colostomy bag was secured and monitor skin condition and report changes. The care plan also revealed the resident had impairment to skin integrity of the abdomen and stoma site related to contact dermatitis. Interventions included identifying and documenting potential causative factors and eliminate/resolve where possible. Provide stoma care daily and as needed as ordered. An observation and interview on 02/28/22 at 9:40	F 691	1. The corrective action will be accomplished for the resident related to care of resident #38□s ileostomy , the facility scheduled a facility visit from Gentell representative on 3/09/2022 to assess resident and provide education. Resident and staff education was provided in resident□s room. Training included use of stoma powder to help stop leakage, proper application to decrease frequency of appliance changes and decrease risk for further skin impairments. Director of Nursing scheduled appointment with surgeon for possible reversal of ileostomy on March 23,2022 per MD order. 2. All residents with urostomies, colostomies, and ileostomies are at risk for this deficient practice. A 100% audit of all residents with ostomies was completed March 24,2022 by Director of Nursing with no noted issues. Sites were assessed for integrity and functionality of appliances. 3. Education will be provided by Director of Nursing for all licensed nursing staff by March 28,2022 on maintaining a functional ostomy with minimal to no leakage. Colostomy education provided for all licensed nursing staff. Useful tips were shared with resident and staff at time of Gentell training on 3/9/2022. Nursing staff will be educated to ensure that the right size pouch accommodates the wafer. Education included colostomy	

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F 691	Continued From page 36 AM revealed Resident #38 sitting in the wheelchair, alert and oriented. The resident stated that she had excessive leakage with her ostomy. She stated that the facility changed her ostomy wafer sometimes three times a day. The Resident stated that she went through 10 ostomy bags in a two-day span. The Resident stated that the facility did not employee an ostomy nurse. She further stated that the facility failed to supply her with an ostomy nurse from an outside source. An interview conducted with the Unit Manager on 02/28/22 at 2:00 PM revealed that Resident #38 used an excessive number of bags in a two-day time span. The Unit Manager further revealed resident #38 had complained about not having enough bags when receiving care, and the resident was applying tape to the wafer. An interview was conducted with Central Supply on 2/28/22 at 2:30 PM which included an observation of the Central Supply closet. The Central Supply Clerk stated that Resident #38 would use a whole box of ostomy bags (which included 10 bags in a box) in a two-day span. She also stated that the resident was using different types of tape including wound vac drape. She stated that she had used all means necessary to get the staff all the supplies they needed to take care of the resident. An Interview with facility Physician was conducted on 02/28/22 at 4:40 PM. The physician stated that he was very aware of Resident #38's medical problems. He stated that the ostomy did leak, and the resident's bag and wafer had to be changed frequently. He further stated that he was personally calling the surgeon to obtain the resident a follow up appointment. He was	F 691	care policy. Resident educated on recommendations of appliance change which is every 3-5 days and as needed. Central Supply Clerk will ensure residents have necessary supplies. Any new staff will be educated upon hire of this process. 4. Unit Managers will monitor each resident ostomies with to assess skin integrity and leakage 5x week for 4 weeks, then 3x week for 4 weeks, then weekly x 4 weeks The results will be discussed monthly by Director of Nursing at Quality Assurance and Performance Improvement meetings reviewing resident centered goals and changes made as needed for 3 months. 5. Completion date 3/28/22	

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F 691	Continued From page 37 requesting the resident's ostomy to be reversed because that resident was now medically stable for the reversal. The Physician was unaware the facility did not have an ostomy trained nurse. An interview conducted with the Director of Nursing (DON) on 3/2/22 at 5:50 PM revealed that the facility did not employ an ostomy trained nurse. She further stated that the facility should have reached out to the local hospital and requested assistance from their ostomy nurse. An interview with the Administrator on 3/2/22 at 6:55 PM revealed Resident #38 had issues with leaking ostomy. The Administrator stated that the Resident picked at her wafer and made it become loose. The administrator stated that the facility does not employ an ostomy nurse, and she is going to reach out to the local hospital and inquire if they had an ostomy specialist available that could give instructions to the staff on ostomy care. She stated that the facility had exhausted all means necessary trying to accommodate the resident's needs. They even ordered special tapes for the resident to use on the ostomy wafer. The Administrator further revealed she expected for nursing staff to have all supplies in hand before giving care and for Residents to feel comfortable and safe in the facility.	F 691		
F 695 SS=D	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	F 695		3/28/22

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F 695	Continued From page 38 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 resident, staff and the Medical Director, the facility failed to administer oxygen as prescribed by the physician for 1 of 2 residents (Resident #80) reviewed for oxygen therapy. The findings included: Resident #80 was initially admitted to the facility on 1/30/15 and re-admitted on 2/9/22 with diagnoses that included chronic obstructive pulmonary disease. A physician order dated 4/26/21 for Resident #80 indicated oxygen therapy at 2 liters via aerosol tracheostomy continuously. A tracheostomy is an opening surgically created through the neck into the trachea (windpipe) to allow direct access to the breathing tube. Resident #80's care plan revised on 11/2/21 indicated Resident #80 had oxygen therapy related to respiratory illness. Interventions included oxygen settings: oxygen at 2 liters via cool aerosol tracheostomy with 36% humidifier air continuously. The quarterly Minimum Data Set (MDS) assessment dated 2/4/22 indicated Resident #80 was cognitively intact and required extensive physical assistance with bed mobility and transfer. Resident #80 received oxygen and tracheostomy care while a resident at the facility.	F 695	1. The corrective action will be accomplished for the resident found to have been affected by the deficient practice. Resident #80 on March 2,2022 was assessed, deemed competent and capable of self-oxygen regulation as evidenced by proper return demonstration and verbalization. On March 3 and March 4,2022 the concentrator and portable tank were found to be on 2 l/min as ordered .Resident #80 received order from physician on 3/22/2022 to include self trach care and oxygen regulation. Resident has personal pulse oximeter and can demonstrate proper usage. BIMS score of 15. It is documented and care planned that resident has been educated and can accurately provide return demonstration of trach care, trach suctioning and management of oxygen regulation. Resident abilities will be reassessed quarterly and PRN. 2. All residents currently on oxygen therapy are at risk for the deficient practice. A 100% audit of all residents was performed by Unit Managers identifying residents currently on oxygen therapy per physician orders. For each resident identified the Kardex and care plan were updated by the Minimum Data Set Nurse. 100% audit done by resident's dependent on supplementary oxygen were found to have correct settings related to MD orders.	

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F 695	Continued From page 39 Resident #80's Medication Administration Record (MAR) for February and March 2022 included an order for oxygen therapy at 2 liters via aerosol tracheostomy continuously. The MAR also indicated Resident #80's oxygen saturation was checked every shift and ranged from 96-98%. The nurses initialed the MAR every shift to confirm the oxygen setting and documented Resident #80's oxygen saturation. Nurse #5 initialed Resident #80's MAR on 2/28/22 and 3/1/22 confirming the oxygen was set at 2 liters per minute. An observation of Resident #80 on 2/27/22 at 10:23 AM revealed Resident #80 had a tracheostomy collar connected to an oxygen concentrator which was running at 3 liters per minute. Resident #80 was lying in bed with her head elevated. During the observation, an interview with Resident #80 revealed she did her own tracheostomy care which included cleaning and changing the inner cannula, cleaning the tracheostomy area, changing the tracheostomy tie, and changing the drain sponge. Resident #80 stated she did not mess with the settings on her concentrator. The nurses checked her oxygen saturation once a shift and they were supposed to check on the oxygen setting on her concentrator. A second observation of Resident #80 on 2/28/22 at 9:44 AM revealed her lying in bed asleep with her tracheostomy collar connected to an oxygen concentrator which was set at 3 liters per minute. A third observation of Resident #80 on 3/1/22 at 11:09 AM revealed her lying in bed asleep with her tracheostomy collar connected to an oxygen concentrator. The concentrator was running at 3 liters per minute.	F 695	3. The following measures were put in place on March 8,2022 to ensure Plan of Correction is effective and remains in compliance. All licensed nursing staff were re-educated by the Director of Nursing to ensure all residents who require oxygen therapy are provided the necessary services to maintain the correct ordered settings, frequent checks of settings of oxygen concentrators/portable oxygen tanks every shift to ensure the correct setting is in place, and that only licensed nurses are trained to make any changes to settings in accordance with the physician order. New hires will be educated upon hire :Agency staff will be educated via agency orientation packet 4. Monitoring: Progress of audits will be discussed in morning stand -up meeting with the Interdisciplinary Team. Beginning 3/28/2022 the Unit Managers will audit all residents on oxygen on their respective units to ensure settings match physician orders. These audits will occur 5x week for 4 weeks, 3x week for 4 weeks and then weekly for 4 weeks to ensure properly regulated/settings correct. The Director of Nursing will bring this information to Quality Assurance and Performance Improvement meeting monthly for review to discuss any trends and solicit suggestions/recommendations as needed. 5. Completion date 3/28/22.	

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F 695	Continued From page 40	F 695		

An observation with Nurse #5 of Resident #80 on 3/1/22 at 2:17 PM revealed that Resident #80's oxygen concentrator was set to 3 liters per minute via aerosol tracheostomy. Nurse #5 changed the oxygen setting to 2 liters per minute and stated it should have been set to 2 liters as ordered by the physician. During the observation, Nurse #5 asked Resident #80 if she had messed with her oxygen concentrator setting and Resident #80 stated she did not, and she did not know who had set her oxygen to 3 liters per minute.

A follow-up interview with Nurse #5 on 3/1/22 at 2:20 PM revealed she took care of Resident #80 on 2/28/22 and 3/1/22. She stated she had only glanced at her concentrator just to make sure she still had humidifier fluid. Nurse #5 stated it didn't dawn on her to check on Resident #80's oxygen concentrator setting to make sure it was running as ordered by the physician. She had documented on the MAR that Resident #80 received 2 liters of oxygen on 2/28/22 and 3/1/22, but she didn't pay attention to the oxygen concentrator setting when she checked Resident #80's oxygen saturation on 2/28/22 and 3/1/22 around 8:30 AM and it was 97%.

Attempts were made to contact Nurse #9 who worked with Resident #80 on 2/27/22 but they were unsuccessful.

A phone interview with the Medical Director (MD) on 2/28/22 at 4:31 PM revealed he expected the nurses to deliver Resident #80's oxygen at the rate it was ordered. The MD stated Resident #80 was meticulous about her own care, but he had never seen her out of the bed and did not think Resident #80 was able to get up out of her bed

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F 695	Continued From page 41 unassisted and change her oxygen setting by herself. The MD stated she might have asked a nurse to change her oxygen to 3 liters per minute, but the nurse should have communicated this to him so that the order for her oxygen would have been changed. An interview with the Director of Nursing (DON) on 3/2/22 at 6:15 PM revealed she had no idea whether Resident #80 or a nurse had set Resident #80's oxygen concentrator at the wrong setting but the nurses should have checked Resident #80's oxygen rate throughout their shift and made sure that it was being given at the rate ordered by the physician. The DON stated the nurses should have checked the correct rate before initialing the MAR to make sure the resident was getting the correct rate ordered by the physician. An interview with the Administrator on 3/2/22 at 7:01 PM revealed she knew Resident #80 had not been able to get up out of the bed by herself and she could not have changed the settings on her oxygen concentrator, but the nurses should have made sure her oxygen was delivered per physician's order.	F 695		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and Medical Director (MD) interviews, the facility failed to prevent a medication error by not administering	F 760	1. The corrective action will be accomplished for resident affected by deficient practice. Resident #83 had	3/28/22

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F 760	Continued From page 42 Trulicity (an injectable diabetes medication given once a week that helps lower blood glucose levels in type II diabetes) to a resident (Resident #83) for four doses with two of the four doses being consecutive weeks for 1 of 1 resident reviewed for mediation errors. The findings included: Resident #83 was admitted to the facility on 02/03/21 and readmitted on 06/09/21 with diagnoses which included diabetes mellitus type II. Resident #83's annual Minimum Data Set (MDS) assessment dated 02/07/22 revealed she was cognitively intact and had insulin injections daily. Resident #83's care plan dated 02/15/22 revealed a plan of care for alteration in blood glucose due to insulin dependent diabetes mellitus type II. The interventions included administer medications as ordered, depression scale upon admission and quarterly, diabetes foot screen upon admission and quarterly, educate patient and/or family members related to Diabetes management and following nutritional recommendations, labs per physician order and prn for change in condition/manifestation of clinical signs or symptoms, observe for high blood sugar symptoms such as increased thirst, increased hunger, increased urinary output, observe for low blood sugar symptoms such as flushed face, sweating, change in usual mental status, lethargy, irritability, fruity breath odor, coma, nervousness, trembling, difficulty concentrating and lightheadedness, and report to the nurse/physician any changes in vision, decreased mental function, poor healing of	F 760	Nurse Practitioner complete medication review on 3/21/2022 with no changes made in regimen. Resident was noted to be on other hyperglycemic meds. Blood sugars reviewed with no changes made by NP. Pharmacy notified that facility will except responsibility for med cost and to send as scheduled. 2. All residents have the potential to be affected by the alleged deficient practice; therefore, the following has been achieved: 100% medication administration record audits performed by Director of Nursing AND Unit Managers on 3/22/2022 to identify missing medications or holes in documentation. During audit it was noted that ten undocumented administrations were observed MD and NP notified of findings. 3. Director of Nursing to educate licensed nursing staff on processes for medication reordering, availability and administration of medications as ordered to include licensed nurse will follow pharmacy reordering process and standard STAT cut-off times to ensure new medications orders are promptly entered in PCC, submitted to pharmacy via electronic order entry system, delivered from pharmacy and available for administration as ordered for next scheduled dose. In the event that medications are not available timely by pharmacy, the licensed nurse will notify the physician and utilize the Cubex back-up system to ensure timely administration as ordered by 3/28/2022. Any newly hired licensed nursing staff will be trained upon hire. New agency	

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F 760	Continued From page 43 wounds, dizziness, dehydration, vomiting, cardiac symptoms and renal dysfunction. Observation and interview on 02/26/22 at 11:20 AM revealed Resident #83 up in her wheelchair in her room dressed for the day. Resident #83 stated she had missed four doses of her Trulicity from November 2021 through February 2022. Resident #83 further stated she could not understand why her medication was not here and available for her when she had been taking it for months. She indicated the nurses had told her it was not available to be given to her. She further indicated she had told the Medical Director (MD) (she could not remember when) that she had not received all her doses of Trulicity. Review of Resident #83's physician orders November 2021 through present revealed an order for Trulicity Solution Pen-injector 0.75 milligrams (mg) per 0.5 milliliters (ml) - inject 0.75 mg subcutaneously one time a day every 7 days for Diabetes Mellitus (DM) type II with hyperglycemia. Start date of 08/25/21. Review of Resident #83's Medication Administration Record (MAR) for November 2021 revealed she missed a dose of Trulicity on 11/17/21 with a blank block for the nurse ' s signature. Review of the nursing progress notes revealed there were no notes indicating why the medication had not been given. Review of the nursing schedule for 11/17/21 revealed Nurse #10 was assigned to care for the resident from 7:00 AM to 7:00 PM on that day. Phone interview was attempted with Nurse #10 on 03/01/22 at 10:21 AM, on 03/01/22 at 4:22 PM and 03/02/22 at 11:55 AM with no return call.	F 760	licensed nursing staff will be educated via their agency orientation packet. 4. Director of Nursing or Unit Manager to audit to ensure ordered medications are available, administered and documented on MAR as ordered by the physician including use of medication audit report missed documentation report and 24 hour report for 5 residents 5x week for 4 weeks, then 3x week for 4 weeks, then 1x week for 4 weeks. The Director of Nursing will bring results to Quality Assurance and Performance Improvement meeting monthly to present results and take recommendations on any process improvement for duration of three months to maintain compliance with residents being free from significant medication errors. 4. Completion date 3/28/22	

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Review of Resident #83's Medication Administration Record (MAR) for January 2022 revealed she missed a dose of Trulicity on 01/26/22 with a blank block for the nurse's signature. Review of the nursing progress notes revealed there were no notes indicating why the medication had not been given. Review of the nursing schedule for 01/26/22 revealed Nurse #3 was assigned to care for the resident from 7:00 AM to 3:00 PM on that day.

Interview on 03/01/22 at 3:36 PM with Nurse #3 revealed she could not recall why she had not given Resident #83's Trulicity on 01/26/22. She stated most likely it was because the medication was not available to be given on that day. Nurse #3 further stated she should have written a note in the progress notes indicating why she had not given the medication. Nurse #3 indicated she should have notified the pharmacy the medication was not available to be given but could not remember if she had contacted them on that day. She further indicated she should have written a note in the progress notes if she had contacted the pharmacy about the medication.

Review of Resident #83's Medication Administration Record (MAR) for February 2022 revealed she missed a dose of Trulicity on 02/02/22 (a second consecutive dose missed) with a blank block for the nurse's signature. Review of the nursing progress notes revealed there were no notes indicating why the medication had not been given. Review of the nursing schedule for 02/02/22 revealed Nurse #4 was assigned to care for the resident from 7:00 AM to 7:00 PM on that day.

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Interview on 03/02/22 at 9:21 AM with Nurse #4 revealed she could not recall why she had not given Resident #83's Trulicity on 02/02/22. She stated it must not have been available from the pharmacy on that day but stated she should have completed a progress note stating the medication was not available instead of leaving it blank and not writing a note. Nurse #4 further stated she should have notified the pharmacy the medication was not available to be given but could not remember if she had contacted them on that day. She indicated she should have written a note in the progress notes if she had contacted the pharmacy about the medication.

Review of Resident #83's Medication Administration Record (MAR) for February 2022 revealed she missed a dose of Trulicity on 02/23/22 with the block for the nurse ' s signature indicating "9" (which means "other / see nurse's notes. Review of the nursing progress notes revealed a note which read,"02/23/22 eMar - Medication Administration Note. Note Text: Trulicity Solution Pen-injector 0.75mg/0.5 ml - inject 0.75 subcutaneously one time a day every 7 days for DM type 2 with hyperglycemia - waiting on pharmacy." Review of the nursing schedule for 02/02/22 revealed Nurse #4 was assigned to care for the resident from 7:00 AM to 7:00 PM on that day.

Interview on 03/02/22 at 9:21 AM with Nurse #4 revealed she had not given Resident #83's Trulicity on 02/23/22 because it had not been available from the pharmacy. She stated that was why she had written a note indicating she was waiting on pharmacy for the medication. Nurse #4 further stated she should have called the NP or MD to get an order to give the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 46	F 760		

medication when the medication was received and should have called the pharmacy to let them know the medication was not available.

Phone interview on 02/28/22 at 4:38 PM with the Medical Director (MD) revealed he had been informed Resident #83 had not received her Trulicity on several days. He stated he would consider it a pretty significant med error since she had missed it on 4 occasions but said it was not detrimental to her since she was on other blood glucose lowering agents such as insulin. The MD further stated it was his expectation that residents received their medications as ordered.

A follow up interview on 03/02/22 at 10:24 AM with the Medical Director (MD) revealed there had been some issues at the facility with getting medications, but all the nurses needed to do was call and alternatives could have been ordered that were available or easier to obtain. The MD stated Resident #83 benefited from the blood glucose lowering properties of Trulicity as well as the cardiovascular benefits of the medication and needed to receive the medication as ordered.

Interview on 03/02/22 at 5:54 PM with the interim Director of Nursing (DON) revealed she expected nurses to look in the medication dispensary for the medications that were not available and if they were not available in the dispensary, they contact the pharmacy. The DON stated if the medication had to come from pharmacy, she expected the nurse or Unit Manager to notify the Medical Director (MD) or Nurse Practitioner (NP) for orders to give the medication when it arrived from pharmacy. According to the DON, Resident #83 should not have missed her Trulicity on 4 occasions and should have been provided the

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F 760	Continued From page 47 medication once it arrived from the pharmacy. Interview on 03/02/22 with the Administrator revealed she expected residents to receive their medications as ordered and would have expected the nurses to have found a remedy for the medication, so it was not missing on 4 occasions. The Administrator stated she expected all residents to be provided their medications as ordered by the providers.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		3/30/22

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F 761	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store unopened medication pens in the refrigerator, discard discontinued medications and date an opened medication pen in 3 of 4 medication carts (West Cart 2, East Cart 2, and East Cart 1). The findings included: a. An observation of West Cart 2 on 3/2/22 at 11:10 AM with Nurse #6 revealed an unopened and undated Insulin detemir pen that belonged to Resident #19 and was available for use. Insulin detemir is a type of insulin used to treat diabetes. The Insulin detemir pen was labeled as dispensed from the pharmacy to the facility on 2/6/22 and had a sticker that read "refrigerate until opened." Further observation of West Cart 2 revealed an opened Liraglutide pen which was dated 2/3/22 and belonged to Resident #80. Liraglutide is also an anti-diabetic medication. An interview with Nurse #6 on 3/2/22 at 11:12 AM revealed she did not know who took Resident #19's Insulin detemir pen out of the refrigerator and thought that another nurse might have done so since her other Insulin detemir pen was almost out. Nurse #6 stated Resident #19 received a dose of her Insulin detemir pen at bedtime but whoever took it out of the refrigerator should have dated it since it was only good for 28 days once it was taken out of refrigeration. Nurse #6 further stated that Resident #80's Liraglutide had been discontinued on 2/10/22 and should have been discarded then and not left in the medication cart available for use.	F 761	1.The corrective action will be accomplished for the residents found to be affected by the deficient practice .On 3/1/2022 improperly stored and discontinued insulins were removed for residents #4,#19,#21, #80 on East Cart #1, East Cart #2, and West Cart #1 by the Unit Managers. Licensed nurses were educated immediately by Director of Nursing on proper storage of All insulin on 3/1/2022. 2. All residents are at risk for deficient practice. A 100% audit of medication carts and storage areas was conducted by pharmacy for proper medication storage related insulin not dated when opened, discontinued medications including insulins removed from medication carts, and properly storing unopened insulins in the refrigerator. Any medications identified were removed and re-ordered by pharmacy if needed. 3. Education: Measures/Systemic changes put in place to ensure the deficient practice does not reoccur. 3/1/2022 the Director of Nursing educated the licensed nursing staff on the proper storage process. All new hires will be educated at time of hire on process. 4.Monitoring of corrected actions to ensure the deficient practice will not reoccur. To ensure medications are properly stored, The Director of Nursing and Unit Managers will audit using an audit tool 5x week for 4 weeks then 3x	

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F 761	Continued From page 49 An interview with Unit Manager #1 on 3/2/22 at 2:29 PM revealed all the nurses were responsible for checking the medication carts but the night shift nurses were supposed to check them each night. She stated a pharmacy consultant had just checked the medication carts on 2/28/22 and was not sure why there were still issues with West Cart 2. She further stated Resident #19's Insulin detemir should have been kept in the refrigerator until it was ready to be used and Resident #80's Liraglutide should have been discarded when the order was discontinued. b. An observation of East Cart 2 on 3/2/22 at 11:35 AM with Nurse #3 revealed an unopened and undated Liraglutide pen belonging to Resident #21. The Liraglutide pen was labeled as dispensed from the pharmacy to the facility on 2/5/22 and had a sticker that read, "refrigerate until opened." An interview with Nurse #3 on 3/2/22 at 11:37 AM revealed Resident #21 had another Liraglutide pen which she used to give her 9:00 AM dose and she discarded because she had used up the last dose. Nurse #3 stated she did not take the unopened Liraglutide pen out of the refrigerator and that it had already been in the medication cart even before she took over the medication cart. Nurse #3 stated she did not know when and who might have taken Resident #21's Liraglutide out of the refrigerator. An interview with Unit Manager #2 on 3/2/22 at 2:01 PM revealed the night shift supervisor was responsible for auditing the medication carts. She stated Resident #21's Liraglutide pen should not have been taken out of the refrigerator until it	F 761	week for 4 weeks, then weekly x 4 weeks for compliance. Unit Managers will bring findings to morning stand up meetings. The Director of Nursing will bring findings to Quality Assurance and Performance Improvement meetings monthly x 3 months. This also will be an ongoing process. Recommendations and results will be discussed at QAPI. 5. Completion date 3/30/22	

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F 761	Continued From page 50	F 761		

was ready to be opened and used.

c. An observation of East Cart 1 on 3/2/22 at 11:56 AM with Nurse #4 revealed an opened and undated Insulin glargine pen that belonged to Resident #4. The Insulin glargine pen was labeled as dispensed from the pharmacy to the facility on 12/27/21. Insulin glargine is a type of insulin used to treat diabetes.

An interview with Nurse #4 on 3/2/22 at 11:58 AM revealed that Resident #4 received a dose of Insulin glargine at bedtime, but she did not know when it had been taken out of the refrigerator or when it was opened. Nurse #4 stated the nurses were supposed to look at the dates of the insulin pens prior to administering the dose but she did not look at Resident #4's Insulin glargine because she did not have to administer it on her shift.

An interview with Unit Manager #2 on 3/2/22 at 2:01 PM revealed the night shift supervisor was responsible for auditing the medication carts. She stated Resident #4's Insulin glargine should have been dated when it was opened because it needed to be discarded after 28 days of being opened.

An interview with the Interim Director of Nursing (DON) on 3/2/22 at 6:15 PM revealed the nurses should keep medications in the refrigerator until they were ready to be used, date insulin pens when opened and discard medications that had been discontinued. The Interim DON stated she had just checked the medication carts on 2/27/22 but the nurses must have placed the undated and unopened medications in the medication carts after she had checked them.

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F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to date an opened bag of buttered garlic bread stored in the walk-in refrigerator failures had the potential to affect greater than a few, but less than all residents. The findings included: Initial tour of the kitchen was conducted on 2/27/2021 at 9:45 AM with Cook #1. Inspection of the walk-in refrigerator revealed an opened bag containing approximately 15 pieces of buttered garlic bread. There was no date on the bag to indicate when it was opened. Interview with Cook #1 on 2/27/2021 at 10:00	F 812	1. To correct deficient practice with food procurement and safety, Dietary staff were educated by Dietary Manager on 2/28/2022 and undated garlic bread was removed by Dietary Manager. 2. All residents are at risk for deficient practice. Dietary Manager conducted%100 audit of food storage on 2/28/2022 and no other items found. 3. Education: On 2/28/2022 education completed by Dietary for all dietary staff on proper food storage, presenting with proper open and use by date. New hires will be trained upon time of hire. 4. Monitoring: Dietary Manager and or Cook will audit food storage verifying open	3/28/22

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F 812	Continued From page 52 revealed the bag of bread was opened on 2/25/2022. Cook #1 stated the bag of bread should have had a date written on the bag indicating when it was opened. Interview with the Facility Administrator on 2/27/2022 at 3:56 PM revealed she had checked the menu and verified the buttered garlic bread had been opened on 2/25/2022 to be served with spaghetti. The Administrator stated she expected staff to date items when opened.	F 812	food is dated and labeled properly on all daily 5x week for 4 weeks, then 3x week x 4 weeks, then weekly x 4 weeks. Findings will be brought by dietary manager to stand up meetings daily and monthly Quality Assurance and Performance Improvement meetings x 3 months for review and revisions if necessary. 5. Completion date 3/28/22	
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review resident and staff interview, the facility failed to provide leadership and oversight to ensure effective systems were in place to ensure the facility had enough linen for resident care. This affected 1 of 6 residents reviewed for dignity (Resident #75). The findings included: This tag is cross referred to F550. Based on record review, resident and staff interview the facility failed to treat 1 of 6 residents in a dignified manner by not ensuring there was enough linen for incontinence care which made the resident feel like she was being treated like a	F 835	1. Pelican Charlotte will be administered in a manner that enables effective and efficient use of resources to help preserve dignity and well-being. This will be evidenced by: Leadership and oversight have been established in the hiring of a full time in a Full time Laundry/Housekeeping Director. Job responsibilities include ensure effective systems are in place to ensure the facility has enough linen for resident care. Prior to survey the IDT met to discuss said concern with plan of action put in place and encouragement of staff feedback. New linen was ordered and will continue to be ordered on a routine basis.	3/30/22

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F 835	Continued From page 53 dog and the facility didn't care about her (Resident #75).	F 835	2. All residents are at risk to be affected by deficient practice. Contract Company to provide increased staffing to cover off shifts in laundry to process linen in evenings making more clean linen available for residents. 3. Education: Residents will be educated in Resident Council regarding the linen distribution process and rationale for process. Residents will also be encouraged to use personal cleansing cloths(wipes) for incontinence care. All staff will be educated on linen process to include linen storage location, linen drop times, and proper procedures to ensure linen availability and undesirable use of linen to include incontinence care and throwing out soiled linen without on March 28,2022. New hires will be educated at time of hire. Administrator/Housekeeping Supervisor will educate all staff on linen processes by March 30, 2022. Housekeeping Supervisor was educated on linen process on 3/24/22 by Regional Housekeeping Supervisor and Administrator. Administrator/Housekeeping Supervisor will educate all staff on linen processes. 4. Monitoring: Housekeeping Supervisor will do monthly audits to determine approximate linen totals will report at monthly Quality Assurance and Performance Improvement meetings. Laundry Manager will ensure linen carts for off shifts are in place prior to her departure each day. Administrator/Housekeeping Manager will converse with staff 5x week for 4 weeks,	

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F 835	Continued From page 54	F 835	3x week for 4 weeks, then weekly for 90 days to ensure process remains effective and accept recommendations for improvement. This will be an ongoing process that will be reviewed and updated as needed. 5. Completion date 3/30/22.	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to maintain the steam table in safe operating condition. The findings included: Review of maintenance logs dated 10/2021 through 2/2022 revealed no documentation of broken brakes on the steam table. Interview with the Maintenance Director on 2/28/2022 at 2:30 PM revealed he had started his role in the facility on 2/27/2022. Observation in the kitchen on 3/2/2022 at 11:30 AM revealed a steam table positioned within 3 feet of where the floor sloped toward the floor drain. Three red bricks were observed to be blocking the wheels of the steam table. The bricks were placed in contact with and perpendicular to the caster - type wheels to prevent the unit from rolling. The bricks	F 908	1. The corrective action will be accomplished or the deficient practice. Bricks were removed from steam table on 3/2/2022 by the Maintenance Director and brakes repaired at that time. 2. All residents currently at risk for deficient practice. The Maintenance Director audited equipment and developed a routine maintenance system on 3/08/2022. Vendors for equipment will be consulted as needed. 3. EDUCATION: ALL staff educated on the use of the TELS system for reporting items that are in improper working order or disrepair. The Administrator and/or IDT team will educate their staff on the work order system. All education to be completed by March 28,2022. Broken equipment will be tagged and taken out of use until repaired. New hires will be trained at time of hire. Maintenance will report on unsafe/broken equipment daily	3/30/22

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F 908	Continued From page 55 protruded from under the steam table for approximately 8 inches posing a potential trip hazard. Interview with the Dietary Manager (DM) on 3/2/2022 at 11:35 AM revealed the DM was aware of the bricks. The DM stated the brake on the wheel of the steam table had been broken for what she described as "months". The DM further disclosed the previous Maintenance Director had put the bricks under the wheels months ago to prevent the table from rolling during use. The DM stated he never came back to fix the brakes. Interview with the interim Director of Nursing (DON) on 3/2/2022 at 6:16 PM revealed she was an agency DON. She stated her expectation was for broken or malfunctioning facility equipment to be reported immediately to the maintenance department. The DON further indicated she expected equipment to be repaired as soon as possible and not to be braced by bricks. Interview with the facility Administrator on 3/2/2022 at 6:25 PM revealed she expected equipment to be maintained in safe operating condition and that bricks should not be in the building period.	F 908	at morning standup 5 days a week. 4. Monitoring: Maintenance will audit essential equipment for safe operating condition 5x week x 4 weeks, then 3x week for 4 weeks then weekly x 4 weeks. Maintenance will bring monthly repair logs to Quality Assurance and Performance Improvement meetings x3 months to ensure all open orders have been finalized and closed. Revisions as needed. 5. Completion date 3/30/22	
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual	F 914		3/28/22

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F 914	Continued From page 56 privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to provide privacy curtains in resident rooms to provide full visual privacy for two (2) of five (5) rooms on the 100 and 200 halls (Room 106 and Room 222). The findings included: 1. Observation and interview on 02/28/22 at 11:20 AM revealed the resident in room 106 B had no privacy curtain around her bed. The resident stated it had been that way since she had been moved into the room in December of 2021 (could not remember the exact date). She stated she received bed baths in her room instead of showers and there was no way to provide her privacy while getting her bed baths. Observation on 02/28/22 at 4:00 PM revealed there was still no privacy curtain around 106 B bed to allow for her privacy. Observation on 03/01/22 at 9:00 AM revealed there was still no privacy curtain around 106 B bed to allow for her privacy. Interview on 03/01/22 at 9:49 AM with the Housekeeping Director revealed she was not aware there was no privacy curtain in 106 around bed B. She stated usually the Nurse Aides (NAs) or housekeepers would notify her if there was an issue with the curtains but said they had not mentioned there not being a curtain around the	F 914	1. The corrective action will be accomplished for residents found to have affected by deficient practice. The Housekeeping Director placed privacy curtain in 106B and 222 on 3/2/22. 2. All residents currently at risk for deficient practice. The Housekeeping Director completed a 100% audit of all rooms on 3/4/2022 ensuring all rooms had curtains suspended from the ceiling that extend around the bed to provide total privacy. All rooms have been checked for curtains both window and privacy curtains. Curtains have been replaced as needed. 3. Education: Administrator and Housekeeping Director provided education to the IDT team on 3/3/2022. All staff will be educated by March 28,2022 to include education regarding the regulations on privacy and dignity. All new hires will be trained at time of hire. Housekeeping will replace stained or torn curtains as needed. 4. Monitoring: Housekeeping Director will audit five rooms 5x week for 4 weeks for presence of privacy curtains, cleanliness and in good condition. Housekeeping Director 3 rooms 3x week for 4 weeks, then weekly for 30 days. Housekeeping Director will use housekeeping checklists and report on findings monthly at Quality Assurance and Performance Improvement meeting monthly for 3 months. Revision as needed.	

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F 914	Continued From page 57 resident's bed. The Housekeeping Director stated she would remedy that immediately and get a curtain hung up in 106 around bed B. Interview on 03/02/22 at 5:54 PM with the interim Director of Nursing (DON) revealed it was her expectation that all rooms were and remained admission ready which would include privacy curtains up and clean in each room. The DON stated each resident was assigned to rounds by a member of the management team and this should have been noted on those rounds. Interview on 03/02/22 at 6:26 PM with the Administrator revealed it was her expectation that all rooms have privacy curtains to ensure the privacy for all residents. The Administrator stated the privacy curtain should have been noted and corrected immediately.	F 914	5. Completion 3/28/22	
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, physician interview, and staff interviews and review the facility failed to maintain an effective pest control program as evidenced by pest observed in common areas, residents room (Rooms 112). The findings included: Review of the facility's invoice from a local pest control company dated:	F 925	1) All residents are at risk for deficient practice. Facility pest extermination company maintains a contract with the community to spray at least monthly, and to make more frequent visits as the community needs it. The pest control company sprayed per monthly contract on 03/21/2022 to include every resident□s room and common areas. 2) Upon inspection, efforts were tailored	3/30/22

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	345201	A. BUILDING _____ B. WING _____	C 03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

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F 925	Continued From page 58 01/21/22 read in part; the service period was monthly and target pest treatment were cockroaches and the service area was listed as kitchen area interior, hallways interior, lobby door, dining interior, exterior area, and patient rooms. 01/28/22 read in part; the service provided was to inspect and treat selected areas and to service rooms on the 100-wing side. Cockroach activity was found. Structural concerns found during this service included a hole and/or gap noted in various rooms around the air condition units, action taken was sealed the area to prevent pest entry. Another concern found was floor tiles and baseboards loose and/ or missing in various rooms, the action taken was to repair the areas to eliminate potential pest harborage/breeding site. 02/21/22 read in part; the service period was monthly, and the target pest treatment was mice and cockroaches, and the service areas was listed as kitchen interior, exterior area, front door, and patient rooms. a. An observation of pest activity (small dark colored pest) occurred on 02/27/2022 at 9:29 AM in the receptionist. The pests were observed crawling on the tissue box located sitting on the coffee table at. b. An observation of pest activity (two small black colored pest) occurred on 2/28/2022 at 11:45 AM in the visitor bathroom #1. The pests were observed crawling up the wall beside the toilet paper holder. c. An observation of pest activity (small dark colored pest) occurred on 2/28/2022 at 3:45 PM in Resident room #112. The rest were observed	F 925	to specific challenges. Efforts included parts of the exterior for a more thorough approach 3) Education: By 3/30/2022 all facility staff will be educated by the Administrator on keeping areas clean and dry, and how to report all pest activity via pest log located at each nurses station. Additionally, the staff was educated on the purposes of the log, assisting in the eradication of bugs by the team understanding how frequently the pest control service should circulate the community, per pest sightings. New staff will be educated upon hire. Environmental Service Director was educated to check the log each day by the Administrator. 4) Monitoring: Environmental Services Director will conduct an audit of 8 rooms five days per week for four weeks, 6 rooms five days per week for four weeks then 4 rooms week for four weeks and bring results of audits to stand up meeting every morning. Results of audits will be brought by Environmental Services Manager to monthly Quality Assurance and Performance Improvement meeting each month for 3 months. Review and revisions will be made as necessary. 5) Completion date 3/30/22	

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F 925	Continued From page 59	F 925		

crawling along the wall outside the bathroom door.

On 02/28/22 at 4:30 PM an interview was conducted with the Physician. The Physician stated there were cockroaches noted in the facility, but that he had not seen any recently. He further stated that the facility does have a pest contract and they come monthly and spray.

On 03/01/22 at 9:50 AM an interview was conducted with Housekeeping Director. The Housekeeping Director revealed she had only been working for the facility for 3 weeks. She stated that she was aware of the pest problem in the facility. She further stated that she relies on the staff to notify her and/or maintenance if they notice any pest activity.

On 03/01/22 at 2:35 PM an interview was conducted with the facility Nurse Practitioner. The NP stated it had been an ongoing issue with bugs being in resident's room. She recalled killing a roach in the floor a couple months ago. Stated residents had complained about staying up at night with lights on to help scare the bugs away. She further stated that she told upper management but wasn't sure if they did anything. The NP stated that she wouldn't want to stay at this facility.

The pest control technician assigned to the building was unable to be reached for an interview.

On 03/02/22 at 3:45 PM an interview was conducted with the facility Maintenance Director. The Maintenance Director stated the facility had a contract with an insecticide company for monthly

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F 925	Continued From page 60	F 925		

maintenance of insects and pests. According to the records provided, the last visit was on 02/21/22 and the facility had been sprayed inside and outside for insects and pests. In addition, the Maintenance Director indicated that residents had reported seeing bugs in their rooms. He indicated that he is a new employee, but he did notice that the residents had food and other items left out and the staff does not clean up after the residents very well.

On 03/02/22 at 4:05 PM an interview was conducted with the Assistant Maintenance Director. The Assistant Maintenance Director stated he has been at the facility for two years. He stated that bugs had been an issue for as long as he had been employed. He stated that residents had food and other items left out and nursing staff doesn't clean up well after them. He further stated that he recalled the exterminating company coming monthly but didn't seem to help.

On 03/02/22 at 4:30 PM an interview was conducted with the Administrator. The Administrator stated she was aware that residents had complained of bugs in their rooms. She indicated that the facility has a contract with a local pest control company, and they were coming monthly. She further indicated since the weather is warmer, she had the pest company spray more frequently in between monthly visits. According to the Administrator the company comes out every month to spray to kill the insects, set traps for pests or whatever they needed, and they made additional trips out as needed and requested for issues. She stated that she had been in conversation with residents, and she feels that the facility is working together to fix the issues. In addition, she added that she is

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F 925	Continued From page 61 committed to get everything fixed. The Director of Nursing (DON) was interviewed on 03/02/22 at 4:40 PM. The DON stated she expected the resident rooms and common area to be clean, healthy and in a state to decrease the risk of infection. She further added, the residents had food and other items left out and the staff doesn't clean up very well after the residents.	F 925		