STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 4/18/22 through 4/21/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #C5DI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 4/18/22 through 4/21/22. Event ID# C5DI11. The following intakes were investigated NC00171927, NC00184526, NC00186199, and NC00187526. Three of the 7 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=G	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	F 550		5/9/22

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

Electronically Signed | 05/06/2022

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to maintain a resident's dignity by not providing incontinence care which made the resident feel terrible and that staff did not care about her. This occurred for 1 of 3 residents (Resident #174) reviewed for dignity and respect. Findings included: Resident #174 was admitted to the facility on 2-11-22. The admission Minimum Data Set (MDS) dated 2-18-22 revealed Resident #174 was moderately cognitively impaired and required dependent assistance with one person for toileting and	F 550	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #174 was provided incontinent care and linens were changed by Certified Nursing Assistant on 4/17/22 at 7:00am. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All incontinent residents are at risk. On 5/3/22 the Director of Health Services, Administrative Nurses and charge nurses completed a 100% audit of bed and chair	

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F 550	Continued From page 2	F 550		

bathing. The MDS also coded Resident #174 always incontinent of bowel and bladder.

Resident #174 was interviewed on 4-18-22 at 3:00pm. The resident discussed on 4-16-22 she had received incontinence care at 3:00pm from the Nursing Assistant (NA) #1 who worked 7:00am to 3:00pm. She stated she had not received incontinence care again until 7:00am on 4-17-22. Resident #174 stated she was aware of the time because of the clock that was on the wall in front of her bed. She explained she had put her call light on for assistance around 7:30pm and a NA had come in, shut off the light and told her she would be back. The resident stated no one came back so she put her light on again around 10:00pm, but no one answered. Resident #174 described her bed linen; floor and her gown were "soaked" with urine. She stated she was unable to sleep, felt "terrible", and that staff did not care about her.

During an interview with NA #1 on 4-19-22 at 3:40pm, NA #1 confirmed she had been assigned to Resident #174 on 4-16-22 on the 7:00am to 3:00pm shift. She also confirmed she had provided incontinence care to Resident #174 around 3:00pm on 4-16-22. NA #1 discussed Resident #174 was not known to have large output of urine and did not require more than every 2-hour checks. The NA stated when she returned to work on 4-17-22 at 7:00am, she was assigned to Resident #174. She stated she made her initial round shortly after 7:00am and found Resident #174 "drenched" in urine. She said the resident was upset and had told her no one had been in all night to provide her care. The NA explained Resident #174's gown, sheets, and pad were soaked with urine, and she could see

linen to ensure linens are clean and dry. All identified issues were corrected immediately by changing the linen and completing incontinence care to ensure resident dignity was maintained.

3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur.

Education began on 4/19/22 by the Director of Health Services and/or Nurse Managers for the Licensed Nurses and certified nursing assistants on ensuring linens are kept clean and dry and if linens are soiled or wet, the resident is provided incontinent care and linens are to be changed to maintain resident dignity.

Education is to be completed by 5/9/22. Any Licensed Nurses and certified nursing assistant not completing education will be removed from the schedule until education is completed.
Education began on 4/19/22 by the Director of Health Services and/or Nurse Manager for the certified nursing assistants on completing incontinent care including but not limited to changing residents when they are soiled or wet.

Education to be completed by 5/7/22. Any nurse or certified nursing assistant not completing education will be removed from the schedule until education is completed.
Education related to providing incontinent care to maintain resident dignity has been added to the general orientation for all

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F 550	Continued From page 3 brown/yellow dried rings of urine under the recent wet urine. NA #1 stated she did not remember any urine on the floor. She stated she provided a bath and changed the resident's linens. NA #2 was interviewed on 4-20-22 at 9:30am by telephone. NA #2 confirmed she was assigned to Resident #174 on 4-16-22 on the 11:00pm to 7:00am shift. She explained she was assigned 25 residents that night and could not remember if Resident #174 had put on her call light for assistance or when she had provided incontinence care to Resident #174. NA #2 also explained she was not always able to provide care to every resident when she had 25 or more assigned to her. The NA confirmed Resident #174 would put on her call light when she needed incontinence care or she stated, "sometimes I just go in to check." She stated she could not remember when she had provided incontinence care but now stated she thought maybe around 5:00am. The NA stated Resident #174 was not known to have a large output of urine that required more than every 2-hour checks. An attempt was made to contact the nurse who worked on 4-16-22 from 11:00pm to 7:00am with no return call. An interview with NA #4 occurred on 4-19-22 at 2:30pm. NA #4 stated Resident #174 would put on her call light when she required incontinence care. She also said Resident #174 was not known to have a large output of urine and did not require more than every 2-hour checks. The NA discussed Resident #174 had to wait 2-3 hours for care to be provided if the facility only had 2-3 NAs working.	F 550	newly hired nursing staff. The Unit managers, weekend manager and/or weekend nursing supervisor, or DHS will audit residents for incontinent care provided timely daily times 7days, weekly times 4 weeks, and then monthly times 3 or until compliance is achieved. 4.How we plan to monitor its performance to make sure that solutions are sustained. The Director of Health Service will review and track and trend the audits completed for provision of incontinent care to maintain resident dignity. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education. Date corrective action will be completed: May 9, 2022	

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F 550	Continued From page 4 During an interview with the Director of Nursing (DON) on 4-21-22 at 10:12am, the DON stated resident #174 "can be a heavy wetter so care could have been done." She also stated Resident #174, nor NA #1 had brought the issue to her attention.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578		5/9/22

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F 578	Continued From page 5 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to determine on admission if 1 of 1 resident had an advance directive (Resident #225). Findings included: Resident #225 was admitted to the facility on 4/14/22. Review of Resident #225's hospital discharge summary dated 4/14/22 revealed no code status. A review of Resident #225's electronic record was conducted which revealed no advance directive or physician's order that indicated Resident #225's code status. An interview on 4/19/22 at 12:29 PM with Nurse #1 revealed she had entered a blank admission order for Resident #225's code status. She stated she had not indicated a code status in the order as the resident was not at the facility at the time and she did not know the resident's code status. She also stated that the admitting nurse should have completed the code status order during the resident admission process.	F 578	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Advance Directive was clarified and corrected on 4-19-2022 for Resident 225. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. An Audit was completed on all residents by the Social Worker on 4-20-2022 to ensure the code status listed on EMAR, written order and care plan were all congruent. 3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur. Licensed Nursing Staff and Social Worker were in-serviced by the Director of Health Services on 4-29-22 on ensuring the physician□s order, yellow DNR or full code request, EMAR and care plan for	

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F 578	Continued From page 6 An interview on 4/19/22 at 12:38 PM with the Director of Nursing (DON) revealed Resident #225 did not have a completed code status order and she should have. She stated that someone had forgotten to complete the order during the admission process. She stated there was a failsafe process where staff were supposed to check the admission paperwork to determine if there was a do not resuscitate form or other code status. An interview on 4/21/22 at 9:16 AM with the Administrator revealed all residents should have an accurate code status in their medical electronic record. She stated that Resident #225's admission orders were not double checked to ensure her admission was complete and accurate.	F 578	any resident is the same. Nurse Managers will follow up within 24 hours for verifying orders. Ongoing education will be provided to all newly hired licensed nurses and social workers. The Social Worker will audit 5 new admission charts each week for four weeks then 5 new admission charts monthly for one month to ensure code status information, including written physician orders, EMAR, code request and care plan are all the same. 4. How we plan to monitor its performance to make sure that solutions are sustained. The Social Worker will report any findings of the Audit results to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education. Date corrective action will be completed: May 9, 2022	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		5/9/22

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F 584	Continued From page 7 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews the facility failed to maintain walls, resident furniture and resident sink in good repair for 3 of 15 rooms (Rooms 307, 308, and 309)	F 584	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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F 584	Continued From page 8 observed for environment. Findings included: a. During an observation of room 307 on 4-18-22 at 10:40am, the observation revealed cracks in the wall by the heat/air wall unit exposing the dry wall and plaster. The resident's nightstand drawer handle was also observed to be hanging off the drawer. A second observation was made on 4-21-22 at 8:33am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed cracks in the wall by the heat/air wall unit exposing the dry wall and plaster. The resident's nightstand drawer handle was also observed to be hanging off the drawer. The Maintenance Director was interviewed on 4-21-22 at 8:35am. The Maintenance Director stated he had not been made aware of the issues in room 307 but he would have them corrected. He explained staff could generate work orders in the computer as well as paper requests that were located at the nursing station. b. Room 308 was observed on 4-18-22 at 11:05am. The observation revealed the resident's sink had a strip of laminate that was pulled away from the edge of the sink. Also observed was a crack in the wall by the heat/air wall unit exposing the dry wall and plaster. During a second observation of room 308 on 4-21-22 at 8:38am with the Housekeeping Supervisor and the Maintenance Director, the observation revealed the strip of laminate had been removed and was laying in the resident's	F 584	Room 307 had the cracks in the wall by the heat/air wall unit repaired and the nightstand drawer handle reattached. Room 308 had the strip of laminate reattached to the edge of the sink and the crack in the wall by the heat/air wall unit repaired. Room 309 had the nightstand drawer handle replaced. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit will be completed by The Director of Maintenance before 5-9-2022 for all patient rooms to ensure that they had no cracks by the heat/air wall units. This same audit inspected for all resident nightstand drawer handles and laminate strips on the sinks. Areas identified from this audit were corrected. 3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur. Facility staff will be re-educated by Maintenance and also shown on the information boards on or before 5-9-2022 on how to report maintenance concerns through the paper work order or through the maintenance electronic reporting system issues for cracks by heat/air wall units, broken/missing bedside drawer	

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F 584	Continued From page 9 sink leaving the particle board showing along the edge of the sink. Also observed was a crack in the wall by the heat/air wall unit exposing the dry wall and plaster. The Maintenance Director was interviewed on 4-21-22 at 8:40am. He stated he was not made aware of the issues observed but would have them fixed. c. Observation of room 309 occurred on 4-18-22 at 10:50am. The observation revealed the resident's nightstand drawer handle was broken off. The resident who resided in room 309 stated she had been asking nursing staff for the handle to be replaced because she can not open her drawer. The resident explained the handle had been broken "for several months." A second observation was made of room 309 on 4-21-22 at 8:43am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed the resident's nightstand drawer handle was broken off. The Maintenance Director was interviewed on 4-21-22 at 8:45am. He stated he was not made aware of the issues observed but would have the nightstand replaced. During an interview with Nursing Assistant (NA) #5 on 4-20-22 at 2:50pm, the NA stated she was aware there were paper forms for maintenance request at the nursing station but said she was usually too busy to fill out a request During an interview with the Administrator on 4-21-22 at 10:12am, the Administrator stated the Maintenance Director was new and had been	F 584	handles and laminate strips on sinks pulling away. . Ongoing education will be provided to all newly hired staff. The Maintenance Director or Administrator will conduct audits of 10 resident rooms for wall cracks by the heat/air wall unit, missing/broken nightstand drawer handles and laminate strips on sinks pulling away weekly times four weeks then monthly times one. 4. How we plan to monitor its performance to make sure that solutions are sustained. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education. Date corrective action will be completed: May 9, 2022	

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F 584	Continued From page 10 working on maintenance requests as he received them. She said she did not know why staff had not entered a request for the issues found during the survey but expected staff to report any maintenance issues they saw. She also explained the facility was changing to a computer-based system for maintenance requests, so all staff had access to report issues to Maintenance.	F 584		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a	F 622		5/9/22

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F 622	Continued From page 11	F 622		

resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is

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F 622	Continued From page 12 necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to allow a resident with behaviors to remain in the facility and to provide written documentation which stated the reason the facility could not meet the residents needs for 1 of 1 resident (Resident #275) reviewed for transfer and discharge. Findings included: Resident #275 was admitted to the facility on 11/04/2019 with diagnoses including schizophrenia. The Minimum Data Set (MDS) dated 11/25/2021 revealed Resident #275 had a moderate cognitive impairment. Resident #275 had no physical or verbal behaviors during the 7-day MDS review period. He had no rejection of care.	F 622	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The resident is no longer here to correct the alleged deficient practice. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit was conducted by the Administrator on May 4, 2022 of all residents discharged in the last 30 days to ensure that they met the criteria for appropriate transfer/discharge via facility policy and procedures. No other issues were identified.	

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F 622	Continued From page 13 The behavior care plan last revised on 08/16/2021 revealed that Resident #275 had threatened staff and residents with physical aggression. Further review of the care plan revealed that Resident #275 should be provided with diversional activities when he is becoming agitated and assess physical factors that may foster behaviors. The care plan last revised on 08/16/2021 revealed that Resident #275 was a long-term care resident until he can discharge to an assisted living facility. The medical record from 01/01/2021 through 02/10/2022 revealed 1 behavioral incident for Resident #275 on 11/14/2021. The nursing progress note dated 11/14/2021 at 2:20pm revealed Resident #275 was in the halls yelling, ranting, talking and shouting at staff and other residents but was redirectable and calmed down in his room. There were no additional behavioral incidents in the medical record during that time period. Nursing progress note dated 02/11/2022 at 7:43pm revealed Resident #275 was noted to be talking very loudly, becoming agitated and verbally aggressive at 5:30 pm. Resident #275 was talking to a female resident asking her to shut up. The female resident was removed from immediate harm while Resident #275 was yelling that he is not crazy but will show the Nurse what crazy is. The Director of Nursing (DON) had all other remaining residents in the room removed from immediate area as Resident #275 stood up and took a step towards the DON and stated that he will put the DON "in the grave". The DON called 911 and requested police and Emergency	F 622	3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur. On 5-3-2022 the Senior Nurse Consultant educated the Director of Health Services, Nursing Home Administrator, Social Service Director and Unit Manager on Transfer and Discharge Requirements. Ongoing education will be provided to newly hired Director of Health Services, Nursing Home Administrator, Social Service Director and Unit Managers. The Social Worker will conduct audits of all discharges to ensure they meet all the requirements. This will occur once a week for four weeks then monthly times one. The Discharge Log Audit Tool will be utilized to record results of the audits 4. How we plan to monitor its performance to make sure that solutions are sustained. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education. Date corrective action will be completed: May 9, 2022	

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Medical Services (EMS) while two staff attended resident from a safe distance. The police arrived but would not transport Resident #275 without an involuntary commitment paper The DON obtained the paperwork, and Resident #275 was transported by EMS to the hospital. The nursing note revealed that the involuntary commitment paper was obtained because Resident #275 was a danger to self and other. The DON sent Notice of Discharge with the Emergency Medical Services staff. The Administrator contacted the facility physician and the on-call Adult Protective Services worker and notified issuance of notice of discharge of Resident #275.

The notice of discharge dated on 02/11/2022 and signed by the Administrator provided the reason of discharge as being, "The safety of individuals in this facility is endangered due to the clinical or behavioral status of the resident." The discharge notice included no specific information on what needs the facility could not meet.

The Emergency Department (ED) record dated 02/11/2022 at 10:01pm revealed the Resident #275 was ready for discharge, and the involuntary commitment paper had been overturned. The ED physician contacted the facility who declined to accept Resident #275 back. The facility felt that Resident #275 was not appropriate. The hospital record stated that, "The Emergency Department Navigator is working with [Department of Social Services] DSS for placement as the facility that sent him will not take him back due to his behavior."

The discharge documentation for Resident #275 by the facility physician dated 02/15/2022 revealed that the resident had a history of

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F 622	Continued From page 15	F 622		

assaulting other residents including an example of a resident assaulted severely on 08/2020 by Resident #275.The letter included no specific information on what needs the facility could not meet.

The hospital record revealed Resident #275 was admitted to the hospital from 02/11/2022 to 02/17/2022 when he discharged to another facility.

Interview with Nurse Aide #5 (NA) revealed that Resident #275 was easy to redirect when he was agitated or was having behaviors. NA #5 stated she believed that the facility found an easy way to discharge Resident #275.

Interview with the Social Worker (SW) on 04/19/2022 at 12:59pm revealed that Resident #275 had prior incidents of physical aggression but was easily redirectable. The interview revealed that the resident was not accepted back to the facility due to his aggression towards residents and staff at the facility. The SW revealed that the facility was working with the Adult Protective Services to transfer Resident #275 to another facility due to Resident #275's behaviors and a facility had not been identified as at time of incident. The SW revealed she believed Resident #275's admission to the hospital was an easy way to transfer out. The discharge notice was not provided to the resident prior to the 2/11/2022 incident.

Interview with the Physician on 04/20/2022 at 2:05pm revealed that Resident #275 had a history of physical aggression towards other residents. The physician was not sure of the dates of the past incidents or which one of the two sister

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F 622	Continued From page 16 facilities Resident #275 residing at the time of incident in August of 2020. The physician stated that due to Resident #275's physical aggression towards other residents and staff, the facility could not accept the resident back for fear of everyone's safety. An interview with the Administrator on 04/19/2022 at 12:30pm revealed that Resident #275 had prior behaviors in August of 2020 injuring a resident and that they were not willing to take him back from the hospital after the 02/11/2021 incident due to his physical aggression towards staff and residents in the past. She revealed there was no documentation involving physical behavioral incidents for Resident #275 after the 08/2020 incident. The Administrator revealed the facility felt they were unable to meet the needs of Resident #275 due to his aggressive behaviors. The interview revealed the Administrator initiated the Notice of Discharge form dated 02/11/2022 for the DON to provide to the resident and his guardian and that a decision had been reached not to allow the resident back to the facility after consultation with her supervisor.	F 622		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous	F 626		5/9/22

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F 626	Continued From page 17 room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to allow the resident to return to the facility after being sent to the Emergency Department (ED) for aggressive behaviors. This resulted in the resident being admitted to the hospital where he remained for 6 days while waiting for placement at another skilled nursing facility. This was for 1of 1 resident (Resident #275) reviewed for transfer and discharge. The findings included:	F 626	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Resident is no longer here to correct the alleged deficiency. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 626	Continued From page 18 Resident #275 was admitted to the facility on 11/04/2019 with diagnoses including Schizophrenia. The Minimum Data Set (MDS) dated 11/25/2021 revealed Resident #275 had a moderate cognitive impairment. Resident #275 had no physical or verbal behaviors during the 7-day MDS review period. He was assessed with no rejection of care. Review of the behavior care plan last revised on 08/16/2021 revealed that Resident #275 has threatened staff, residents and has been physically aggressive. Care plan revealed that Resident #275 should be provided with diversional activities when he is becoming agitated and assess physical factors that may foster behaviors. Review of the care plan last revised on 08/16/2021 revealed that Resident #275 was a long-term care resident until he can discharge to an assisted living facility. Nursing progress note dated 02/11/2022 at 7:43pm revealed Resident #275 was noted to be talking very loudly, becoming agitated and verbally aggressive at 5:30 pm. Resident #275 was talking to a female resident asking her to shut up. The female resident was removed from immediate harm while Resident #275 was yelling that he is not crazy but will show the Nurse what crazy is. The Director of Nursing (DON) had all other remaining residents in the room removed from immediate area as Resident #275 stood up and took a step towards the DON and stated that he will put the DON "in the grave". The DON called 911 and requested police and Emergency	F 626	The Administrator completed an audit on 5-3-2022 of all discharges/transfers to the hospital for the last 30 days, no other residents were denied readmission to the facility. PruittHealth Senior Nurse Consultant in-serviced the Director of Health Services, Administrator, Social Worker and Unit Manager on the Regulation of permitting residents to return to the facility on . 3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur. The Administrator will audit discharges/transfers to the hospital to ensure the resident returns to the facility when medically cleared. This will occur weekly for 4 weeks then monthly times one. Ongoing education will be provided to newly hired Director of Health Services, Administrator, Social Worker and Unit Manager. 4.How we plan to monitor its performance to make sure that solutions are sustained. These audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education.	

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F 626	Continued From page 19	F 626	Date corrective action will be completed May 9, 2022	

Medical Services (EMS) while two staff attended resident from a safe distance. The police arrived but would not transport Resident #275 without an involuntary commitment paper.

The DON obtained the paperwork, and Resident #275 was transported by EMS to the hospital. The nursing note revealed that the involuntary commitment paper was obtained because Resident #275 was a danger to self and other. The DON sent Notice of Discharge with the Emergency Medical Services staff. The Administrator contacted the facility physician and the on-call Adult Protective Services worker and notified issuance of notice of discharge of Resident #275.

The notice of discharge dated on 02/11/2022 and signed by the Administrator provides the reason of discharge as being, "The safety of individuals in this facility is endangered due to the clinical or behavioral status of the resident." The discharge notice included no specific information on what needs the facility could not meet.

The Emergency Department (ED) record dated 02/11/2022 at 10:01pm revealed the Resident #275 was ready for discharge, and the involuntary commitment paper had been overturned. The ED physician contacted the facility who declined to accept Resident #275 back. The facility felt that Resident #275 was not appropriate. The hospital record stated that, "The Emergency Department Navigator is working with [Department of Social Services] DSS for placement as the facility that sent him will not take him back due to his behavior."

The hospital record revealed Resident #275 was

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F 626	Continued From page 20	F 626		

admitted to the hospital from 02/11/2022 to 02/17/2022 when he discharged to another facility.

Interview with Nurse Aide #5 (NA) revealed that Resident #275 was easy to redirect when he was agitated or was having behaviors.

Interview with the Social Worker (SW) on 04/19/2022 at 12:59pm revealed that the Resident #275 had prior incidents of physical aggression but was easily redirectable. The interview revealed that the resident was not accepted back to the facility due to his aggression towards residents and staff at the facility. The interview with the SW revealed that the facility was working with the Adult Protective Services to transfer Resident #275 to another facility and that a facility had not been identified. The interview with the SW revealed Resident #275 admission to the hospital was easy way to transfer out.

Interview with the Physician on 04/20/2022 at 2:05pm revealed that Resident#275 had a history of physical aggression towards other residents. The physician was not sure of the dates of the past incidents or which one of the two sister facilities Resident #275 residing at the time of incident in August of 2020. The physician stated that due to Resident #275's physical aggression towards other residents and staff, the facility could not accept the resident back for fear of everyone's safety. He reported he contacted the Emergency Department and informed them that the resident would not be accepted back to the facility. Physician stated he informed the emergency department that if Resident #275 came back, he was likely to hurt somebody. The physician stated that he did not know what the

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F 626	Continued From page 21 triggers were for the resident's aggression. The Physician revealed he felt the resident needed to go to an inpatient psychiatric facility. An interview with the Administrator on 04/19/2022 at 12:30pm revealed that Resident #275 had prior behaviors in August of 2020 injuring a resident and that they were not willing to take him back from the hospital after the 02/11/2021 incident due to his physical aggression towards staff and residents in the past. She revealed there was no documentation involving physical behavioral incidents for Resident #275 after the 08/2020 incident. The Administrator revealed the facility felt they were unable to meet the needs of Resident #275 due to his aggressive behaviors. The interview revealed the Administrator initiated the Notice of Discharge form dated 02/11/2022 for the DON to provide to the resident and his guardian and that a decision had been reached not to allow the resident back to the facility after consultation with her supervisor.	F 626		
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews the facility failed to provide incontinence care for a dependent resident resulting in the resident feeling "terrible" and that staff did not care about her. This occurred for 1 of 3 residents (Resident #174) reviewed for incontinence care.	F 677	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 174 was provided incontinent care and linens were changed by the	5/9/22

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F 677	Continued From page 22 Findings included: Resident #174 was admitted to the facility on 2-11-22 with multiple diagnoses that included hemiplegia and hemiparesis, muscle weakness. The admission minimum Data Set (MDS) dated 2-18-22 revealed Resident #174 was moderately cognitively impaired. The MDS had coded Resident #174 for verbal behaviors towards others 1-3 days out of 7 but not for refusal of care. Resident #174 was also coded as always incontinent of bowel and bladder and coded as dependent for toileting and bathing with one person assist. Review of Resident #174's Medication Administration Record (MAR) for April 2022 revealed Resident #174 was not taking a diuretic. Resident #174 was interviewed on 4-18-22 at 3:00pm. The resident discussed on 4-16-22 she had received incontinence care at 3:00pm from the Nursing Assistant (NA) who worked 7:00am to 3:00pm. She stated she had not received incontinence care again until 7:00am on 4-17-22. Resident #174 stated she was aware of the time because of the clock that was on the wall in front of her bed. She explained she had put on her call light for assistance, but no one answered. Resident #174 described her bed; floor and her gown were "soaked" with urine. She stated she was unable to sleep, felt "terrible", and that staff did not care about her. Observation of incontinence care occurred on 4-19-22 at 2:15pm with NA #4. The resident's skin was observed to be intact with no redness.	F 677	Certified Nursing Assistant. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All incontinent residents are at risk. On 5-3-22 the Director of Health Services, Administrative Nurses and charge nurses completed a 100% audit of bed and chair linen to ensure linens and residents were clean and dry. All identified issues were corrected immediately by changing the linen and completing incontinence care. 3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur. Education began on 4/19/22 by the Director of Health Services and/or Nurse Managers for the Licensed Nurses and certified nursing assistants on insuring linens are kept clean and dry and if linens are soiled or wet, the resident is provided incontinent care and linens are to be changed. Education is to be completed by 5/9/22. Any Licensed Nurses and certified nursing assistants not completing education will be removed from the schedule until education is completed. Education began on 4/19/22 by the Director of Health Services and/or Nurse Manager for the certified nursing assistants on completing incontinent care including but not limited to changing residents when they are soiled or wet.	

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F 677	Continued From page 23 Resident #174's brief was noted to be wet but not saturated. An interview with NA #4 occurred on 4-19-22 at 2:30pm. NA #4 discussed checking her residents every 2 hours for incontinence care but stated if there were not enough staff, the resident may have to wait 2-3 hours for care to be provided. She stated Resident #174 would put on her call light when she required incontinence care and said Resident #174 did not require more frequent incontinence care. During an interview with NA #1 on 4-19-22 at 3:40pm, NA #1 confirmed she had been assigned to Resident #174 on 4-16-22 on the 7:00am to 3:00pm shift. She also confirmed she had provided incontinence care to Resident #174 around 3:00pm on 4-16-22 and that Resident #174 was not known to have a large output of urine. The NA stated when she returned to work on 4-17-22 at 7:00am, she was assigned to Resident #174. She stated she made her initial round shortly after 7:00am and found Resident #174 "drenched" in urine. She said the resident was upset and had told her no one had been in all night to provide her care. The NA explained Resident #174's gown, sheets, and pad were soaked with urine, and she could see brown/yellow dried rings of urine under the recent wet urine. NA #1 stated she did not remember any urine on the floor. She stated she provided a bath and changed the resident's linens. NA #2 was interviewed on 4-20-22 at 9:30am by telephone. NA #2 confirmed she was assigned to Resident #174 on 4-16-22 on the 11:00pm to 7:00am shift. She explained she was assigned 25 residents that night and could not remember if	F 677	Education to be completed by 5/9/22, any nurse or certified nursing assistant not completing education will be removed from the schedule until education is completed. The Unit managers, weekend manager and/or weekend nursing supervisor, or DHS will audit residents for timely incontinent care daily times 7 days, weekly times 4 weeks, and then monthly times 3 or until compliance is achieved. 4.How we plan to monitor its performance to make sure that solutions are sustained. The Director of Health Service will review and track and trend the audits completed for provision of incontinent care. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education Date corrective action will be completed May 9, 2022	

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	345357	A. BUILDING _____ B. WING _____	C 04/21/2022

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F 677	Continued From page 24 Resident #174 had put on her call light for assistance or when she had provided incontinence care to Resident #174. The NA confirmed Resident #174 would put on her call light when she needed incontinence care or she stated, "sometimes I just go in to check." She stated she could not remember when she had provided incontinence care but now stated she thought maybe around 5:00am. The NA stated Resident #174 was not known to have a large output of urine that required more than every 2-hour checks. During an interview with the Director of Nursing (DON) on 4-21-22 at 10:12am, the DON stated resident #174 "can be a heavy wetter so care could have been done." She also stated Resident #174, nor NA #1 had brought the issue to her attention.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to provide an environment without a potential accident hazard when 2 of 15 resident rooms (Rooms 301 and 311) were observed to have a heat/air wall unit without a cover exposing the wires and coils and a wall plug outlet loose	F 689	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident room # 301 had its heat/air wall	5/9/22

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F 689	Continued From page 25 from the wall allowing access to the wires. Findings included: 1.Room 301 was observed on 4-18-22 at 10:00 am. The observation revealed the resident's heat/air wall unit was missing the cover exposing the coils and wires to the unit. On 4-21-22 at 8:27 am, room 301 was observed with the Housekeeping Supervisor and the Maintenance Director. The observation revealed the room's heat/air wall unit was missing the cover exposing the coils and wires to the unit. The Maintenance Director was interviewed on 4-21-22 at 8:30 am. He stated he was not aware the front cover had been removed. The Maintenance Director stated he needed to find a solution so the resident could not remove the cover and injure himself. 2. During an observation of room 311 on 4-18-22 at 11:20 am, the observation revealed a plug outlet was loose from the wall causing a gap and access to the wiring. A second observation of room 311 was conducted on 4-21-22 at 8:48 am with the Housekeeping Supervisor and the Maintenance Director. The observation revealed a plug outlet was loose from the wall causing a gap and access to the wiring. The Maintenance Director was interviewed on 4-21-22 at 8:50 am. He stated he was not made aware the outlet was loose from the wall and commented it was potentially dangerous. The Maintenance Director stated he would have the outlet fixed immediately.	F 689	unit cover replaced. Resident room # 311 had its wall plug replaced. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. Resident Room Facility audits will be conducted before 5-9-22 by maintenance personnel to ensure that all resident rooms had a heat/air wall unit cover on them. No others were identified as being without a cover. Resident Room Facility audit will be conducted before 5-9-22 by maintenance personnel to ensure that all wall plug outlets were not loose. Outlets identified during the audit were corrected. 3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur. Facility maintenance director or administrator will audit 10 resident rooms weekly times four weeks then monthly times one to ensure that the heat/air wall units have covers on them and that all wall plug outlets are not loose. Facility staff will be re-educated by Maintenance Director and also shown on the information boards in the facility on or before 5-9-2022 on how to report maintenance issues via paper work order or through the maintenance electronic reporting system concerning heat/air wall unit covers missing and wall outlets being	

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F 689	Continued From page 26 During an interview with Nursing Assistant (NA) #5 on 4-20-22 at 2:50 pm, the NA stated she was aware there were paper forms for maintenance request at the nursing station but said she was usually too busy to fill out a request. During an interview with the Administrator on 4-21-22 at 10:12 am, the Administrator stated the Maintenance Director was new and had been working on maintenance requests as he received them. She said she did not know why staff had not entered a request for the issues found but expected staff to report any maintenance issues they saw.	F 689	loose. Ongoing education will be provided to all newly hired maintenance staff. 4. How we plan to monitor its performance to make sure that solutions are sustained. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education Date corrective action will be completed 5-9-22	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		5/9/22

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F 690	Continued From page 27 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to prevent a urinary catheter tubing from encountering the floor to reduce the risk of injury or infection. This occurred for 1 of 1 resident (Resident #175) reviewed for urinary catheter. Findings included: Resident #175 was admitted to the facility on 4-1-22 with multiple diagnoses that included other specified disorders of the bladder. The admission documentation showed Resident #175 was alert and oriented. Observation of Resident #175 occurred on 4-18-22 at 11:40am. The observation revealed Resident #175 was sitting up in his wheelchair with the catheter bag hanging from the side of the wheelchair and the catheter tubing laying on the floor.	F 690	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 175 had his catheter tubing disinfected and secured off the floor. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. On 5-3-2022 an audit of all residents having a catheter was conducted to ensure that the catheter tubing was off the floor. No other deficiencies were found. 3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur.	

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F 690	Continued From page 28 On 4-19-22 at 9:55am, another observation of Resident #175's catheter was conducted. The observation revealed Resident #175 was sitting in his wheelchair with the catheter bag hanging on his wheelchair below bladder level and the tubing was on the floor with the resident's right heel of his foot on top of the tubing. Another observation of Resident #175's catheter occurred on 4-19-22 at 2:10pm. Resident #175 was observed sitting up in his wheelchair with the catheter bag hanging under his wheelchair and the catheter tubing was laying on the floor. Observation of Resident #175's catheter occurred on 4-20-22 at 9:45am. Resident #175 was observed sitting up in his wheelchair with his catheter bag hanging behind the front left wheel of the wheelchair and the catheter tubing was laying on the floor. During an interview with Nursing Assistant (NA) #4 on 4-20-22 at 2:50pm, NA #4 stated she was aware Resident #175's catheter tubing was dragging on the floor, but she stated, "the tubing is too long and I don't know how to fix it." The NA said she had told the nurses in the past about the issue, but no one had fixed it. Nurse #4 was interviewed on 4-20-22 at 3:00pm. The nurse confirmed she had been assigned to Resident #175 during the 7:00am to 3:00pm shift and stated she had not looked at the resident's catheter or tubing today (4-20-22) so she was not aware the catheter tubing had been laying on the floor. The nurse stated she was aware the catheter tubing should not be laying on the floor due to possible infection and/or injury to the	F 690	Current nursing staff will be educated by 5-9-22 by Administration nurses on catheter tubing to be stored off the floor. Ongoing education will be provided to newly hired nursing staff. The Unit Manager or Administration nurse will randomly observe each resident with a catheter to ensure that the catheter tubing is stored off the floor five times a week for two weeks then weekly times two. The Director of Health Services or designee will review the audits of the catheter tubing off the floor weekly to ensure completion. 4. How we plan to monitor its performance to make sure that solutions are sustained. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education. Date corrective action will be completed 5-9-22	

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F 690	Continued From page 29 resident. The Director of Nursing (DON) was interviewed on 4-21-22 at 10:12am. The DON discussed Resident #175's catheter tubing being too long and the resident being mobile in his chair as cause to why the tubing was on the floor. She also stated she was aware catheter tubing should not have contact with the floor.	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		5/9/22

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F 758	Continued From page 30 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a stop date for an as needed antianxiety medication for 1 of 5 residents reviewed for unnecessary medications (Resident #225). Findings included: Resident #225 was admitted to the facility on 4/14/22 with diagnoses which included anxiety. Resident #225's physician's order dated 4/14/22 revealed she was ordered Alprazolam 1 mg twice a day as needed (PRN) for anxiety. The order had a start dated of 4/14/22 with no end date and was documented as open ended.	F 758	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 225 had the Alprazolam order changed to include a stop date of April 27, 2022. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by medications without stop dates.	

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F 758	Continued From page 31 An interview on 4/19/22 at 12:23 PM with Nurse #2 revealed she had entered the admission medication orders for Resident #225. She stated she should have contacted the physician for a stop date for the PRN Alprazolam. She stated she had just missed it. An interview on 4/19/22 at 12:38 PM with the Director of Nursing (DON) revealed the Alprazolam PRN medication should have a stop date. She stated she would have caught it during the chart audits she usually performs on admission charts. An interview on 4/21/22 at 9:18 AM with the Administrator revealed she was aware all PRN psychotropic medications should have a stop date. She stated it was missed on the order entry by the nurse. She also stated that the second check had not been done which would have caught the entry error.	F 758	An audit was performed by the Director of Health Services on April 27, 2022 for all antipsychotic medications to ensure that each medication had a stop date. No other antipsychotic medications were identified without stop dates. 3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur. Licensed nurses were reeducated on April 27, 2022 by the Infection Preventionist on ensuring that all antipsychotic medications have stop dates. Ongoing education will be provided to all newly hired licensed nurses. The Director of Health Services and the Infection Preventionist began auditing new antipsychotic medications to ensure compliance that all have stop dates when the medication was ordered. This will occur five times a week for two weeks then weekly times two. 4. How we plan to monitor its performance to make sure that solutions are sustained. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education.	

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F 758	Continued From page 32	F 758	Date corrective action will be completed: May 9, 2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		5/9/22

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F 880	Continued From page 33 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to don gloves and a gown prior to entering an enteric precaution room for 1 of 3 residents reviewed for isolation precautions (Resident #34).	F 880	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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F 880	Continued From page 34 Findings included: Resident #34 was admitted to the facility on 3/2/22. Her active diagnoses included anemia, coronary artery disease, hypertension, and Enterocolitis due to Clostridium difficile (C-Diff). Resident #34's minimum data set assessment dated 3/4/22 revealed she was assessed as severely cognitively impaired. She had no behaviors and required limited assistance with bed mobility. She required extensive one-person assistance with transfers as well as toileting and required supervision with setup support for eating. She was occasionally incontinent of urine and always incontinent of bowel. Resident #34's physician orders revealed on 3/2/22 she was ordered to be on isolation enteric precautions related to Clostridioides difficile. During observation on 4/18/22 at 1:07 PM Resident #34's room was observed to have a sign for enteric precautions and Personal Protective Equipment (PPE) at the door. The sign indicated staff were to wear a gown and gloves when entering and remove them before exiting the room. During observation on 4/18/22 at 1:13 PM Nurse Aide #3 was observed taking Resident #34 her lunch tray. The nurse aide did not don a gown or gloves, entered the room, and put the tray on the resident's bedside table. The nurse aide then moved the bedside table and adjusted its height. The nurse aide moved the resident's walker to the side of the resident's chair. She then moved the bedside table in front of the resident and set	F 880	The Infection Preventionist began in-servicing all personnel on 4/20/22 regarding contact precautions and personal protective equipment. All in-servicing will be complete by May 9, 2022. Certified Nursing Assistant # 3 was re-educated on 4/20/22 by the Infection Preventionist regarding contact precautions and infection control procedures. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. 3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur. The Infection Preventionist or nurse manager will complete an infection control audit by completing a checklist of room rounds to ensure all Personal Protective Equipment is being used per infection control guidelines. All staff will be required to complete Personal Protective Equipment Donning and Doffing and this education will be provided to all newly hired staff.	

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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 880	Continued From page 35 up the tray. The nurse aide used hand sanitizer and exited the room. During an interview on 4/18/22 at 1:14 PM Nurse Aide #3 stated when residents were on enteric precaution she was to wear a gown and gloves with any patient care. She concluded because she was touching items the resident would regularly touch, she should have gowned and gloved when providing the resident their meal tray. During an interview on 4/19/22 at 8:15 AM the Infection Control Nurse stated Resident #34 was on enteric precautions for C-Diff and receiving by mouth vancomycin until 4/28/22. She further stated if a staff member was providing meal tray the staff should don a gown and gloves. She further stated the resident had not had any symptomatic stool in a while however due to the enteric precaution the nurse aide should absolutely have had the gloves on when providing the meal tray and she would begin education. During an interview on 4/19/22 at 12:29 PM the Director of Nursing stated if any staff members went into Resident #34's room and were going to touch anything in the resident's room they were to don a gown and gloves for infection control due to enteric precautions in place for Resident #34.	F 880	The Infection Preventionist or nurse manager will observe five partners entering and exiting resident rooms with isolation to validate infection control procedures are in place weekly for one month, then five partners per month for two months. If anyone observes improper infection control precautions being utilized, the Infection Preventionist nurse manager will complete corrective action through individual in-servicing to ensure understanding of infection control practices. 4.How we plan to monitor its performance to make sure that solutions are sustained. These audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education. Date corrective action will be completed May 9, 2022	
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.	F 925		5/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/21/2022

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F 925	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, the facility failed to provide pest free environment for 2 of 15 resident rooms (Rooms 308 and 309) observed for pest control. Findings included: The pest control company's service reports were reviewed and revealed monthly treatments as well as multiple visits a month for cockroach activity with the last visit and treatment of rooms 308 and 309 on 4-13-22. Remarks from the pest control company after each visit read "no signs of cockroach activity." a. Observation of room 308 on 4-20-22 at 10:25am with Nursing Assistant (NA) #5 revealed 3 live cockroaches climbing up the wall behind the resident's bed. The NA commented, "I am sick of these things. They are everywhere." The Resident #45 also commented she sees cockroaches every day on her wall. During a second observation of room 308 on 4-21-22 at 8:38am with the Housekeeping Supervisor and the Maintenance Director. The Maintenance Director was informed of the cockroaches seen on 4-20-22 and the resident also informed him that she saw the cockroaches daily on her wall. b. Observation of room 309 occurred on 4-18-22 at 10:50am. The observation revealed 5 small cockroaches and what appeared to be a cockroach egg located around the resident's nightstand.	F 925	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident room 308 & 309 were deep cleaned by housekeeping and the entire perimeter of the room was treated by the pest control company for cockroaches. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. Resident rooms will be inspected by maintenance before 5-9-22 for pests and any issues identified will be treated as necessary. 3.What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur. Facility staff will be educated by maintenance director on or before 5-9-22 on the process for reporting to maintenance by paper work orders or through maintenance electronic reporting system when pests are noted anywhere within the facility. The education will emphasize on ensuring that personal food items remain in sealed containers and that other items are kept clean and free of spills of food and drink to minimize the attraction of cockroaches or other pests. Ongoing education will be provided to all	

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F 925	Continued From page 37 A second observation was made of room 309 on 4-21-22 at 8:43am with the Housekeeping Supervisor and the Maintenance Director. The Maintenance Director was informed of the findings of 5 small cockroaches and a cockroach egg located around the resident's nightstand. The Maintenance Director was interviewed on 4-21-22 at 8:45am. He stated there had been an infestation of cockroaches in room 312 approximately 1.5 weeks ago and he was still working with the pest control company to eradicate the infestation. The Maintenance Director discussed purchasing glue traps to be placed throughout hall 300 to help stop the cockroaches spreading to other areas of the building however he stated he did not plan on placing the glue traps until the week of 4-25-22 due to other work he needed to complete. During an interview with the Administrator on 4-21-22 at 10:12am, the Administrator discussed the pest control company coming monthly to treat for cockroaches and the Maintenance Director was taking steps to help with the issue.	F 925	newly hired staff. Maintenance Director or Administrator will audit 10 resident rooms for pests weekly times four weeks and then monthly times one. 4.How we plan to monitor its performance to make sure that solutions are sustained. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education. Date corrective action will be completed: May 9, 2022	