STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted from 6/6/22 through 6/9/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 0IP611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 6/6/22 through 6/9/22. Event ID# 0IP611. The following intakes were investigated NC00185205, NC00186262, NC00186733, NC001870123, NC00187310, NC00187530, NC00187766, and NC00188454. 2 of the 22 complaint allegations was substantiated resulting in a deficiency, F804.	F 000		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, staff, Medical Doctor, and Nurse Practitioner interviews the facility failed to follow their abuse policy in the areas of reporting, notification, assessment, and	F 607	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported	7/5/22

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

Electronically Signed | 06/27/2022

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F 607	Continued From page 1 investigation procedures for (Resident # 5 and Resident #284) for 1 of 1 facility abuse investigations reviewed. The Findings Included: Review of the facility policy titled Abuse, Neglect, Misappropriation/ Crime with a effective date of 11/01/19, revealed the following: Policy: A licensed nurse will immediately respond to all allegations and/or reasonable suspicions of staff to patient, patient to patient, and/or visitor to patient, abuse, neglect, mistreatment, exploitation or any misappropriation of patient property or crime against a patient. 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of a patient property are to be reported immediately but (a) no later than 2 hours after the allegation is made if the events that cause the allegation involves abuse or result in serious bodily injury or (b) no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 5. A licensed will closely monitor and document thoroughly the behavior and condition of the patient involved to evaluate any injury. 6. For all patients involved in the incident, a licensed nurse must notify the following: a.) Attending Physician b.) Responsible Party 10. The Administrator or his/her designee must immediately initiate an investigation. This investigation includes interviewing all staff involved (directly and indirectly), and family involved, all patients involved, and any visitors involved.	F 607	conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F607 1. Resident # 284 who is no longer in the center and resident # 5 the time frame had already passed. 2. Current residents in the center have the potential to be affected. When an allegation is received regarding patient-to-patient interactions, the patients will be removed and placed on 1:1 supervision until resolution. Administrator, Director of Nursing, and Regional Nurse consultant will be educated by VP of clinical services/designee regarding appropriate reporting to outside agencies. Education provided to administrator, DON and Regional nurse consultant include all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of a patient property are to be reported immediately but (a) no later than 2 hours after the allegation is made if the events that cause the allegation involves abuse or result in serious bodily	

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F 607	Continued From page 2 An interview was conducted on 6/8/22 at 10:43AM with Resident # 5 which revealed a man came into her room and scared her to death. She further stated he got over beside the table and reached for my arm. She stated she started screaming. She stated she did not want to get anyone in trouble. Review of Resident # 5's most recent MDS dated 5/21/22 revealed she was cognitively impaired. An interview conducted on 6/9/22 at 10:23AM with Resident #284 revealed he does get turned around in the building. He further revealed he remembered going into another room but does not remember anything else. Review of Resident #284 most recent Admission MDS (in progress) dated 6/2/22 revealed he was a wanderer and cognitively impaired. An interview conducted on 6/8/22 at 2:47PM with Resident #72's responsible party (RP) revealed Resident #72 had called her and stated a man was wandering around the facility and he raped someone. An interview with Receptionist (Service Ambassador) # 1 on 6/7/22 at 10:04AM revealed she received a call from Resident #72 responsible party last week (the week of 5/30/22). She further revealed the RP expressed concerns her mother (Resident #72) had told her someone had been assaulted or raped. She stated she told Resident #72 responsible party (RP) she would let the facility know, and someone would take care of it. She revealed she reported it to the MDS Nurse #1.	F 607	injury or (b) no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Education was completed on 07/01/2022 Director of Nursing or designee will educate current staff in all departments on abuse policy and reporting requirements to include all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of a patient property are to be reported immediately but (a) no later than 2 hours after the allegation is made if the events that cause the allegation involves abuse or result in serious bodily injury or (b) no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Current staff will provide a written statement of what has been reported to them to the Director of Nursing and Administrator at the time of the report Education completed on 07/01/2022. Any staff who is not educated will not be allowed to work until education received. Any new staff will be educated by Staff Development Nurse or Director of Nursing or designee during orientation on abuse policy and timely reporting. 3. Review of any allegations of abuse will be audited by Administrator 3x weekly x 4 weeks, then weekly x 4weeks, then monthly x 1 to ensure timely reporting, reporting to outside agencies and ensuring a thorough investigation. 4. Results of the audits will be reviewed	

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F 607	Continued From page 3 An interview with MDS Nurse #1 on 6/7/22 at 10:01AM revealed last week Resident #72 daughter called and asked to speak with a service ambassador. She further stated during the phone call the RP was concerned because her mother (Resident #72) had called and told her an assault or rape had occurred at the facility. The MDS Nurse #1 stated she reported it immediately to Unit Manager #2 to investigate. On 6/7/22 at 9:55AM an interview was conducted with Unit Manager # 2 She revealed she did not speak with the nurse assigned to these residents. The Unit Manager #2 revealed she reported it to the DON and was only responsible for asking the questions to the alert and oriented residents. An interview was conducted on 6/6/22 at approximately 2:15PM with the Director of Nursing (DON). The Director of Nursing revealed there was an incident reported regarding Resident #284 wandering and she had some of the information regarding the incident. She further revealed Unit Manager #2 was not scheduled to work today and she would provide the additional information tomorrow. By the end of the day the DON provided Unit Manager #2 statement and a handwritten note. The DON revealed the facility had interviewed the alert and oriented residents and obtained the Unit Manager #2 statement. She stated Regional Nurse Consultant #1 concluded no body checks or 24 hour/5 day report was needed. On 6/7/22 at 3:30PM an interview with Regional Nurse Consultant #1 and DON was conducted. The Regional Nurse Consultant #1 revealed the	F 607	at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. 5. Administrator is responsible for monitoring the audits 6. Date of Completion 07/05/2022	

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F 607	Continued From page 4	F 607		

DON called her after the in-house investigation had been completed. She further stated after the discussion she decided there was nothing to report. She revealed she was not aware of any conversations Resident #5 had concerning someone hurting her. The DON stated the wound care nurse practitioner did a head-to-toe assessment on Resident #5 on 6/1/22.

An interview conducted on 06/08/22 02:36 PM with Wound Nurse Practitioner revealed she did not perform a head-to-toe assessment on Resident #5 on 6/1/22. She further revealed she provided assessment only to the wound she was treating.

An interview was conducted with Unit Manger #2 on 6/7/22 at 3:50PM which revealed she did not interview or assess Resident # 5 after she reported it to the DON.

A joint interview conducted with Unit Manager #2 and DON on 6/8/22 at 4:21PM revealed the facility did not contact Resident #5's RP or Resident #284's RP. DON revealed no assessment was done on Resident #5 or Resident #284. The DON and Unit Manager #2 further revealed no-one had spoken to the nurse or certified nursing assistants that worked on 5/30/22. They further revealed the time of the incident was still uncertain, but it was between the evening to night. The DON revealed that her instinct was to do a 24 hour and 5-day report but after discussion with the Regional Nurse Consultant #1 it was decided it was not reportable. The DON stated we have the Unit Manager #2 statement and the alert and oriented residents on that hall interviews regarding any screams heard or if they felt safe. The DON

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F 607	Continued From page 5 further stated we did not feel like this was something to investigate related to the Resident #72 periods of confusion. An interview conducted on 6/8/22 with Nurse #5 who was assigned on 5/30/22 stated no-one from the facility had called her to ask about the incident. An interview with Nurse Practitioner conducted on 6/8/22 at 10:52AM revealed she was not notified of incident regarding Resident #5 and Resident #284. An interview conducted on 6/8/22 at 11:06AM with Medical Doctor revealed he was Resident #5 and Resident # 284 physician and was not aware of any incidents regarding Resident #5 and Resident #284. Review of Resident #5's progress notes revealed no documentation related to the incident on 5/30/22. An interview conducted on 6/9/22 1:39 PM with the Administrator revealed he was informed from the DON and the Nurse Consultant #1 that it was not a reportable and they had investigated it. He further revealed the DON had talked to other staff members and other cognitive patients about this incident. He stated he was told that Resident #77 was cognitively impaired. He further stated it was the DON and the Nurse Consultant #1 decision to not report. He further revealed the way the information was presented it was just a discussion and not an allegation.	F 607		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		7/5/22

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F 636	Continued From page 6	F 636		

§483.20 Resident Assessment
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication

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F 636	Continued From page 7 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an Admission Minimum Data Set (MDS) assessment within 14 days after the admission date for 1 of 3 residents reviewed for new admissions (Resident #21) and failed to complete a Significant Change in Status Assessment (SCSA) MDS within 14 days after a significant change was determined for 1 of 1 resident reviewed for SCSA MDS (Resident #37). Findings included: 1. Resident #21 was admitted to the facility 4/14/2022. The Admission MDS with an Assessment Reference Date (ARD, the last day of the observation/lookback period) of 4/19/2022 was not completed until 5/2/2022.	F 636	F636 1. . Resident #21 is no longer in the center Resident # 37 significant change assessment was completed 2. A review of MDS(s) completed in the last 30 days was completed to ensure timeliness for new admission assessments and to ensure any significant change MDS(s) were completed timely. Regional Director of Clinical Services performed review 07/01/2022 3. Minimum Data Set Coordinators were educated by the Regional Director of MDS/designee on the timely completion of the MDS assessment by the guidelines of	

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F 636	Continued From page 8 An interview was conducted with MDS nurse #2 on 6/9/2022 at 2:27 PM. MDS nurse #2 reported that the facility had been working with 2 MDS nurses instead of the required 3 nurses, and this had delayed the completion of MDS assessments. MDS nurse #2 reported in April 2022 there was only 1 MDS nurse working and that caused further delays. The Administrator was interviewed on 6/9/2022 at 2:49 PM. The Administrator reported he expected MDS assessments to be completed in a timely manner. 2. Resident #37 was admitted to the facility 9/17/2021. A SCSA MDS with an Assessment Reference Date (ARD, the last day of the observation/lookback period) of 4/18/2022 was not completed until 5/10/2022. An interview was conducted with MDS nurse #2 on 6/9/2022 at 2:27 PM. MDS nurse #2 reported that the facility had been working with 2 MDS nurses instead of the required 3 nurses, and this had delayed the completion of MDS assessments. MDS nurse #2 reported in April 2022 there was only 1 MDS nurse working and that caused further delays. The Administrator was interviewed on 6/9/2022 at 2:49 PM. The Administrator reported he expected MDS assessments to be completed in a timely manner.	F 636	the RAI Manual for new admissions and any significant change MDS assessments. Education completed on 07/01/2022 4. Regional Minimum Data Set Nurse/ designee will audit 5 Minimum Data Set for timely completion weekly for 4 weeks, biweekly for 4 weeks, and then monthly times one 5. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further problem resolution if needed. 6. Administrator is responsible for monitoring the audits needed. 7. Date of Completion 07/05/2022	
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		7/5/22

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F 655	Continued From page 9	F 655		

Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's 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

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F 655	Continued From page 10 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and resident interviews, the facility failed to provide the resident with a written summary of the baseline care plan for 1 of 1 resident (Resident# 240). This practice had the potential to affect other residents. The findings included: Resident 240 was readmitted to the facility on 6/1/22. A baseline care plan was developed within the comprehensive care plan dated 6/2/22 indicated Resident #240 required 1-2 person assist with bathing, showering, transfers and personal hygiene. A review of Discharge Planning/ Social Work progress note dated 6/2/22 indicated Resident #240 was able to answer questions and make decisions on her own. An interview with Resident #240, on 6/7/22 at 9:39 AM, revealed she did not receive a copy of the 48-hour baseline care plan summary. An interview with MDS coordinator on 6/8/22 at 11:58 AM indicated she was not responsible for the 48-hour baseline care plan. She further indicated she was unsure if residents receive a summary of their baseline care plan. An interview with the Discharge Planning	F 655	F655 1. Resident #240 was provided with a copy of her care plans. 2. An audit of residents who were admitted to the facility during the past 14 days completed on 07/01/2022 to ensure a copy of the baseline care plan was provided to the resident/resident representative. 3. The Director of Nursing or designee will provide education to licensed nurses on the requirements for Baseline Care Plans. Education was provided on 07/01/2022. The unit manager is responsible for providing the resident with a copy of their baseline care plans and will make a progress note indicating baseline care plan was given. Unit Managers educated on 07/01/2022. Any Licensed Nurse who is not educated will not be allowed to work until education received. Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of baseline care plan 4. Director of nursing or designee will audit new admission care plans for completion and ensure that a paper copy of the care plan was provided to the patient and or representative 5x per week x 4 weeks, 2x per week x4 weeks, then monthly x1	

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F 655	Continued From page 11 Manager and discharge planning assistant on 6/8/22 at 12:52 PM revealed it was not the facility's standard practice to provide residents with a copy of a 48-hour baseline care plan summary. She stated a comprehensive care plan was entered into the electronic medical record on 6/2/22 and would satisfy the development of the 48-hour baseline care plan. An interview with Director of Nursing (DON) on 6/8/22 at 11:51 AM indicated she had been employed at facility for 3 weeks. She further indicated she was not responsible for implementing care plans and was unaware if it was the facility's standard practice for residents or their representatives receive a copy of the baseline care plan. An interview with the Administrator on 6/9/22 at 2:29 PM revealed he had been employed at the facility for one month and he was unsure what the baseline care plan entailed and that it was not standard practice for residents to receive a copy of the 48-hour baseline care plan.	F 655	5. Results of audits will be reviewed at Quarterly Quality Assurance Risk Meeting X 1 for further problem resolution if needed. Administrator is responsible for monitoring the audits 6. Date of Completion 07/05/2022	
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 700		7/5/22

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F 700	Continued From page 12 §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to repair a broken grab bar for a Resident (Resident #24) for 1 out of 7 residents reviewed for a safe, clean, comfortable, and homelike environment. Findings included: Resident #42 was admitted to the facility on 2/12/22 with diagnoses which included hypertension, paraplegia, and muscle weakness. The admission Minimum Data Set (MDS) dated 5/6/22 indicated Resident #42 was cognitively intact and required extensive with two people assist for bed mobility. An observation and interview conducted on 6/6/22 at 11:15 AM revealed Resident #42's left side grab rail was broken. Resident #42 was further observed moving the grab rail and moved it side to side and picked the rail up to show that it was broken. The grab rail was observed to not be attached to the bed. Resident #42 stated he was frustrated that it had been broken since admission, and he had reported to the nursing	F 700	F700 1. Resident # 42 side grab bar was fixed at the time of notification 2. An audit of current residents in the center using grab bars was completed to ensure the grab bars were functional and in good repair. Audit completed by Maintenance Director on 06/23/2022. 3. Director of Maintenance or designee will educate current staff in all departments on the process of reporting work orders that need to be fixed including loose side grab bars. Education done on 07/01/2022. Staff who are not educated will not be allowed to work until education received. Any new staff will be educated by Director of Maintenance or designee during orientation for process of turning in work orders and when work orders should be completed. 4. Work orders will be audited by administrator or designee to ensure completion of work order 5x weekly for 4 weeks, biweekly for 4 weeks, and then monthly times one. The Director of	

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F 700	Continued From page 13 staff multiple times. Resident #42 indicated he used the grab rail to assist with bed mobility. An interview conducted with Nurse Aide (NA) #1 on 6/7/22 at 2:05 PM revealed Resident #42 had complained bout the broken bed rail multiple times since admission. NA #1 further revealed she had told the Director of Maintenance when Resident #42 was admitted the bed rail was broken and it had not been fixed. NA #1 indicated Resident #42 liked to use the bed rail for re-positioning and assist with incontinence care. An interview conducted with the Director of Maintenance (DOM) on 6/7/22 at 2:45 PM revealed he was not aware Resident #24's left side grab rail was broken and stated nursing staff were supposed to put in a work order on the computer when something needed to be repaired. He stated he did not have an order for the broken grab rail for Resident #24. The DOM stated the grab rail was broken and should have been fixed before resident had moved into the room. An interview conducted with the Administrator on 6/8/22 at 2:45 PM revealed he was not aware Resident #42's grab rail was broken. The Administrator further revealed nursing staff should have completed a work order to have the grab rail repaired.	F 700	Maintenance/designee will audit grab bars on a monthly basis to ensure they are functional and in good repair. 5. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed. Administrator is responsible for monitoring the audits 6. Date of Completion 07/05/2022	
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 726		7/5/22

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F 726	Continued From page 14 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on an observation, interviews with staff, manufacturer's recommendations, and record review, the facility failed to ensure that of 2 of 2 staff members (Medication Aide #1 and Nurse #7) were aware of how to clean and disinfect a glucometer in between residents. Findings included: Cross Refer to F880: Based on an observation, interviews with staff,	F 726	F726 1. Staff performing ineffective cleaning and disinfecting of glucometer after use were immediately provided with education on procedure. 2. Residents that require glucometer checks have the potential to be affected 3. Director of Nursing or designee will educate licensed nurses on the proper cleaning and disinfecting technique of glucometers using manufacturer□s	

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F 726	Continued From page 15 manufacturer's recommendations, and record review, the facility failed to clean and disinfect a glucometer per manufacturer's recommendation for 1 of 1 staff observed for finger stick blood sugar (FSBS) checks (Medication Aide #1) and failed to establish a policy for minimizing risk of infectious disease through a policy to either disinfect the glucometer per manufacturer's guidelines or have each resident utilize their own assigned glucometer.	F 726	guidelines of the recommended product. Education was completed by 07/01/2022 Any Licensed Nurse who is not educated will not be allowed to work until education received. Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of proper cleaning of glucometers 4. Director of Nursing or designee will audit glucometer cleaning and disinfecting after patient use on all shifts 5 observations of cleaning and disinfecting weekly for 4 weeks, biweekly for 4 weeks, and then monthly times 1 Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed. Administrator is responsible for monitoring the audits 5. Date of Completion 07/05/2022	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interviews, sample test tray, and staff interviews,	F 804	F804	7/5/22

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F 804	Continued From page 16 the facility failed to provide meals that were palatable and at an appetizing temperature to 2 of 2 sample residents (Resident #72 and #13). The findings included: a. Resident #72 was admitted to the facility on 5/13/22. An Admission Minimum Data Set (MDS) assessment dated 5/13/22, assessed Resident #72 with clear speech, adequate hearing/ vision, able to understand and be understood, intact cognition and independent with eating after tray set up. On 6/6/22 at 12:47 PM Resident #72 was interviewed. She revealed sometimes the food was cold. She further revealed this morning she had to ask them to reheat the English muffin so that the butter would melt. b. Resident #13 was readmitted to the facility on 4/7/22. An Admission MDS assessment dated 4/11/22 indicated Resident #13 was cognitively intact, speech was clear, hearing was adequate, able to understand and be understood, cognitively intact and independent with eating after tray set up. A test tray was requested on 6/8/22 at 9:17AM for a regular lunch meal tray. An observation of the satellite kitchen on 6/8/22 at 11:35AM revealed food was transported to the satellite kitchen in an enclosed cart. Further observation at 12:05PM revealed the food was placed on the steam table. An observation at 12:30PM revealed 300 Hall trays was plated with food warmer under the bottom of the plate and dome that covered the top. The trays were placed	F 804	1. Resident #13 is no longer a resident at the facility. Resident #72 is now receiving his food preferences as well as his food being palatable and served at the correct temperatures. 2. Current residents have the potential to be affected. 3. Dietary Manager/Administrator to educate current full time, part time, and as needed dietary staff and nursing staff on the expectation of serving foods that are palatable and at the resident□s preferred temperature. Education also to include the expectation of reheating a meal that was at an undesired temperature as well as offering an alternate to residents. Education completed on 07/01/2022. Education will be added to new hire orientation. 4. The Dietary Service Director or designee will complete a test tray to ensure temperature and palatability of tray 5 x a week x 4 weeks, 3 x a week x 4 weeks, and 1x per week x 4 weeks, using the Dietary QA Audit. In addition, the Dietary Services Director will interview 5 residents weekly to ensure food temperature and palatability are met 5. Results of audits will be reviewed in Quarterly Quality Assurance meeting x1. Administrator is responsible for monitoring the audits 6. Date of Completion 07/05/2022	

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F 804	Continued From page 17	F 804		

in an enclosed cart. The tray delivery started on 300 halls at 12:47PM and all residents on the 300 Hall were served by 12:58 PM. The 300 Hall was the last hall in the facility to be served lunch.

The test tray meal was plated at 1:00 PM with meatballs, mashed potatoes, mixed vegetables, pasta, boiled potatoes, and fish. The Dietary Manager (DM) raised the lid off the tray and observed no steam coming from the tray. The DM and surveyor sampled the foods and observed the following: the fish was without visible steam, hard to chew and had no taste, while mashed potatoes were room temperature, bland and observed to not hold shape when plated. The pasta, boiled potatoes, and meatballs were warm. The green beans were not hot and were heavily seasoned.

An interview with the Dietary Manager (DM) on 6/8/22 at 1:15 PM revealed all the food could have been hotter. He further revealed the green beans were salty. He stated the meatballs had a good flavor. And the pasta could have been warmer. He further revealed the fish was cold, dry, and overcooked. He stated the fish was not good. The DM stated the texture of the fish was not palatable and could not have been served to those with choking potential. He further stated there was no steam present and it was their responsibility to make sure the temperature of the food was hot. He stated the food should be presentable and palatable and was not.

On 06/08/22 at 3:15 PM Resident # 13 indicated that at lunch some of the food was cold and it could have used more flavor.

An interview with the Administrator on 6/9/22 at

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F 804	Continued From page 18 3:31 PM indicated it was the DM responsibility to make sure the food served is palatable and hot.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to date, remove, and/or discard food items stored for use with signs of spoilage, stored past the use by date and/or stored open to air in 1 of 1 walk in cooler, 1 of 1 walk in freezer, and 1 of 1 dry storage area. These practices had the potential to affect residents served this food. The findings included: 1. An observation of the walk-in cooler was made on 6/6/22 at 10:22 AM along with Dietary	F 812	F812 1. Expired foods were immediately discarded as well as any food items with any signs of spoilage. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Current Dining Services employees will be in-serviced by the Dietary Manager/designee regarding proper procedures for discarding expired food items, labeling and dating item, storing	7/5/22

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F 812	Continued From page 19 Manager (DM). The observation revealed the following: a. 11 red bell peppers that was noted to be discolored, mushy, and wilted. b. 4 large bags of shredded cabbage with use by date of 5/10/22 with dark brown discoloration throughout, soft texture, and wilted. c. 3 bags of lettuce wilted with brown discoloration throughout each bag. 2. An observation of the walk-in freezer was made on 6/6/22 at 10:30 AM along with DM. The observation revealed the following: a. 3 frozen pork chops out of the box, in a bag, not labeled or dated b. 20 frozen fried chicken patties out of the box, open to air, not labeled or dated. c. 11 frozen French toast out of the box, in a bag, not labeled or dated d. 15 frozen cheese omelets out of the box, in a bag, not labeled or dated e. 20 frozen English muffins out of the box, in a bag, open and not dated 3. An observation of the dry storage area was made on 06/6/22 at 10:35 AM along with DM. The observation revealed the following: a. Ground nutmeg dated 4/13/20 to be discarded 4/13/22 b. Dill weed spice dated 4/30/20 to be discarded 4/30/22 c. Rosemary spice dated 4/6/20 to be discarded 4/6/22 d. 1 box of quick grits open to air not dated, stored on shelf above the stove.	F 812	food items when received, and proper procedure for storing foods in refrigerated/freezer storage. Education completed on 07/01/2022 New hires will receive in-service education by Dietary Services Manager on proper procedures for discarding expired food, labeling and dating items when received and opened. 4. A sanitation inspection will be conducted by Corporate Registered Dietician or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions and sanitation standards. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. 5. Findings from sanitation inspections will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. Administrator is responsible for monitoring the audits 6. Date of Completion 07/05/2022	

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F 812	Continued From page 20 The Dietary Manager (DM) was interviewed on 6/6/22 at 10:35 AM. Dietary Manager stated the staff was to discard anything that was out of date or showed signs of spoilage. He further stated the dietary supervisor along with himself was responsible for going behind the chefs and checking the products every morning. He further indicated the items should be stored and dated properly and should not be left open to air. The Administrator was interviewed on 6/9/22 3:31PM he revealed it is the DM responsibility to make sure there was no expired food and food was to be stored properly in the kitchen.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 2/28/20 recertification survey. This was for one deficiency in the area of: F812, which was originally cited in February 2020. The deficiency was recited again on the current recertification with an exit date of 6/9/22. The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality	F 867	F867 1. Expired foods were immediately discarded as well as any food showing signs of spoilage 2. Current residents have the potential to be affected. 3. Current Dining Services employees will be in-serviced by the Dietary Manager/designee regarding proper procedures for discarding expired food items, labeling and dating item, storing food items when received, and proper	7/5/22

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F 867	Continued From page 21 Assessment and Assurance program The findings included: This tag is cross referenced to: F812-Based on observations and staff interview the facility failed to date, remove, and/or discard food items stored for use with signs of spoilage, stored past the use by date and/or stored open to air in 1 of 1 walk in cooler, 1 of 1 walk in freezer, and 1 of 1 dry storage area. These practices had the potential to affect residents served this food. During the recertification survey of 2/28/20 the facility was cited for failure to monitor produce (medium sized red tomatoes) with signs of spoilage in 1 of 1 walk-in refrigerator and failed to label and date 1 bag of vegetables (mini corn on the cob) in 1 of 1 walk in freezer. An interview was conducted with the Administrator on 6/9/22 at 2:41 PM. The Administrator stated he had not received complaints about the food at the facility since he had arrived a little over a month ago. He further stated he had not had problems with the contracted company he had who managed the dietary department. He provided information about the Quality Assurance (QA) Committee, the frequency they met, who attends the meetings, a brief overview of a topic which had recently been addressed. He stated the QA committee had not reviewed, nor discussed deficient practices which had been cited during the last recertification which took place more than 2 years ago since he had become administrator.	F 867	procedure for storing foods in refrigerated/freezer storage. Education completed 07/01/2022 New hires will receive in-service education by Dietary Services Manager on proper procedures for discarding expired food, labeling and dating items when received and opened. 4. A sanitation inspection will be conducted by Corporate Registered Dietician or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions and sanitation standards. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. 5. Findings from sanitation inspections will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. Administrator is responsible for monitoring the audits 6. Date of Completion 07/05/2022	
F 880 SS=E	Infection Prevention & Control	F 880		7/5/22

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F 880	Continued From page 22 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 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	F 880		

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	345570	A. BUILDING _____ B. WING _____	C 06/09/2022

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F 880	Continued From page 23 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 an observation, interviews with staff, manufacturer's recommendations, and record review, the facility failed to clean and disinfect a glucometer per manufacturer's recommendation for 1 of 1 staff observed for finger stick blood sugar (FSBS) checks (Medication Aide #1) and failed to establish a policy for minimizing risk of infectious disease through a policy to either disinfect the glucometer per manufacturer's guidelines or have each resident utilize their own	F 880	F880 1. The center initiated a policy for disinfecting and cleaning of glucometers between use to minimize risk of infectious disease. Staff performing ineffective cleaning and disinfecting of glucometer after use were immediately provided with education on facility policy which states to disinfect glucometers per manufacturer□s guidelines between patients.	

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F 880	Continued From page 24 assigned glucometer. Findings included: Glucometer manufacturer recommendations for cleaning and disinfecting were reviewed. The glucometer manufacturer recommended and provided a list of validated disinfectant wipes. Further review revealed other Environment Protection Agency (EPA) registered wipes may be used for disinfecting the meter. Review of directions for use for the disinfectant wipes which were in use at the facility revealed the produce was a virucidal (kills viruses) in the presence of organic soil (5% blood serum) against Human Immunodeficiency Virus (HIV) type 1, Strain HTLV-IIIB (HIV-1) associated with AIDS) at minutes contact time. Further review revealed for virucidal activity: The product was an effective virucide on hard, non-porous surfaces against: HIV when the treated surface is to remain wet for 2 minutes. The facility did not have a policy to either disinfect the glucometer per manufacturer's guidelines or have each resident utilize their own assigned glucometer. An observation and interview were conducted of Medication Aide (MA) #1 on 6/7/22 during her medication pass which started at 3:27 PM. The MA removed a glucometer which was stored in the medication cart. The MA stated each resident did not have their own glucometer and after each FSBS the glucometer was cleaned. The MA proceeded to go to the room of Resident #76 and was observed performing a finger stick blood sugar (FSBS) on Resident #76. Upon leaving the	F 880	2. Residents that require glucometer checks have the potential to be affected 3. Director of Nursing or designee will educate licensed nurses on the proper cleaning and disinfecting technique of glucometers using manufacturer□s guidelines of the recommended product between each patient use as per facility policy states. Education was completed by 07/01/2022 Any Licensed Nurse who is not educated will not be allowed to work until education received. Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of proper cleaning of glucometers 4. Director of Nursing or designee will audit glucometer cleaning and disinfecting after patient use on all shifts 5 observations of cleaning and disinfecting weekly for 4 weeks, biweekly for 4 weeks, and then monthly times 1 Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed. Administrator is responsible for monitoring the audits 5. Date of Completion 07/05/2022	

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room, the MA returned to the medication cart, opened two alcohol wipe pads and proceeded to wipe down the glucometer with the alcohol wipe pads and placed the glucometer on the top of the cart. The MA picked up the glucometer from the medication cart and proceeded to go to the room of Resident #39 and was about to conduct a FSBS on Resident #39 when she was informed to not conduct the FSBS. The MA stated she had wiped the glucometer down with the two alcohol pads and which had disinfected the glucometer. An observation of the glucometer revealed no evidence of bodily fluids. The MA stated she was going to ask the nurse who was supervising her if there was another way, she should have been disinfecting the glucometer.

During an observation and interview conducted on 6/7/22 at 3:52 PM with MA #1 and Nurse #7, Nurse #7 stated there were "clean" wipes in the bottom drawer of the nurse ' s cart, in a round container. She said those wipes were to be used to clean the glucometer. She further explained each resident should have had their own glucometer. The nurse and the MA then went to the medication room where there were several glucometers in boxes, but the nurse stated there were not enough glucometers for each resident on the hall.

MA #1 returned to the cart at 3:55 PM on 6/7/22 and an observation and interview were conducted. The MA was observed to remove a wipe from the round container of sanitizer wipes, wiped down the glucometer she had used for Resident #76. She discarded the first wipe into the garbage, then utilized a second sanitizer wipe to wipe down the glucometer and discarded the second wipe into the garbage. The MA stated

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she had not received any training regarding cleaning the glucometers with the disinfectant wipes.

Nurse #7 approached MA #1 at the nurse's cart at 4:00 PM on 6/7/22 and was heard to tell the MA to make sure she was wiping the glucometers "real good."

At 4:05 PM on 6/7/22 MA #1 opted not to use the glucometer she had wiped down with the disinfectant wipe. The MA stated she would use on of the glucometers which was from the medication room and was new in the box. The NA was then observed to utilize the new glucometer to obtain a FSBS on Resident #39.

During an interview conducted on 6/7/22 at 4:15 PM with the Staff Development Coordinator (SDC) she stated each resident who required FSBS at the facility should have their own glucometer.

An interview was conducted on 6/7/22 at 4:37 PM with the Administrator, the Director of Nursing (DON), the SDC, and the Regional Nurse Consultant (RNC). The SDC stated during orientation staff were not trained specifically how to clean or disinfect the glucometers, but they were trained to read the directions for use for the glucometers and the sanitizer wipes. The RNC stated the facility did not have a policy for how to clean the glucometers and that staff were expected to follow the manufacturer ' s directions for the glucometers and the disinfectant wipes. The DON stated the glucometers should not be cleaned with alcohol pads and should be cleaned with the disinfectant wipes according to the directions for the glucometer and the directions

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F 880	Continued From page 27 for the disinfectant wipes. The RNC stated there was no policy for each resident receiving their own glucometer, however, each resident who required FSBS monitoring was to receive a new glucometer at the time of admission and then they were allowed to take it home with them when they were discharged. The Administrator stated it was his expectation for the glucometers to be cleaned as per the manufacturer ' s recommendations and following the directions for the sanitizer wipes.	F 880		