STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

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E 000	Initial Comments An unannounced recertification and complaint survey were conducted on 06/20/2022 through 06/24/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# H60G11.	E 000		
F 000	INITIAL COMMENTS An onsite unannounced recertification survey and complaint investigation were conducted on 06/20/2022 through 06/24/2022. A total of 38 allegations were investigated and 23 were substantiated. Intakes: NC00179555, NC00180351, NC00182612, NC00182843, NC00183166, NC00184066, NC00184774, NC00185833, NC00186184, NC00186475, NC00186651, NC00186682, NC00187139, NC00187225, NC00189904, NC00190318, Event ID# H60G11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		7/25/22

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

Electronically Signed | 07/21/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to treat a resident in a dignified manner, when a nurse spoke abruptly to a resident (Resident #44) without looking at her to acknowledge her request for a cup of ice. This affected 1 of 4 residents reviewed for dignity and respect and made Resident #44 "feel bad." The findings included: Resident #44 was admitted to the facility on 09/30/19 with diagnoses which included cerebrovascular accident or stroke, and	F 550	Resident #44 was provided with a cup of ice as requested on 6/21/22. Resident #44 was interviewed by Director of Nursing and Administrator on 6/21/2022. Resident did not voice any concerns about the incident and did not recall the incident or appear to have experienced any related mental anguish. On 7/13/22-7/15/2022 current residents were interviewed regarding whether they felt as though employees treated them with dignity and respect. Every resident was provided a list of resident rights. For	

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F 550	Continued From page 2	F 550		

hemiplegia.

Resident #44's annual Minimum Data Set (MDS) assessment revealed she was severely cognitively impaired and was on a therapeutic diet with thin liquids. Resident #44's assessment also revealed the resident was always understood and always understands.

Observation on 06/21/22 at 3:05 PM of Resident #44 revealed she was at the nurse's station sitting in her wheelchair holding a white cup. Nurse #4 walked in front of the resident and the resident asked Nurse #4 for a cup of ice. Nurse #4 without looking at the resident, and in an abrupt tone stated, "you are just going to have to wait." Nurse #4 picked up her clipboard and walked in front of Resident #44 again without acknowledging her and continued to walk down the hall to the medication cart. Nurse #4 did not ask the 2 nursing aides sitting at the desk to assist the resident and did not get the resident a cup of ice as she had requested.

An interview was conducted on 06/21/22 at 3:25 PM with the Director of Nursing (DON). The DON was informed about Nurse #4 abruptly responding to the request of Resident #44 for a cup of ice and the subsequent failure to provide the cup of ice to the resident. The DON revealed Nurse #4 had not worked a lot at the facility and stated the facility would not tolerate residents being spoken to in an abrupt manner and their requests being "ignored" by any employee. The DON stated Nurse #4 would be relieved of her duties immediately pending an investigation.

Interview on 06/21/22 at 3:35 PM with Resident #44 revealed she was alert to person, place and

residents who were unable to be interviewed, their responsible parties were interviewed on their behalf. Any concerns were addressed immediately.

On 7/19/2022 the Director of Nursing and/or designee provided education to all staff members on treating residents with dignity and respect and if a staff member is unable to fulfill a resident's request to find another staff member who is able to. Newly hired staff will be educated upon hire. Agency staff will have education provided prior to working their shift.

Starting on the 7/18/2022 the Director of Social Services and/or designee will complete quality monitoring of residents to determine if they feel they are treated with dignity and respect. Audits will be completed three times per week for 12 weeks.

The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 7/18/22. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance

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F 550	Continued From page 3	F 550		

time at the time of the interview. Resident #44 recalled the interaction at the nurse's station with Nurse #4 and stated the nurse "made me feel bad but I couldn't say anything because I am just a resident." Resident #44 went on to explain that "some of the employees working here only wanted money and didn't want to take care of the residents."

A follow up interview on 06/24/22 at 9:59 AM with the DON revealed she had done one on one education with Nurse #4 about how to appropriately speak to residents and had sent her home and notified her agency that Nurse #4 was not to return to the facility.

A phone interview on 06/24/22 at 3:38 PM with Nurse #4 revealed she had just reported for work and checked to see where she was working for her shift and was going to count the medication cart with the nurse that was leaving and went to grab her clipboard when the resident asked her for some ice water. Nurse #4 stated the resident was not assigned to her and had passed her nurse coming to the nurse's station and said there were 2 Nurse Aides (NAs) at the desk, and she told the resident, "you are just going to have to wait a minute." Nurse #4 stated she was not aware the "State was in the building" and said when she completed counting the medication cart with the nurse that was leaving, she was told to report to the DON's office. She stated she went into the DON's office, and she had her sign a paper and go home. Nurse #4 further stated, "I didn't say nothing more to the resident than what I said" but the DON sent me home.

An interview on 06/24/22 at 6:50 PM with the Administrator revealed she expected all staff to

Improvement Committee monthly for three months.
Date of Completion 7/25/22

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F 550	Continued From page 4 always treat all residents with dignity and respect.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, and staff interviews the facility failed to honor a resident's request to get out of bed to attend a scheduled activity for 1 of 5 residents reviewed	F 561	Resident #16 was up and ready for Bingo activity provided on 6/27/2022. On 6/30/2022-7/14/2022 current residents	7/25/22

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F 561	Continued From page 5 for choices (Resident #16). The findings included: Resident #16 was admitted to the facility on 04/30/18 with diagnoses including lack of coordination and heart failure. Review of the annual Minimum Data Set (MDS) dated 04/25/22 assessed Resident #16's cognition was intact with no refusal of care during the lookback period. The MDS also indicated Resident #16 required total assistance by 2-person using a mechanical lift for transfers. The Care Plan (CP) revised on 01/26/22 revealed Resident #16 was independent for meeting social needs but due to immobility and physical limitations might need encouragement and reminders to activities. The CP goals included to attend and participate in activities of choice. The interventions directed nursing staff to assist and escort and listed bingo as one of Resident #16's preferred activities. During an interview on 06/21/22 at 9:05 AM Resident #16 revealed she wanted to participate in bingo, a scheduled activity on 06/20/22. Resident #16 revealed she made Nurse Aide (NA) #3 aware she wanted out of bed to play bingo and called the front desk to request assistance out of bed. When Resident #16 revealed she was not assisted out bed and missed bingo she became tearful. Resident #16 stated when bingo was a scheduled activity, she wanted to get out of bed to attend and indicated staff were aware of this. Resident #16 was unable to recall who she spoke with on phone on 06/20/22 to request assistance out of bed.	F 561	were ask about their preferences in attending scheduled Bingo activities. Any changes in preferences related to activities were addressed accordingly. On 7/19/2022 the Director of Nursing and/or designee provided education to Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistances on getting residents up for scheduled activities as requested by the resident. Newly hired staff will be educated upon hire. Agency staff will have education provided prior to working their shift. Starting on the 7/18/2022 the Director of Nursing and/or designee will completed quality monitoring of residents getting up for scheduled activities as requested by the resident. Audits will be completed three times per week for 12 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 07/18/22. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for	

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F 561	Continued From page 6 An interview was conducted on 06/22/22 at 12:20 PM with the Business Office Manager (BOM). The BOM revealed Resident #16 frequently called the front office to make her needs known and they could assist with no hands-on care or encourage her to use the call light for NA staff or if engaged office staff would find a NA to assist with care. The BOM revealed to her knowledge Resident #16 hadn't called to request assistance with getting out of bed. An interview was conducted on 06/22/22 at 12:35 PM with NA #3. NA #3 revealed he was responsible for the care of Resident #16 on 06/20/22 and was aware she wanted to get out of bed on Monday and Wednesday to play bingo. NA #3 revealed on 06/20/22 due to a being short staffed he was assigned approximately 30 residents to care for and three with outside appointments he had to get ready. NA #3 stated he didn't have time to get Resident #16 out of bed for bingo and revealed at times residents who needed 2-person assistance using a mechanical lift stayed in bed due to being short of staff. NA #3 stated it only happened once in while that he couldn't get residents out of bed upon request. A joint interview was conducted on 06/24/22 at 6:48 PM with the Administrator and Director of Nursing (DON). The DON revealed she was not aware Resident #16 wanted to get out of bed on 06/20/22. The DON indicated if she knew Resident #16 wanted out of bed she would have provided assistance. Both the Administrator and the DON stated their expectation was for nursing staff to assist a resident out of bed upon request.	F 561	three months. Date of Completion 7/25/22	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment	F 584		7/25/22

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F 584	Continued From page 7 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §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	F 584		

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F 584	Continued From page 8 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to properly label and store personal items for 2 of 36 bathrooms (bathrooms of Room 204 and Room 208), maintain clean and sanitary walls for 1 of 36 bathrooms (bathroom Room 204), maintain walls in good repair for 1 of 54 rooms (Room 204), and maintain clean and sanitary privacy curtains for 3 of 54 rooms (Rooms 313, 408, and 409) reviewed for safe, clean, comfortable, and homelike environment. The deficient practice affected 3 of 5 halls (200, 300, and 400 halls). Findings included: 1. An observation and interview on 06/20/22 at 11:20 AM revealed Resident #38's privacy curtain in room #409 had several white stains scattered in the middle and lower part of the dark green curtain. Resident #38 voiced she did not like that her privacy curtain looked "dirty and stained" and stated when she mentioned it to facility staff, they were going to replace it with a new one but haven't. She added, "maybe they could at least try to wash it." Subsequent observations on 06/21/22 at 9:58 AM and 06/24/22 at 9:20 AM revealed the condition of the privacy curtain remained unchanged. An observation and interview were conducted on 06/24/22 at 3:10 PM with the Housekeeping Account Manager. The Housekeeping Account Manager observed the white stains on the privacy	F 584	Privacy curtains in Room #409, Room #408A, Room #313B□s room were immediately replaced with curtains in good repair and free of stains. Unlabeled personal items in Room #208 and Room #204 were immediately discarded and replaced with new labeled items as needed. Brown substance in bathroom of Room #204 was immediately cleaned. Exposed sheetrock in Room #204B was immediately repaired. Beginning on 7/13/22 privacy curtains in 100% of resident rooms were audited by housekeeping supervisor for stains, substances, and to ensure good repair. Any curtains not in good repair were immediately removed and replaced. Beginning on 6/27/22, the interdisciplinary team conducted a quality review audit of 100% of rooms and bathrooms to ensure no personal items were unlabeled. All unlabeled items were immediately discarded and replaced with new labeled items as needed. Beginning on 7/13/22, the housekeeping supervisor conducted a quality review audit of 100% of rooms and bathrooms to ensure no brown substances were found on walls. Any issues identified were immediately cleaned. Beginning on 7/13/22, maintenance director conducted an audit of 100% of rooms to ensure no exposed sheetrock. Any identified issues were immediately repaired.	

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F 584	Continued From page 9 curtain in Room #409. The Housekeeping Account Manager explained privacy curtains were changed or washed as needed, during a room change, and/or when the room was deep cleaned once a month. He further explained privacy curtains should be checked for cleanliness when resident rooms were cleaned daily. The Housekeeping Account Manager stated he would ensure Resident #38's privacy curtain in room #409 would be washed and/or replaced. During an interview on 06/24/22 at 5:25 PM the Administrator revealed it was her expectation privacy curtains were changed when resident rooms were deep cleaned and as needed. The Administrator stated she expected staff to notice dirty and/or stained privacy curtains in order for them to be cleaned or replaced. 2. An observation on 06/21/22 at 2:55 PM revealed the beige privacy curtain in Room #408-A was pulled around the bed, visible from the hall, and had a several green stains scattered throughout the center of the curtain. Subsequent observations on 06/21/22 at 4:40 PM and 06/24/22 at 9:20 AM revealed the privacy curtain in Room #408-A was pulled around the bed, visible from the hall and the condition of the privacy curtain remained unchanged. An observation and interview were conducted on 06/24/22 at 3:10 PM with the Housekeeping Account Manager. The Housekeeping Account Manager observed the green stains on the privacy curtain in Room #408-A and stated the stains were permanent and would not wash out. The Housekeeping Account Manager explained privacy curtains were changed or washed as	F 584	On 7/19/22 all Administrative, Housekeeping, Nursing, and Therapy staff were educated on personal items to be bagged and labeled appropriately, notifying housekeeping of stained curtains, substances on walls, and notifying maintenance of any exposed sheetrock. Newly hired employees will be educated during orientation and contracted staff will be educated prior to their first shift Staff will not be allowed to work until they have been educated. Starting on 7/18/22 the interdisciplinary team will complete quality review monitoring of random resident rooms and bathrooms to determine if their curtains are in good repair, walls are free of stains/ substances, personal items are labeled, and to ensure no sheetrock is exposed. These quality monitors will be completed on 5 random residents rooms 3 times weekly for 12 weeks. The Executive Director introduced the plan of correction to the Quality Assurance Perform Improvement Committee on 7/18/22. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and minimum of one direct care giver. The Executive Director will report findings to the Quality Assurance Performance Improvement Committee monthly for	

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F 584	Continued From page 10 needed, during a room change, and/or when the room was deep cleaned once a month. He further explained privacy curtains should be checked for cleanliness when resident rooms were cleaned daily. The Housekeeping Account Manager stated he would ensure the privacy curtain in room #408-A would be replaced. During an interview on 06/24/22 at 5:25 PM the Administrator revealed it was her expectation privacy curtains were changed when resident rooms were deep cleaned and as needed. The Administrator stated she expected staff to notice dirty and/or stained privacy curtains in order for them to be cleaned or replaced. 3 a. An observation of the shared bathroom of Room 208 on 06/20/22 at 10:35 AM revealed an unlabeled razor sitting on the side of the sink and 2 unlabeled and uncovered bath pans stacked inside each other sitting on the floor under the sink. An observation of the shared bathroom of Room 208 on 06/23/22 at 03:26 PM revealed an unlabeled razor sitting on the side of the sink and 2 unlabeled and uncovered bath pans stacked inside each other sitting on the floor under the sink. An observation of the shared bathroom of Room 208 on 06/24/22 at 03:19 PM revealed an unlabeled razor sitting on the side of the sink and 2 unlabeled and uncovered bath pans stacked inside each other sitting on the floor under the sink. An observation of the shared bathroom of Room	F 584	three months. Date of Completion 7/25/22	

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208 was conducted with the Director of Nursing (DON) on 06/24/22 at 03:20 PM. An interview with the DON at the same date and time revealed she expected all personal items to be labeled and stored appropriately. She stated any staff member who placed personal items in bathrooms was responsible for labeling and storing the items appropriately.

An interview with the Administrator on 06/24/22 at 06:23 PM revealed she expected all personal items to be labeled and stored appropriately.

b. An observation of the shared bathroom of Room 204 on 06/20/22 at 12:02 PM revealed 2 unlabeled razors, an unlabeled comb, and an unlabeled brush were sitting on the side of the sink.

An observation of the shared bathroom of Room 204 on 06/23/22 at 08:26 AM revealed 2 unlabeled razors, an unlabeled comb, and an unlabeled brush were sitting on the side of the sink.

An observation of the shared bathroom of Room 204 on 06/24/22 at 02:05 PM revealed an unlabeled brush was sitting on the side of the sink and an unlabeled toothbrush was sitting on the back of the toilet.

An observation of the shared bathroom of Room 204 was conducted with the DON on 06/24/22 at 03:20 PM. An interview at the same date and time revealed she expected all personal items to be labeled and stored appropriately. She stated any staff member who placed personal items in bathrooms was responsible for labeling and storing the items appropriately.

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An interview with the Administrator on 06/24/22 at 06:23 PM revealed she expected all personal items to be labeled and stored appropriately.

c. An observation of the wall between the toilet and sink of the shared bathroom of Room 204 on 06/20/22 at 12:02 PM revealed a brown substance that was easily removable with a paper towel.

An observation of the wall between the toilet and sink of the shared bathroom of Room 204 on 06/23/22 at 08:26 AM revealed a brown substance that was easily removable with a paper towel.

An observation of the wall between the toilet and sink of the shared bathroom of Room 204 on 06/24/22 at 02:05 PM revealed a brown substance that was easily removable with a paper towel.

An observation of the wall of the shared bathroom of Room 204 was conducted with the Housekeeping Accounts Manager on 06/24/22 at 03:13 PM. An interview at the same date and time revealed bathrooms were cleaned daily and that included checking the walls for any stains or splashes. He stated the brown substance should not be on the bathroom wall of Room 204 and it was overlooked when the bathroom was cleaned.

An interview with the Administrator on 06/24/22 at 06:23 PM revealed she expected she expected the bathroom walls to be clean.

d. An observation of Room 204 on 06/20/22 at 10:49 AM revealed an exposed area of sheetrock

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approximately 6 to 8 inches long on the wall beside B bed.

An observation of Room 204 on 06/23/22 at 08:21 AM revealed an exposed area of sheetrock approximately 6 to 8 inches long on the wall beside B bed.

An observation of Room 204 on 06/24/22 at 02:09 PM revealed an exposed area of sheetrock approximately 6 to 8 inches long on the wall beside B bed.

An observation of the wall in Room 204 was conducted with the Maintenance Director on 06/24/22 at 03:23 PM. An interview at the same date and time revealed he tried to interact frequently with residents and he checked their rooms for needed repairs when he was taking with residents. He stated he was in Room 204 frequently but overlooked the area of exposed sheetrock next to B bed.

An interview with the Administrator on 06/24/22 at 06/23 PM revealed she expected the walls to be maintained in good repair.

4. An observation on 06/21/22 at 9:23 AM revealed the resident's privacy curtain in Room #313-B had a brown colored smear stain on lower part of the curtain.

On 06/22/22 at 9:17 AM the privacy curtain in Room #313-B continued to have the same brown colored stain.

An observation and interview were conducted on 06/24/22 at 3:10 PM with the Housekeeping Account Manager. The Housekeeping Account

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F 584	Continued From page 14 Manager observed the brown colored smear stain on the privacy curtain in Room #313-B. The Housekeeping Account Manager revealed privacy curtains were changed or washed as needed and monthly when the room was deep cleaned and during a room change. He also expected privacy curtains were checked daily when a resident's room was cleaned. The Housekeeping Account Manager stated he would ensure the privacy curtain in Room #313-B would be washed and/or replaced. During an interview on 06/24/22 at 5:25 PM the Administrator revealed it was her expectation privacy curtains were changed when resident rooms were deep cleaned and as needed. The Administrator stated if a stain on the privacy curtain appeared to be fecal matter or blood, she wanted it changed as soon as possible. The Administrator revealed she expected staff to notice dirty privacy curtains to ensure if needed it would be cleaned or replaced.	F 584		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 644		7/25/22

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F 644	Continued From page 15 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) review for residents with a new mental health diagnosis for 4 of 6 sampled residents reviewed for PASRR (Residents #10, #37, #62, and #69). Findings included: 1. A PASRR Notification letter dated 08/08/16 revealed Resident #10 had a Level 1 PASRR with no expiration date. Resident #10 was admitted to the facility on 06/07/17 with diagnoses that included anxiety and bipolar disorder. Review of Resident #10's list of cumulative diagnoses contained in his medical record revealed a new diagnosis of major depressive disorder with the onset date of 06/02/21. The annual Minimum Data Set (MDS) dated 12/05/21 revealed Resident #10 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. During an interview on 06/10/22 at 9:47 AM, the Social Worker (SW) explained she was new to the position and was unaware of the regulation	F 644	On 6/20/22 residents #10 #37 #62 and #69 were found to have inaccurate Level 1 PASRR. Residents were reviewed and updates were sent to determine if the resident needed a Level 1 or Level 2 PASRR by the Social Services Director on 6/21/22. A quality review was conducted by the Social Services Director on 6/21/22 of current residents to ensure accuracy of PASRR. Issues or concerns were addressed as they were identified. Re-education was completed by the Vice President of Clinical Services to Administrator, then Administrator to Social Services Director, Admissions Directors, Director of Nursing, and MDS Nurse on 6/20/22 on the components of this regulation with emphasis on ensuring accuracy of resident□s PASRR. The interdisciplinary team will meet five times weekly to discuss new diagnoses and changes of condition. The Director of Nursing. Assistant Director of Nursing, or Designee will present new mental health diagnoses to director of social services for appropriate follow up. The Social Services Director/ Designee will conduct quality review monitoring of 5 residents weekly x 12 weeks to ensure accuracy of PASRR. The findings of these quality reviews will	

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F 644	Continued From page 16 requirement to request a PASRR review for any resident with a new mental health diagnosis or significant change in condition. The SW confirmed she had not requested a Level II PASRR evaluation for Resident #10. During an interview on 06/10/22 at 12:09 PM, the Administrator confirmed knowledge of the regulation requirement to request a Level II PASRR evaluation when a resident had a new mental health diagnosis or a significant change in condition. The Administrator explained during the survey process, they realized they did not have a system for requesting PASRR re-evaluations and going forward, the SW would be the person responsible for requesting Level II PASRR reviews when indicated. 2. Resident #37 was admitted to the facility on 12/11/15 with multiple diagnoses that included schizophrenia, major depressive disorder, and anxiety disorder. A PASRR Notification letter dated 10/24/18 revealed Resident #37 had a Level I PASRR with no expiration date. Review of Resident #37's psychiatric progress note dated 10/11/21 revealed a new diagnosis of delusional disorder. The annual Minimum Data Set (MDS) dated 01/14/22 revealed Resident #37 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. During an interview on 06/10/22 at 9:47 AM, the Social Worker (SW) explained she was new to	F 644	be reported to the Quality Assurance/ Performance Improvement Committee monthly x 2 months or until committee determines substantial compliance has been met. Date of Completion 7/25/22	

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the position and was unaware of the regulation requirement to request a PASRR review for any resident with a new mental health diagnosis or significant change in condition. The SW confirmed she had not requested a Level II PASRR evaluation for Resident #37.

During an interview on 06/10/22 at 12:09 PM, the Administrator confirmed knowledge of the regulation requirement to request a Level II PASRR evaluation when a resident had a new mental health diagnosis or a significant change in condition. The Administrator explained during the survey process, they realized they did not have a system for requesting PASRR re-evaluations and going forward, the SW would be the person responsible for requesting Level II PASRR reviews when indicated.

3. A PASRR Notification letter dated 02/24/19 revealed Resident #62 had a Level I PASRR with no expiration date.

Resident #62 was admitted to the facility on 06/22/20 with multiple diagnoses that included hip fracture.

Review of Resident #62's list of cumulative diagnoses contained in her medical record revealed a new diagnosis of major depressive disorder with an onset date of 07/05/21 and unspecified psychosis with an onset date of 08/31/21.

The annual Minimum Data Set (MDS) dated 08/15/21 revealed Resident #62 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

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The annual Minimum Data Set (MDS) dated 06/02/22 revealed Resident #62 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

During an interview on 06/10/22 at 9:47 AM, the Social Worker (SW) explained she was new to the position and was unaware of the regulation requirement to request a PASRR review for any resident with a new mental health diagnosis or significant change in condition. The SW confirmed she had not requested a Level II PASRR evaluation for Resident #62.

During an interview on 06/10/22 at 12:09 PM, the Administrator confirmed knowledge of the regulation requirement to request a Level II PASRR evaluation when a resident had a new mental health diagnosis or a significant change in condition. The Administrator explained during the survey process, they realized they did not have a system for requesting PASRR re-evaluations and going forward, the SW would be the person responsible for requesting Level II PASRR reviews when indicated.

4. A PASRR Notification letter dated 06/08/17 revealed Resident #69 had a Level I PASRR with no expiration date.

Resident #69 was admitted to the facility on 04/18/22 with multiple diagnoses that included anxiety disorder.

Review of Resident #69's list of cumulative diagnoses contained in her medical record revealed new diagnoses of adjustment disorder

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with anxiety and delusional disorder, both with an onset date of 04/21/22.

The admission Minimum Data Set (MDS) dated 04/25/22 revealed Resident #69 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

Review of Resident #69's medical record revealed a Consent for use of Psychoactive Medication Therapy form dated 05/15/22 that listed the specific conditions to be treated were mood disorder with psychotic features and schizophrenia. The proposed course of the medication was listed as prolonged treatment.

The significant change MDS dated 06/10/22 revealed Resident #69 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

During an interview on 06/10/22 at 9:47 AM, the Social Worker (SW) explained she was new to the position and was unaware of the regulation requirement to request a PASRR review for any resident with a new mental health diagnosis or significant change in condition. The SW confirmed she had not requested a Level II PASRR evaluation for Resident #69.

During an interview on 06/10/22 at 12:09 PM, the Administrator confirmed knowledge of the regulation requirement to request a Level II PASRR evaluation when a resident had a new mental health diagnosis or a significant change in condition. The Administrator explained during the survey process, they realized they did not have a

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F 644	Continued From page 20 system for requesting PASRR re-evaluations and going forward, the SW would be the person responsible for requesting Level II PASRR reviews when indicated.	F 644		
F 677 SS=D	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, resident, and staff interviews, the facility failed to provide bathing as scheduled for 1 of 9 residents dependent on staff for activities of daily living (Resident #68). The findings included: Resident #68 was admitted to the facility on 07/08/21. Resident #68's diagnoses included cerebrovascular accident (loss of blood flow to the brain) and chronic obstructive pulmonary disease (restricted airflow to the lungs). The Care Plan last revised on 05/16/22 identified Resident #68 as having a self-care performance deficit related to impaired balance and limited mobility. The goal was for Resident #68 to remain at her current level of functioning and included the intervention to provide extensive to total assistance with showers per protocol and as necessary. Review of Resident #68's activity of daily living documentation for April, May and June 2022 revealed bathing was scheduled during evening	F 677	On 6/25/22 resident #68 received a full shower. On 6/27/22 Resident #68 was interviewed by Director of Nursing regarding bathing preference. Resident was satisfied with current schedule for Wednesday and Saturday on 3p-11p shift. On 7/14/22-7/15/22 all residents/responsible parties were questioned regarding shower preference by the Unit Manager. On 7/15/22 a shower schedule was developed by the Director of Nursing to reflect the current shower preferences. On 7/18/22 The Director of Nursing and/or designee will re-educate Licensed Nurse/Certified Nursing Assistant regarding showers, shower schedules and documentation on the daily bathing list/PCC. Newly hired staff will be educated upon hire, contracted staff will be educated prior to their first shift, staff cannot work until they have been educated.	7/25/22

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F 677	Continued From page 21 shift on Wednesday and Saturday. For the month of April bed baths were documented as given on 04/06/22, 04/09/22, 04/13/22, 04/20/22, 04/23/22, and 04/30/22. On 04/02/22 the documentation indicated Resident #68 refused and on 04/16/22 and 04/27/22 a partial bed bath was given. For the months of May and June the records revealed Resident #68 did not have assistance with a bed bath or shower documented on the following days: 05/14/22, 06/11/22, and 06/18/22. The quarterly Minimum Data Set (MDS) dated 06/10/22 assessed Resident #68's cognition as moderately impaired with no rejection of care behaviors during the lookback period. The assessment of Resident #68's functional status for activities of daily living indicated extensive assistance was needed with bed mobility, transfers, toilet use, personal hygiene, and bathing. An interview was conducted on 06/21/22 at 9:36 AM with Resident #68. Resident #68 stated her bathing scheduled was to receive a shower twice a week but wasn't done. Resident #68 was unable to recall her last shower and indicated there were several weeks she didn't receive one. Resident #68 revealed she had complained about missed showers, but nothing was done. When she didn't get her scheduled shower Resident #68 stated she didn't always get a bed bath either and the Nurse Aides (NA) would tell her there wasn't enough staff to assist her. An interview was conducted on 06/22/22 at 9:18 AM with Resident #68. Resident #68 revealed there were times her bed baths weren't done or not done good, and she still felt dirty.	F 677	Starting on 7/18/22 The Director of Nursing and/or designee will conduct Quality improvement monitoring of 5 random resident showers three times a week for 12 weeks, then as needed to ensure compliance. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 7/18/22. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly for 2 months or until substantial compliance is met, and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. Date of Completion 7/25/22	

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A follow-up interview was conducted on 06/24/22 at 12:02 PM with Resident #68. Resident #68 revealed when her shower wasn't given a bed bath was okay but if no bathing was offered it wasn't. Resident #68 stated she often went without a shower or bed bath.

An interview was conducted on 06/24/22 at 12:12 PM with Nurse Aide (NA) #1. NA #1 revealed she worked from 7 AM to 7 PM and was assigned to assist Resident #68 on 06/18/22 with a shower. NA #1 revealed she was the only NA assigned to the hall Resident #68 resided and had more than 20 residents to care for. NA #1 stated could not get scheduled showers done and didn't provide a shower for Resident #68 on 06/18/22. NA #1 revealed when she was the only NA on the hall, she could feed residents, answer call lights, and provided incontinence care. NA #1 revealed when a shower wasn't provided, she tried to give a bed bath but wouldn't be a complete head to toe bath, she would clean the resident's face and perineal area.

An interview was conducted on 06/24/22 at 3:28 PM with NA #2. NA #2 revealed she worked second shift and was assigned to hall where Resident #68 resided on 06/20/22. NA #2 revealed on 06/20/22 she was the only NA assigned on the hall and had a lot of residents that require total care and couldn't give her scheduled showers. NA #2 stated Resident #68 had not refused her shower and voiced she smelled and asked to be wiped up. NA #2 stated she couldn't give a shower on 06/20/22 but did provide a partial bed bath and washed the resident's face, neck, under the arms, and perineal area. NA #2 revealed two or three times a week she would be the only NA on the hall and

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F 677	Continued From page 23 wasn't able to provide residents their scheduled showers. A joint interview was conducted on 06/24/22 at 6:34 PM with the Administrator and Director of Nursing (DON). The Administrator stated she would expect Resident #68 was offered a shower twice a week as scheduled. The Administrator stated it was the facility's policy to provide bathing to residents per their preference. The DON revealed she was aware staffing was short and showers weren't being done. The DON revealed she often stayed over to provide resident showers.	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 observations, record review, resident, and staff interviews, the facility failed to prevent a fall during a transfer with a mechanical lift which resulted in the resident bumping his head and right hand on the floor for 1 of 4 residents reviewed for supervision to prevent accidents (Resident #56). The findings included: Resident #56 was admitted to the facility on	F 689	1. On 6/18/22 resident SH was being transferred from chair to bed by 2 CNAs. CNA statements show that resident SH had hoyer sling under him in his wheelchair, CNA connected hoyer sling at all 4 points appropriately with leg straps crossed. CNA stated she was moving resident from wheelchair to bed when resident□s shoulder began sliding out of the left top side of the hoyer sling. CNA slowly lowered resident to floor with hoyer	7/25/22

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F 689	Continued From page 24 07/13/20 with diagnoses of spinal cord injury. Review of Resident #56's care plan dated 07/21/20 and revised on 05/19/21 revealed in part, he had a self-care deficit in the area of activities of daily living and required total assist of 1-2 staff to turn and reposition in bed as necessary. He also required a mechanical lift with the assistance of 2 staff members for transfers between his wheelchair and bed. The care plan also indicated Resident # 56 was at risk for falls. Fall prevention interventions included in part, reminders to keep his call bell within reach and providing re-education for Resident # 56 on the risks of keeping his bed in a high position. Resident #56's most recent quarterly Minimum Data Set (MDS) dated 05/22/22 revealed he was cognitively intact for daily decision making. The MDS further revealed he required extensive assistance from 2 staff members for toileting, personal hygiene and bed mobility and was dependent upon 2 staff members for transfers. Review of an incident report for Resident #56's fall was dated 6/18/22 and completed by the DON revealed in part, the witnesses to the fall were Nurse Aide (NA) #1 and NA #4. The incident report further revealed he slid out of a lift sling while being transferred by 2 staff members using a mechanical lift and bumped his right hand and the left side of his head on the floor. No apparent injuries were noted but the resident was transported to the hospital. The facility's nursing progress notes revealed Resident #56 was sent to the hospital on 06/18/22 and returned later that evening. The hospital reported scans were completed of his	F 689	lift, and stayed with resident while the other CNA went to get a nurse. The licensed nurse immediately assessed the resident, assessment revealed no redness, tenderness, bruising or open areas. Stated resident complained of pain. Vital signs obtained by the nurse □ stable. On call NP notified, resident RP notified, new order to send resident to ED for evaluation. Resident out of facility at approximately 16:25 p.m. Resident evaluated at Mission Hospital. X-rays and CT completed and within normal limits. Resident was readmitted back to facility on 6/18/22 at 23:30. 2. Both involved CNAs immediately removed from duty and educated on 6/18/22 to ensure appropriate positioning while using the Mechanical Lift. Upon competition of education by licensed nurse and return demonstration completed, CNAs returned to regular duty. No other residents affected. Hoyer lift and sling in question removed from rotation until assessed by maintenance director to ensure proper functioning. 3.Reeducation to Nursing staff (all CNAs, Med Aides, and Nurses) started on 6/18/22 by the Director of Nursing/Designee regarding hoyer lift transfers and appropriate positioning in sling. All nursing staff who had not yet been educated will be educated prior to next scheduled shift. Education was initially completed by 6/22/22, but remains ongoing for new hired and contracted staff. New full body hoyer sling has been ordered for resident SH to trial upon arrival. Offered and encouraged use of an	

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F 689	Continued From page 25 head, neck, and pelvic area none indicated injury. Review of Resident #56's Change of Condition Assessment (referred to as SBAR in facility electronic medical record) dated 06/18/22 at 4:09 PM indicated Resident # 58 was being transferred from his chair to his bed with the assist of 2 staff members. During the transfer, he slid out of the sling on the upper left side and was then lowered to the floor. He was then assisted into his bed. The SBAR further revealed the resident complained of pain in his right hand and on the left side of his head, but no injury was visible. The Nurse Practitioner (NP) on call was notified about the fall and she gave an order to send him to the emergency room for evaluation. In an interview with Resident #56 on 06/20/22 at 4:22 PM, he stated he had fallen on 06/18/22. He indicated staff lifted him with the mechanical lift to put him to bed. He stated he fell and hit his head and right hand. He also stated these staff members had worked with him in the past and knew how to care for him properly, but he thought one of the straps on the lift sling was not attached causing his fall. He further revealed he went to the hospital emergency department and there was no injury, but he continued to have pain in his head and hand. On 6/22/22 at 4:55 PM an interview was conducted with NA #1. She stated on the afternoon of 06/18/22 NA #4 asked her for assistance with transferring Resident #56. She indicated the resident was in his chair and the mechanical lift sling was under him. NA #1 revealed she checked the sling placement, raised him up in the mechanical lift and handed the lift control to NA #4 so that she could support his	F 689	alternate full body sling until arrival of new sling, however resident declined stating he preferred cross strap sling. Transfer assessments will be completed for residents residing in the facility by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Designee. Resident Kardex will be updated with the results of the transfer assessments by the Director Nursing, Assistant Director of Nursing, Unit Manager or designee. Resident care plans will be update to correspond with transfer assessments and Kardex□s Director of Nursing and/or Designee educated nursing and therapy staff on Mechanical lift transfers. The DCS/Nurse Manager/Designee will observe random nursing employees to ensure that appropriate transfer technique is being demonstrated during resident transfers Random weekly observations of transfers will be conducted by the Director of Nursing/Nurse Management/Designee for three (3) employees to ensure that appropriate transfer technique is being sustained by nursing staff during resident transfers 3 times a week x 12 weeks An adhoc QAPI meeting was held on 7/18/2022 to discuss the plan of correction and corrective measures. 4. The Director of Nursing will present this plan to the Quality Assurance Performance Improvement Committee. Results of random weekly observations will be discussed at the monthly QAPI meeting for three (3) months to sustain substantial compliance.	

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F 689	Continued From page 26	F 689	Date of Completion 7/25/22	

feet. She then stated when they moved him toward the bed, his upper body slipped toward his left side, which was flaccid, and his lower body was still in the sling. She stated Resident #56 hit his arm and head, but they were able to safely lower him the rest of the way down to the floor. NA #1 stated that she knew the loops were all attached correctly to the lift because she recalled unhooking all 4 sling loops after he was lowered to the floor. She further revealed she was not certain what had caused Resident #56's fall from the mechanical lift.

In an interview on 06/23/22 at 8:45 AM, NA #4 revealed she was assigned to care for Resident #56 on the afternoon of 6/18/22. She stated that when he requested to be transferred to bed, she requested assistance from NA #1 for the transfer using the mechanical lift. She further revealed she made sure the sling straps were attached to the hooks of the lift and she ensured he was secure in the sling. She stated NA #1 was holding his legs and she was operating the lift with the handheld control. She stated as they were transferring him Resident #56 went backwards and to his left side and she immediately left to get a nurse. She then stated Nurse #3 came and checked him and there was no bleeding or obvious injury, but he complained about his head hurting and his right hand hurting. NA #4 revealed she did not know how the fall occurred. She further revealed Resident #56 frequently provided direction to caregivers and was able to tell staff if he thought he was not positioned correctly. She stated it was possible his body shifted left, and the sling shifted right causing him to fall but she could not say for certain what occurred because the fall happened very quickly.

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In an interview on 06/24/22 at 9:21 AM with Nurse #3 she revealed she was on duty at the facility the evening Resident #56 fell. She further revealed NA #1 and NA #4 told her he slid out of the mechanical lift sling on his left side but did not know what caused him to slide. She stated she examined Resident #56 and did not see any obvious injuries, but he was sent to the ER for x-rays with complaints of head and right hand pain.

On 06/19/22 the nursing progress notes indicated Resident #56's right hand appeared swollen and had light colored bruising. The right hand was elevated, and ice was applied. The NP on call was notified and an order was obtained for a right hand x-ray.

Review of the facility NP progress note dated 6/20/22 revealed he was examined for complaints of a sore right hand from the fall. She indicated the x-ray of his right hand showed no fracture or dislocation. The NP progress note revealed upon exam he had no bruising or boney abnormalities of the right hand but did have mild edema. She recommended treatment with ice to hand as needed for discomfort.

Review of Resident #56's Electronic Medical Record revealed a Radiology report dated 06/20/22 that indicated no fracture or dislocation was seen on the right hand x-ray.

A nursing progress note dated 06/20/22 at 3:11 PM revealed Resident #56 had no latent injuries from his fall. He had complaints of pain and was given ordered pain medication which was effective.

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F 689	Continued From page 28 An observation and joint interviews were conducted on 06/23/22 at 2:05 PM with The Regional Vice President of Operations, the Staff Development Coordinator (SDC) and NA#1. The facility staff demonstrated the use of the mechanical lift with the sling used by Resident #56. NA #1 revealed on the afternoon of his fall, she lifted Resident #56 up and out of his chair and turned him in the direction of his bed and the fall occurred as they moved him toward the bed. The demonstration revealed it would not have been possible to elevate the resident from his chair if all 4 of the sling straps were not attached to the arms of the lift. The Corporate nurse, SDC and NA #1 agreed that the probable cause was the back of the sling was too low on his back and when the resident's flaccid left side slid out of the sling, the weight of his body shifted left and out of the sling causing the fall. A joint interview was conducted with the Corporate Vice President of Clinical Operations, DON, and Administrator on 6/24/22 at 5:19 PM. The Administrator stated she interviewed Resident #56 after the fall on 6/18/22 and he was not able to tell her how the fall occurred, but he did report staff unhooked all 4 sling straps after he was lowered to the floor. She stated she interviewed all staff involved after the fall and the only explanation was that the sling was too low on the resident's back. The Corporate Clinical Manager stated he also investigated the incident and was not able to determine a definite cause. The Administrator and DON both indicated Resident #56 had an accident, and it should not have occurred.	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		7/25/22

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F 690	Continued From page 29 §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 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 and staff and Nurse Practitioner (NP) interviews the facility failed to	F 690	Resident #3 was discharged from the facility on 2/20/2022 to the hospital.	

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F 690	Continued From page 30 obtain laboratory testing as ordered for a resident with complaints of abdominal pain and decreased appetite. Resident #3 was sent to the Emergency Department (ED) after a change in condition and diagnosed with a urinary tract infection (UTI) requiring hospitalization. This was for 1 of 1 resident reviewed for hydration. Findings included: Resident #3 was admitted to the facility 08/21/15 with diabetes and adult failure to thrive (a state of decline). Review of NP #1's note dated 02/14/22 revealed she saw Resident #3 for decreased appetite and epigastric discomfort (upper abdominal pain just below the ribs). The note stated she would check a complete blood count (abbreviated as CBC and meaning a blood test which can check for a variety of conditions including anemia, infection, and kidney function), and a comprehensive metabolic panel (abbreviated as CMP and meaning a test which checks the body's chemical balance and metabolism) for leukocytosis (a check of white blood cells that can indicate infection if elevated) and electrolyte balance. A Physician order dated 02/14/22 revealed orders to obtain a hemoglobin A1 C (a blood test which measures blood sugar control over time), a CBC, and a CMP on 02/15/22. Review of NP #1's note dated 02/15/22 revealed laboratory results were still pending and if they revealed evidence of dehydration intravenous (abbreviated as IV and meaning in the vein) fluids would be ordered.	F 690	On 6/30/2022 current residents were provided a quality monitoring for lab orders by the Director of Nursing for the past 30 days. Any discrepancies were addressed accordingly. On 7/19/2022 the Director of Nursing and/or designee provided education to Registered Nurses and Licensed Practical Nurses on placing lab order in the lab book after obtaining the order from the physician. Follow up will be conducted after the result of the lab has been obtained. If lab was unable to be obtained, physician will be notified for follow up instruction. Newly hired staff will be educated upon hire, agency staff will have education provided prior to working their shift. Staff will not be allowed to work until education has been completed. Starting on the 7/18/2022 Director of Nursing and/or designee will audit lab orders for completion of being drawn as ordered, that results were obtained, and if results were unable to be obtained that provider was notified for further instruction three times per week for 12 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 07/18/22. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development	

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F 690	Continued From page 31 Review of Resident #3's medical record did not reveal any results for a hemoglobin A1C, a CBC, or a CMP obtained on 02/15/22. A nurse's note written by Nurse #1 dated 02/20/22 revealed Resident #3 was sent to the hospital at the request of her Responsible Party (RP) to be evaluated because she was not eating or drinking, not taking her medications, and was having a hard time swallowing. A hospital discharge summary dated 03/01/22 revealed Resident #3 was hospitalized from 02/20/22 to 03/01/22. The summary stated Resident #3 present to the ED on 02/20/22 with decreased responsiveness and being more withdrawn for the past week. The summary noted Resident #3 had a history of altered mental status, poor oral intake, and a possible UTI over the last week and was admitted to the medical floor and treated empirically (treatment given based on experience without having precise knowledge of the cause of a disorder) with IV fluids and antibiotics. Resident #3 completed a 7-day course of ceftriaxone (an antibiotic) and continued to remain very lethargic. She required a one-to-one caregiver for meals and there was a concern that she would not maintain adequate nutrition and hydration as an outpatient. Resident #3's family declined a feeding tube and she was discharged back to the facility 03/01/22. Discharge diagnoses included hypernatremia (an elevated level of sodium in the blood), decreased oral intake, altered mental status, vascular dementia, and acute UTI. The significant change Minimum Data Set (MDS) dated 03/22/22 revealed Resident #3 was severely cognitively impaired and did not reject	F 690	Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months or until substantial compliance is met. Date of Completion 7/25/22	

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care.

An interview with NP #1 on 06/24/22 at 10:35 AM revealed she saw Resident #3 on 02/14/22 because she was having a poor appetite and abdominal pain. She stated she ordered laboratory tests to be collected 02/15/22 to aide in evaluating Resident #3's condition. NP #1 stated when she saw Resident #3 on 02/15/22 the laboratory tests were still pending. NP #1 stated she was not notified the blood for the laboratory tests ordered for 02/15/22 had not been collected and she should have been notified the tests had not been done. She stated she had no way of knowing if she had received Resident #3's laboratory tests ordered for 02/15/22 if that would have prevented Resident #3 from being hospitalized on 02/20/22.

During an interview with the Assistant Director of Nursing (ADON) on 06/24/22 she confirmed the hemoglobin A1C, CBC, and CMP ordered 02/15/22 had not been collected. She stated an outside laboratory company was unsuccessful in obtaining the laboratory specimen on 02/15/22 and came again to collect the specimen on 02/16/22. The ADON stated the laboratory company was unable to collect the laboratory specimen on 02/16/22. She stated she was off 02/17/22 and assumed the Unit Manager working 02/17/22 would follow-up on making sure Resident #3's laboratory specimen was collected but the order for Resident #3's lab work ordered 02/15/22 fell through the cracks.

During an interview with Unit Manager #1 on 06/24/22 at 03:54 PM she confirmed she worked 02/17/22 and was not aware she needed to follow-up on obtaining lab work for Resident #3.

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F 690	Continued From page 33 A joint interview with the Administrator and Director of Nursing (DON) on 06/24/22 at 06:23 PM revealed laboratory tests should be collected as ordered.	F 690		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident	F 725	Resident #68 was provided a full shower	7/25/22

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and staff interviews, the facility failed to maintain sufficient nursing staff to ensure a resident's (Resident #16) request to get out of bed was honored. The facility also failed to ensure showers or complete baths were provided as scheduled (Resident #68). These failures affected 2 of 14 residents sampled in areas of choices and activities of daily living.

The findings included:

This tag is cross referenced to:

1. F 561: Based on record review, observations, resident, and staff interviews the facility failed to honor a resident's (Resident #16) request to get out of bed to attend a scheduled activity for 1 of 5 residents reviewed for choices.

2. F 677: Based on observations, record review, resident, and staff interviews, the facility failed to provide bathing as scheduled for 1 of 9 residents dependent on staff for activities of daily living (Resident #68).

Review of the nursing staff scheduled from 06/18/22 through 06/24/22 revealed during first and second shifts there were assignments with one Nurse Aide (NA) on the hall for the following days: 06/18/22, 06/19/22, 06/20/22, and 06/24/22.

During an interview on 06/22/22 at 2:09 PM NA #7 stated staffing was awful and when she was assigned the entire hall did her best to complete her assigned showers but wasn't always able to.

During an interview on 06/22/22 at 2:59 PM the Staff Development Coordinator/Wound Care/Scheduler revealed on 06/20/22 a NA called

on 6/25/22. Resident #16 was assisted to Bingo on 6/27/22 as requested.

On 6/28/2022, the Executive Director met with the Director of Nursing and Staff Development Coordinator to ensure recruiting efforts for open positions were in place along with approved incentives for new hires and referrals. Additionally, wages were increased beginning pay period 7/14/22 for current staff members and bonus structure reviewed by the Executive Director for staff who work additional shifts as needed. Agency contracts in place to meet staffing needs. Recruiting efforts and interviews completed in attempt to secure full time Human Resources coordinator.
The Executive Director, Director of Nursing and the Staff Development Coordinator reviewed staffing levels on 7/15/22 to ensure adequate staffing levels based on residents needs and acuity. No inadequacies noted.
On 7/15/22 the Executive Director and the Director of Nursing reviewed the nursing staffing schedule was completed and if there was sufficient staff scheduled to care for the residents. Additionally, the staffing assignment sheets were reviewed to ensure adequate staffing to the residents as per the schedule on 7/15/22 and no issues were identified.
On 7/14/22- 7/15/22, the Unit Manager interviewed interview-able (BIMS of 8 and above) residents on bathing preferences. Bathing preferences were utilized by the Director of Nursing to establish a bathing schedule for current residents on 7/15/22.

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F 725	Continued From page 35 out, a NA was sent home, and a Nurse resigned. He was unable to find staff to cover those shifts and NA #3 was reassigned to provide care for larger group of residents. During an interview on 06/23/22 at 3:24 PM NA #6 revealed on 06/19/22 she was the only NA on the 300-hall giving her approximately 25 residents and couldn't get a resident who needed 2-person assist using the mechanical lift out of bed upon request. NA #6 stated it was impossible to get rounds done every two hours when she was the only NA on the hall. An interview was conducted on 06/24/22 at 4:32 PM with the Staff Development Coordinator/Wound Care/Scheduler. The Staff Development Coordinator/Wound Care/Scheduler revealed he tried to schedule eight NA staff for day shift, six for evenings, and four for nights. If he had two NA staff drop from the schedule, he started calling other staff to come in. The Staff Development Coordinator/Wound Care/Scheduler revealed pay incentive programs were initiated to help with weekend staffing issues and indicated it had improved. He revealed it was difficult to get shifts covered with current staff already working a lot of hours and issues with agency staff not showing up and having to find coverage on short notice. Right now, his focus was trying to find staff for night shift and indicated he had more flexibility to find coverage on day shift due to more staff were available. The Staff Development Coordinator/Wound Care/Scheduler revealed he hadn't received complaints from NA staff when scheduled as the only one on the hall and not able to complete their assigned residents shower. The Staff Development Coordinator/Wound	F 725	The Interdisciplinary Team then updated the residents plans of care and Kardexes accordingly by 7/18/22. On 7/13/22 the Activities Director interviewed all residents to determine whether they had a preference to attend Bingo when it was offered. A list was created on 7/15/22 to include all residents who would prefer to get up for Bingo and posted Beginning on 7/18/22 the Director of Nursing/Assistant Director of Nursing/RN Nurse Manager educated Nursing Staff on regulation F-725 and to directly notify the ED, DCS, or ADCS for any call outs, so that facility leadership is aware of and can intervene with any staffing needs that could lead to inadequate staffing to meet residents needs. The ED, DCS, or ADCS will attempt to replace the staff member who is calling out by calling on facility staff to stay over or come into work, using a current nursing staff roster/phone list and/or by notifying contracted agency of staffing needs. If staffing needs cannot be met using these means, the ED, DCS, ADCS may enforce mandating for staff member (s) currently working. Facility Nursing Staff has been educated on waiting for their relief to arrive prior to leaving the facility at the end of their shifts. Facility Nursing Staff was also educated on giving a shift to shift resident report to the oncoming employee relieving them of their job duties. This shift to shift report should encompass the status of the residents on their staff assignment to include any baths, refusals of baths, or baths that were not	

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F 725	Continued From page 36 Care/Scheduler revealed nursing staff come in early or stay late when resident showers weren't given in attempt to make it up. An interview was conducted on 06/24/22 at 6:34 PM with the Administrator and Director of Nursing (DON). The Administrator revealed the facility had increased wages and offered referral bonuses to staff. She revealed the DON covered shifts along with the Social Worker and Admission Director who were both certified NA. The DON revealed she had stayed and worked as NA to help provide resident care and agency staff were also utilized to fill gaps in the schedule. Both the Administrator and DON indicated there were staffing issues, but staff worked good as team.	F 725	completed, so that they can be followed up to completion. The shift to shift report should also encompass any known upcoming activities for the following shift and any residents who would prefer to be assisted up and to these activities. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 7/18/22. The Director of Nursing/Assistant Director of Nursing will conduct QI monitoring of regulation F-725 to ensure sufficient direct care nursing staff to meet the needs of residents and to ensure residents are bathed per their preferences and assisted to the activities of their . QI monitoring will be conducted three times weekly x 12 weeks. The Director of Nursing/Assistant Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for 6 months or until substantial compliance is met. Date of Completion 7/25/22	
F 806 SS=B	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		7/25/22

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F 806	Continued From page 37	F 806		

by:
Based on observation, record review, resident and staff interviews, the facility failed to honor food preferences for 1 of 4 sampled residents reviewed (Resident #51). This failure had the potential to affect all residents.

Findings included:

Resident #51 was admitted to the facility on 06/22/17.

The quarterly Minimum Data Set (MDS) dated 05/27/22 indicated Resident #51 was cognitively intact and required set-up help only with meals.

During an interview on 06/21/22 at 9:30 AM, Resident #51 stated she often received food items she did not like with her meals, such as cucumbers and tomatoes. Resident #51 explained she had discussed her dislikes with the Dietary Manager (DM) on several occasions in the past; however, she still continued to receive food she did not like with certain meals.

Review of Resident #51's dietary preferences provided by the DM on 06/22/22 at 2:03 PM revealed tomatoes were listed as a dislike. Cucumbers were not listed as a dislike.

An observation of the lunch meal on 06/23/22 at 12:21 PM revealed Resident #55 was served two scoops of macaroni and cheese, a bowl of diced cooked tomatoes and dessert.

During a follow-up interview on 06/23/22 at 12:21 PM, Resident #51 restated she did not like tomatoes and was served a bowl with her lunch meal. Resident #51 voiced she spoke with the

Resident #51□s food preferences were updated and meal tickets were examined on 6/24/22 to ensure dislikes were showing as active on the meal tickets.

On 7/13/22- 7/19/22 a quality assurance audit was completed by the Dietary Manager to update 100% of current resident food preferences and ensure they are accurately documented on their meal tickets. Responsible parties were interviewed regarding food preferences for all residents who were unable to be interviewed. All issues identified were corrected.

By 7/18/22 the Dietary Manager and all dietary staff was educated by Regional Dietary Manager regarding the expectation that residents are not served disliked food items and a suitable alternate is provided with similar nutritive value. On 7/19/22 Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides were be educated on resident□s rights to include food preferences and to report new resident dislikes/ preferences to the nurse who will notify dietary as necessary. Newly hired staff and contracted staff will be educated upon hire and will not be allowed to work until education is completed.

Starting on 7/18/22 the Dietary Manager and/or designee will conduct Quality improvement monitoring of 5 resident meal trays to include one meal per day x three days per week for 12 weeks to

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F 806	Continued From page 38 DM again yesterday (06/22/22) regarding her food preferences. During an interview on 06/24/22 at 9:30 AM, the DM explained a resident's dislikes only printed on the meal card if a particular item was part of the meal being served that day and a substitution would be provided for the disliked food item. The DM stated she spoke with Resident #51 on 06/22/22, updated her dietary preferences and confirmed tomatoes were listed as a dislike. The DM could not explain why Resident #51 was served diced tomatoes with her lunch meal on 06/23/22 and stated the food item should have been substituted with another vegetable. During an interview on 06/24/22 at 5:17 PM, the Administrator stated she would expect for residents' dietary preferences to be updated and followed when meals were served. The Administrator voiced she would prefer residents were not served food items they did not like.	F 806	ensure dislikes are listed on meal tickets and not present on resident tray. The Administrator introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 7/18/22. The Administrator is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. Administrator will report to Quality Assurance Performance Improvement committee monthly for three months. Date of Completion 7/25/22	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/25/22

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F 880	Continued From page 39 §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 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.	F 880		

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F 880	Continued From page 40 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to establish and implement infection control policies and procedures to reduce the risk of growth and spread of Legionella in the building water systems which could affect 83 out of 83 residents. In addition, the facility failed to implement infection control policies and procedures when the Staff Development Coordinator failed to perform hand washing after the removal of gloves during wound care for 1 of 1 sampled resident (Resident #44) and when 1 of 7 Nurse Aides (NA #5) and the Staff Development Coordinator (SDC) failed to perform hand washing after the removal of gloves following the transfer of 1 of 1 resident (Resident #56) observed during a mechanical lift transfer. These failures occurred during a global pandemic. The findings included: 1. Review of the facility's Emergency Preparedness plan revealed no information related to a facility water safety management program to minimize the risk of transmission of	F 880	Current residents had the potential to be affected related to this citation in regards to Legionella. On 6/24/22 the Administrator and Maintenance Director were re-educated on Infection Control as it relates to the Water Management Program, specifically Legionella, by the Divisional Director of Safety. The Staff Development Coordinator was re-educated on 6/22/22 at 4:00 PM by the Director of Nursing and Vice President of Clinical Services on the hand hygiene policy to include proper hand sanitation/washing after doffing gloves. On 6/24/22 The Divisional Director of Safety reviewed the facility□s Emergency Preparedness Plan related to water management related to Legionella. The Administrator and Maintenance Director completed a quality review by re-establishing the water management program with the guidance of the CDC Toolkit on Water Management. This program includes a detailed outline of the	

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F 880	Continued From page 41 Legionella Disease to the residents, staff, and visitors by testing the water. In an interview on 06/24/22 at 6:50 PM, The Administrator stated she was unaware of the requirement to develop a program to minimize the risk of transmission of Legionella through the facility's water system. She stated that she spoke with the facility Maintenance Director, and he was also unaware of the requirement. She further revealed the facility water was supplied by the city and no water testing had been done. The Administrator stated she and the Maintenance Director had contacted the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) and had been told by them they did not have to test the water since they were on city water. 2.. Review of the facility policy and procedure entitled "Hand Hygiene" revised on 02/05/2021 revealed the following overview statement: "The Center for Disease Control and Prevention (CDC) defines hand hygiene as cleansing your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e., alcohol-based hand sanitizer including foam or gel)." The policy listed specific indications for activities that required hand hygiene and included after the removal of gloves. An observation on 06/21/22 at 9:18 AM was made of wound care performed by the Staff Development Coordinator (SDC) on Resident #54. The SDC donned clean gloves and proceeded to cleanse Resident #44's 2nd digit on his right foot with sterile normal saline and proceeded to the 1st digit on the right foot and	F 880	water system in the facility, including where the water enters, exits, and any potential sites for Legionella to grow. The water management program also has measurable and visual inspections to include daily water temperature checks. A quality review was completed by observation by the Director of Nursing with the Staff Development Coordinator during wound care on 6/27/22, Staff Development Coordinator properly washed hands each time after doffing gloves. On 6/27/22 through 7/25/22 the Director of Nursing and/or designee performed a Quality Improvement Monitoring for nursing staff to include: Licensed Nurses, Certified Nursing Assistants, temporary nursing staff and Medication Aides to ensure proper Handwashing/Hand Hygiene performed by completion of Hand Hygiene Competency. The Root Cause Analysis was completed by the Regional Director of Clinical Services, Executive Director, and the Director of Nursing on 7/14/22. An ADHOC Quality Assurance Performance Improvement Committee was held on 7/18/22 to formulate and approve a plan of correction for the deficient practice. The facility has an established water program to reduce the risk of growth and spread of Legionella in the building□s water system. On 6/24/22 the Executive Director and Maintenance Director were re-educated by the Divisional Director of Safety on the Emergency Preparedness Plan as it relates to the facility risk assessment to identify where Legionella	

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F 880	Continued From page 42 cleansed it with sterile normal saline and then moved to the right heel and cleansed it with sterile normal saline. The SDC then doffed his gloves and without performing hand hygiene donned a new pair of clean gloves and proceeded to paint the 2nd digit on the right foot with betadine, and then painted the 1st digit with betadine and then proceeded to paint the right heel with betadine. The SDC then doffed his gloves and washed his hands with soap and water. An interview on 06/22/22 at 3:11 PM was conducted with the Staff Development Coordinator (SDC). The SDC revealed he had not sanitized his hands after doffing his gloves following cleansing Resident #44's wounds with sterile normal saline. The SDC stated there was no hand sanitizer in the resident rooms and the facility did not have handheld sanitizers provided to employees for use in the resident rooms. The SDC further stated he should have sanitized his hands after doffing his gloves and before donning a clean pair of gloves to continue the wound care for Resident #44. An interview on 06/22/22 at 6:55 PM with the Director of Nursing (DON) and Administrator revealed it was their expectation that staff perform hand hygiene after the removal of gloves. 3. Review of the facility policy entitled "Hand Hygiene" revised on 02/05/21 revealed the following overview statement: "The CDC defines hand hygiene as cleansing your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand	F 880	and other opportunistic waterborne pathogens could grow and spread in the facility water system. The Divisional Director of Safety also reviewed the water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as: physical controls, temperature management, and visual inspections. Nursing staff to include licensed nurses, certified nursing assistants, temporary nursing staff, and medication aides were educated by the Director of Nursing on hand hygiene and watched the CDC video entitled Clean Hands to ensure understanding of when and how to wash hands properly. Director of Nursing / Designee will provide education to any contracted services prior to the start of their first shift to facility and all new employees will be educated during new hire orientation. The education will be completed by 7/25/22. The Administrator/ Designee will conduct quality reviews of water safety management monitoring to include control measures such as: physical controls, temperature management, and visual inspections once weekly for 12 weeks. The Director of Nursing/Assistant Director of Nursing or designee will conduct random Quality reviews of nursing staff to ensure staff are washing hands after doffing gloves. Beginning on 7/18/2022 The Director of Nursing and/or designee will conduct Quality improvement monitoring by observing 5 random employees to ensure they wash their	

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F 880	Continued From page 43 rubs (i.e., alcohol- based sanitizer including foam or gel)." The policy listed specific indications for activities that required hand hygiene and included after glove removal. An observation of the Staff Development Coordinator (SDC) and Nurse Aide (NA) #5 transferring Resident #56 with a mechanical lift was conducted on 06/22/22 at 11:12 AM. Prior to the transfer, the SDC washed his hands with soap and water in the resident's bathroom. He donned gloves and he and NA #5 transferred the resident. The SDC then removed his gloves and placed them in the pocket of his pants. He did not perform hand hygiene. He proceeded to straighten up personal items in the resident's room. The SDC then donned new gloves and wiped the cover of the resident's air mattress with a disposable wipe. He removed the gloves, discarded them in a trash can and left the room without performing hand hygiene. On 6/22/22 at 3:00 PM an interview was conducted with the SDC. He stated he should have sanitized his hands when he removed his gloves during the observation of the resident transfer. He also stated there was no hand sanitizer available in the room. In a joint interview on 6/22/22 at 6:55 PM the DON and Administrator indicated the expectation was that staff performed hand hygiene after removing gloves.	F 880	hands after doffing gloves. These monitor tools will be completed 3 x weekly x 12 weeks, then as needed to ensure compliance. The Executive Director and Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. Date of Completion 7/25/22	