STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	C 01/20/2023

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BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/17/23 through 1/20/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #4WIG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/17/23 through 1/20/23. Event ID# 4WIG11. The following intake was investigated NC00197086. 1 of the 5 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately complete the Minimum Data Set (MDS) for discharge and anticoagulant (blood thinning medication) use for 3 of 18 residents whose MDS assessments were reviewed (Resident #48, Resident #26, and Resident #30). Findings Included: 1. Resident #48 was admitted to the facility on 11/28/22 with diagnosis that included chronic kidney disease and congestive heart failure.	F 641	Issues: • The facility failed to accurately code an Admission Minimum Data Set for resident #48, #26,AND #30. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • The facility modified resident #48 to reflect discharge home on discharge assessment on 12/23/22 and retransmitted on 01/20/23. • The facility modified resident #30	2/23/23

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

Electronically Signed | 02/13/2023

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F 641	Continued From page 1 Review of the discharge Minimum Data Set (MDS) dated 12/15/22 indicated Resident #48 was discharged to a local hospital. Review of a nursing progress note dated 12/15/22 indicated Resident #48 was discharged home with her husband. An interview was conducted on 1/20/23 at 9:42 A.M. with the MDS nurse. The MDS nurse reviewed the discharge MDS and confirmed it was inaccurate. The MDS nurse stated Resident #48 was discharged home and indicated the wrong discharge location was mistakenly marked on the MDS form. An interview was conducted on 1/20/23 at 11:46 A.M. with the Administrator. During the interview the Administrator indicated he expected the MDS assessment to be accurate. 2. Resident #26 was admitted to the facility on 12/16/22 with diagnoses which included hypertension and end stage renal disease. A review of Resident #26's physician orders included an order dated 12/16/22 for Aspirin 81 milligrams (mg) one time a day for therapeutic monitoring. Her admission Minimum Data Set (MDS) dated 12/23/22 indicated she had received an anticoagulant (blood thinner) medication 6 times during the look back period. An interview with the MDS Nurse #1 on 1/19/23 at 12:57 PM revealed she had coded Resident #26's anticoagulant medication in error. She stated it was a data entry. She was aware that Aspirin was not an anticoagulant and should not be coded as	F 641	assessment reflected that resident did not receive anticoagulant(blood thinner) on 12/16/2022 and resubmitted on 01/20/23. • The facility modified resident #26 assessment reflected that resident did not receive anticoagulant(blood thinner) on 12/23/22 and resubmitted on 01/20/23. How the facility will identify other residents having the potential to be affected by the same deficient practice: • An audit of all current residents on anticoagulants discharge resident was completed by the DON/or Designee to ensure accurate MDS coding. Any alterations identified will be corrected/modified as appropriate. • Starting 1/23/2023 Minimum Data Set Nurses and Corp reviewed 30 days of discharge residents to ensure accuracy of coding discharge home. No additional concerns identified. • Starting 1/23/2023 Minimum Data Set Nurses and Corp MDS reviewed 30 days of current resident admitted on anticoagulants to ensure accuracy of coding. No additional concerns identified. • DON/Designee address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • The DON/assign Designee provided education to MDS staff on accuracy of	

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F 641	Continued From page 2 one. She confirmed that Resident #26 was not on any anticoagulants. An interview with the Administrator on 1/20/23 at 9:56 AM he stated that MDS assessments should be coded accurately. 3. Resident #30 was admitted to the facility on 12/09/2022. The 5-day Minimum Data Set (MDS) assessment dated 12/16/2022 indicated Resident #30 had received anticoagulant medication (blood thinner) daily. A review of Resident #30's physician orders included Clopidogrel Bisulfate (anti-platelet medication to prevent blood clots) 75 milligrams (mg) once a day for a blood thinner. A review of the December 2022 Medication Administration Record revealed Resident #30 received Clopidogrel Bisulfate daily as ordered. On 1/19/2023 at 10:02 a.m. an interview was conducted with MDS Nurse #1 and the Corporate MDS Coordinator. MDS Nurse #1 stated the physician order indicated Clopidogrel Bisulfate was a blood thinner, she knew it was an antiplatelet medication but included it incorrectly as an anticoagulant on the MDS assessment. The Corporate MDS Coordinator stated Clopidogrel Bisulfate was an antiplatelet medication and should not be included as an anticoagulant. On 1/20/2023 at 1:12 p.m. during an interview	F 641	coding MDS and review of current anticoagulant/discharge assessments on 01/23/2023. • DON/designee will audit 5 discharge assessments weekly, x4 weeks and then monthly x1 to ensure discharge assessments are coded accurately. • DON/ designee will audit 5 admission assessments weekly, x4 weeks and then monthly x1 to ensure assessment for anticoagulants are coded accurately. • Results of these audits will be reviewed monthly in Quality Assurance Meeting for further problem resolution if needed. DON/Designee will review the results of weekly audits to ensure any issues identified are corrected. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • An audit of all current residents on anticoagulants was completed by the DON/ assign Designee to ensure accurate MDS coding. Any alterations identified will be corrected/modified as appropriate. • Systematic Changes: The DON/assign Designee provided education to MDS staff on accuracy of coding MDS and review of current anticoagulant/discharge assessments on 01/23/2023. • Monitoring: The corporate MDS consultant will audit new MDS's weekly for one month then bimonthly for two months to ensure compliance with resident's anticoagulant/ discharge assessments.	

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F 641	Continued From page 3 with the Administrator he stated MDS assessments should be completed accurately.	F 641	• Results of these audits will be presented by DON/Designee monthly at the Quality Assurance Committee meeting for further recommendations. • The DON/assign Designee will implement the plan of correction and ensure any additional recommendations are carried out.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		2/22/23

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F 656	Continued From page 4 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement a comprehensive individualized person-centered care plan for 4 of 16 residents reviewed for comprehensive care plans (Resident #8, Resident #28, Resident #30, and Resident #31). Findings included: 1. Resident #8 was admitted to the facility on 7/22/2022 with diagnoses including hemiplegia. The care plan dated 7/25/2022 indicated Resident #8 had an activity of daily living self-care deficit. The interventions included providing daily skin care to the contractures of the upper and lower extremities. There was no plan addressing the use of splints or providing range of motion (ROM).	F 656	Issues: • Care plans were lacking or not completed for some residents. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • The care plan for resident #8, #28, #30, and #31 was corrected to reflect current splints/ROM, antipsychotic, blood thinner. • The corrective action for the residents found to have been affected by the deficient practice. • Resident #8 Splints were added to the care plan. • Resident #8 Splints were added to EMAR to ensure the license nurses document when the splints are on and	

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F 656	Continued From page 5 The admission Minimum Data Set (MDS) dated 7/29/2022 indicated Resident #8 was severely cognitively impaired, had impairments to both upper extremities and one lower extremity and required total assistance for all activities of daily living. Resident #8 had completed skilled therapy services on 8/16/2022. Instructions were given for Resident #8 to wear a left upper extremity splint, and right and left lower extremity splints 4-6 hours a day for 5-7 days a week as tolerated, and to complete two sets of 15 repetitions of passive range of motion (PROM) of the left upper extremity, and bilateral ankle flexion exercises 5-7 days a week as tolerated. Restorative care documentation dated 8/18/2022 revealed Resident #8 was receiving PROM of the left upper extremity and flexion exercises to the left and right ankles, and splint application to the left and right lower extremities. Restorative care was last documented as performed on 1/6/2023. On 1/19/2023 at 9:38 a.m. during an interview with the Corporate MDS Consultant, she stated she had been the MDS nurse at the facility when Resident #8 was admitted but the former Director of Nursing had been responsible for creating and maintaining Resident #8's care plan at that time. The Corporate MDS Consultant stated the therapy department may have written up a plan of care for Resident #8's ROM and splint application but was unable to locate a care plan from the therapy department. On 1/19/2023 at 11:05 a.m. during an interview with Director of Therapy, she stated Resident #8 was discharged from therapy services on	F 656	when they are off. • Resident # 28 nutritional status was added to care plan. • Resident #30 antipsychotic medication was added to the care plan. • Resident #31 baseline care plan was completed and up that was on blood thinners. How the facility will identify other residents having the potential to be affected by the same deficient practice: • Facility had already identified this as an issue and had a plan of correction that was being implemented. • Current residents' splints/ROM, Nutritional status, antipsychotics, and blood thinners orders. were reviewed by the MDS coordinator and the interdisciplinary team on 01/23/2023 and the care plans were reviewed and revised. • On 01/23/2023 the MDS coordinator and interdisciplinary team were re-educated on reviewing and revising care plans with changes in care regarding the use of splints by the regional nurse consultant. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • Effective 02/20/2023 the MDS Coordinator and Director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan	

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F 656	Continued From page 6 8/16/2022 and rehabilitation instructions had been given to the former Director of Nursing. She explained nurses and MDS department were responsible for creating the restorative plan of care. On 1/20/2023 at 1:12 p.m. during an interview with the Administrator, he stated Resident #28's care plan should have been completed timely and accurately. 2. Resident #28 was admitted to the facility on 11/28/2022 with diagnoses including failure to thrive. The admission Minimum Data Set (MDS) dated 12/5/2022 indicated Resident #28 was severely cognitively impaired, received a mechanical soft (foods prepared for ease of chewing) diet, was dependent on one person for eating and had not experienced a change in her weight. Nutritional status was triggered for further assessment in the care area assessment and was not marked addressed in the care plan. A review of Resident #28's weights revealed on 11/28/2022 she weighed 101.8 pounds (lbs.) and on 12/19/2022 she weighed 87.2 lbs. indicating a 14.71% decrease in her weight. Dietary notes dated 12/29/2022 revealed Resident #28 had a significant weight loss and was receiving a high calorie, high protein nutritional shake twice a day with meals, high protein cheesecake and an appetite stimulant at bedtime to manage weight loss. No plan of care addressing Resident #28's nutritional status was discovered.	F 656	monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. • MDS Nurse/DON or designee will audit assessments weekly x4 until we have 2 consecutive months of compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • The Director of Nursing and/or Minimum Data Set Coordinators will review 5 residents weekly, with orders for splints/ROM, Nutritional status, antipsychotics, and blood thinners orders to ensure that it is implemented /applied as ordered This will be done on a weekly basis for 4 weeks then monthly for 3 months. • Any errors found in the audits will be reported by DON/Designee to the QA committee until 3 months of compliance has been reached and DON will adjust as necessary to ensure continued compliance.	

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F 656	Continued From page 7	F 656		

On 1/20/2023 at 9:37 a.m. during an interview with MDS Nurse #1 and the Corporate MDS Consultant, MDS Nurse #1 stated former Dietary Manager #2 would have addressed Resident #28's weight loss and had been responsible for care plans related to nutrition.

On 1/20/2023 at 9:46 a.m. during an interview with Dietary Manager #1, she stated she started employment at the facility seven days ago. She explained the dietary manager was responsible for nutrition care plans, and Resident #28 should have been cared plan for significant weight loss.

On 1/20/2023 at 1:12 p.m. in an interview with the Administrator, he stated Resident #28's care plan should have been completed timely and accurately.

3. Resident #30 was admitted to the facility on 12/9/2022 with diagnoses including traumatic brain injury, dementia, depression, Parkinson's disease, and autism.

The care plan dated 12/9/2022 for Resident #30 included a plan with a focus area for impaired cognitive function and dementia which had no interventions listed. There was no plan for the use of antipsychotic medications.

A review of the December 2022 and January 2023 Medication Administration Record (MAR) revealed Resident #30 received Aripiprazole (antipsychotic) 1 milligram at bedtime as ordered.

The 5-day Minimum Data Set (MDS) assessment dated 12/16/2022 indicated Resident #30 was

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F 656	Continued From page 8	F 656		

severely cognitively impaired and received antipsychotic medication daily.

On 1/19/2023 at 10:02 a.m. an interview was conducted with the MDS Nurse #1 and the Corporate MDS Consultant. MDS Nurse #1 stated Resident #30 was receiving an antipsychotic and was not care planned for receiving the medication. She stated Resident #30's care plan was based on his medications and diagnoses and should have included the use of antipsychotic medication.

On 1/20/2023 at 9:15 a.m. during an interview with the Director of Nursing, she stated Resident #30 received antipsychotic medication, and his care plan should include the use of antipsychotic medication and behaviors.

On 1/20/2023 at 1:12 p.m. in an interview with the Administrator, he stated Resident #30's care plan should have been completed timely and accurately.

4. Resident #31 was admitted to the facility on 12/28/2022 with diagnoses including atrial fibrillation and hip joint prothesis.

A review of the December 2022 and January 2023 Medication Administration Record revealed Resident #31 received Apixaban (blood thinner) 5 milligram twice a day as ordered.

The admission Minimum Data Set (MDS) assessment dated 1/3/2023 indicated Resident #31 was cognitively intact, had one lower extremity with an impairment, required assistance of one person for dressing and personal hygiene,

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F 656	Continued From page 9 and assistance in setting up his bath that he could perform independently. The MDS also indicated Resident #31 had received anticoagulant medication daily. The care plan dated 1/11/2023 for Resident #31 included a focus for deficit in activities of living self-care performance. The interventions did not include information regarding his need for assistance with dressing, hygiene or set up assistance for bathing. The care plan also did not include a focus for the use of anticoagulants. On 1/19/2023 at 9:55 a.m. during an interview with MDS Nurse #1, she stated she had twenty-one days to complete Resident #31's care plan and it was currently two days overdue. She stated Resident #31's care plan was not individualized and should have been care planned for anticoagulant use. On 1/20/2023 at 9:37 a.m. during an interview with the Director of Nursing, she stated MDS Nurse #1 and the former MDS nurse were responsible for completing comprehensive care plans. She stated Resident #31 should have an individualized care plan for the use of anticoagulants. On 1/20/2023 at 1:12 p.m. in an interview with the Administrator, he stated Resident #30's care plan should have been completed timely and accurately.	F 656		
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	F 677		2/10/23

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F 677	Continued From page 10 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide hair care for 1 of 1 dependent resident reviewed for activities of daily living (Resident #20). Findings included: Resident #20 was admitted to the facility on 3/10/14 with diagnoses which included hypertension. Resident #20's quarterly Minimum Data Set dated 11/09/22 revealed she had severe cognitive impairment with no behaviors or rejection of care. She was totally dependent on staff for personal hygiene and 1-person physical assistance for bathing. Resident #20's care plan last reviewed on 12/11/22 included a goal that read in part to maintain maximum function with ADLs (activities of daily living). Resident #20 had scheduled shower days of Tuesday and Friday. An observation and interview with Resident #20 on 1/17/23 at 8:06 AM revealed her hair was very greasy. She stated she wanted her hair washed. An observation and interview were conducted with the Director of Nursing (DON) on 1/18/23 at 3:04 PM. She confirmed that Resident #20's hair was dirty. She also stated that the facility had shower caps to wash the residents' hair if they did	F 677	Issues: • Surveyor reported resident had not had her hair washed for an extended period of time. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • Resident #20 hair was washed the day the surveyor team reported this. • Facility disagreed with surveyor assessment because documentation and interviews indicate information in contradiction to the narrative in the 2567. • Resident has oily hair and often looks oily the day after being washed. How the facility will identify other residents having the potential to be affected by the same deficient practice: • All patients in the facility that require assistance with ADL care and more specifically bathing and showering. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • Education with competency verification has been provided to the facility certified nursing assistant staff regarding performing bathing assistance on 01/31/2023. • All residents care plans will be reviewed to ensure they are properly care planned for the appropriate bathing and	

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F 677	Continued From page 11 not want out of the bed. Another interview with the DON on 1/19/23 at 11:04 AM revealed the last time the resident had a shower which included having her hair washed was December 18, 2022, as a family member had called the facility and requested that the resident be showered and dressed for a family visit. An interview with Nursing Assistant (NA) #1 on 1/19/23 at 3:09 PM revealed she was assigned to provide care for Resident #20. She stated she usually gave her a bed bath but did not wash her hair. She also stated that she will use a shower cap to wash the resident's hair in bed if it is oily. She stated the last shower the resident had been given was the December 18, 2022. She stated the resident usually preferred bed baths instead of showers. An interview with NA #2 on 1/20/23 at 6:57 AM revealed she was frequently assigned to provide care for Resident #20. She stated she didn't remember the last time she had given the resident a shower or washed her hair. She also stated that the resident preferred a bed bath and the facility had shower caps to wash the residents' hair in bed. An interview with the Administrator on 1/20/23 at 9:56 AM revealed he believed that residents should have their personal hygiene maintained to the extent they will allow.	F 677	showering schedule. Review will be completed by 2/16/2023. • DON or designee will conduct audits of ADL care and documentation weekly until 100% compliance on bathing or documenting refusals for a period of four weeks starting 1/31/2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • Departments heads will be asked to bring to DON or designees' attention if they see residents in need of personal care. • DON or designee will conduct audits of ADL care and documentation weekly until 100% compliance on bathing or documenting refusals for a period of four weeks. • Any errors found in the audits will be reported to the QA committee until four consecutives of compliance has been reached and DON will adjust as necessary to ensure continued compliance.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		2/24/23

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F 688	Continued From page 12 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to perform rehabilitation services per the rehabilitation instructions(orders) for 1 of 1 resident reviewed for limited range of motion. (Resident #8). Findings included: Resident #8 was admitted to the facility on 7/22/2022, and diagnoses included hemiplegia. The care plan dated 7/22/2022 revealed Resident #8 had an activities of daily living self-care performance deficit, and interventions included providing skin care daily and as needed to contractures of the upper and lower extremities. There were no focus areas or interventions to conduct rehabilitation services (range of motion and splint application) for Resident #8 in the care plan.	F 688	TAG f688 Issues: Resident was not consistently documented as receiving recommended splinting after receiving therapy. Nursing orders for continued splinting were not implemented. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • Resident #8 was evaluated by Therapy services on 01/31/2023. Occupational Therapy and Physical Therapy started services on 01/31/2023 for bilateral hand and feet, Splint adjustments and establishing a restorative program. • Resident #8 is also being seen by restorative nursing to ensure the splinting	

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F 688	Continued From page 13 The quarterly Minimum Data Set (MDS) assessment dated 10/25/2022 indicated Resident #8 was severely cognitively impaired, required total assistance with all activities of daily living and had limited range of motion to both upper extremities and on one lower extremity. The MDS further indicated Resident #8 was not receiving occupational and physical therapy services or restorative care. A review of the physician orders revealed no orders for rehabilitation services for Resident #8. Discharge therapy recommendations dated 8/16/2022 were for Resident #8 to continue to receive bilateral (right and left) lower extremity splints up to 4 hours and left upper extremity passive range of motion (PROM) and splinting left upper extremity (hand/wrist and elbow) for 4 hours as tolerated A review of the Rehabilitation Instruction Record, orders from therapy department to the nursing staff for continuation of rehabilitation services, indicated Resident #8 was to wear bilateral lower splints and left upper extremity splint 4-6 hours a day, 5-7 days a week as tolerated and was to complete PROM with both (right and left) ankles dorsal and plantar flexion with 15 repetitions two times 5-7 days a week as tolerated and PROM with the left upper extremity for 15 repetitions two times 5-7 days a week as tolerated. The Rehabilitation Instruction Record (orders) was not dated and was marked as instructions for the nursing staff. Nursing documentation for Resident #8's rehabilitation services revealed Resident #8 did	F 688	and ROM are being done as ordered. Completed by Therapy director on 1/31/2023. How the facility will identify other residents having the potential to be affected by the same deficient practice: • All patients in the facility that were discharged from therapy and had nursing orders or splinting devices and contractures could be affected. • All these residents were identified and orders, care plans, and MARS were reviewed to ensure orders were correct and splinting and contracture reducing interventions were appropriately documented. Audits and orders were completed by Therapy director on 1/31/2023. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • On 01/31/2023 an audit was done by the Rehab Services Director to assess for any resident who completed rehabilitation services over the previous 90 days and were found to have a need for restorative nursing. The audit was to determine if all referrals to restorative nursing were complete. Of the 44 residents audited, none were found to be without services. • DON was educated on 01/31/2023 on how and when to put in orders in for splints/ROM by Administrator/Designee. • Weekly IDT meeting will be reviewing splints and assisted devices to ensure they are appropriate and being utilized. DON/DESIGNEE Will start reporting to weekly IDT on 2/16/2023.	

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F 688	Continued From page 14 not receive rehabilitation services (PROM and splint application to both ankles and left upper extremity) 5 -7 days a week (Sunday to Saturday) as instructed in the Rehabilitation Instruction Record orders: August 21-27, 2022: There was documentation Resident #8 received rehabilitation services for three days: 8/23/2022, 8/25/2022 and 8/26/2022. August 28-September 3,2022: There was documentation Resident #8 received rehabilitation services for three days: 8/29/2022, 9/1/2022 and 9/2/2022. September 4-10, 2022: There was no rehabilitation services documented. September 11-17, 2022: There was documentation Resident #8 received rehabilitation services for two days: 9/15/2022 and 9/16/2022. September 18-24, 2022: There was documentation Resident #8 received rehabilitation services for two days: 9/22/2022 and 9/23/2022. September 25 -December 12/11/2022: There was no rehabilitation services documented. December 11-17, 2022: There was documentation Resident #8 received rehabilitation services for four days: for two days: 12/12/2022, 12/13/2022, 12/14/2022 and 12/15/2022. December 18-24,2022: There was documentation Resident #8 received rehabilitation services for two days: 12/19/2022 and 12/23/2022. December 25-31, 2022: There was documentation Resident #8 received rehabilitation services for two days: 12/28/2022 and 12/29/2022. January 1-7, 2023: There was documentation	F 688	• The Rehab Services Director will provide a copy of the Restorative referral to the Director of Nursing as each resident has been evaluated for an appropriate restorative program. The Director of Nursing/ Assign Designee will implement the appropriate program with the restorative team (to include the Restorative Nurse and Restorative Aides). This process will be audited weekly X 8 weeks then monthly X 1 month. • Results of the audits will be presented monthly by DON/Designee in the QAPI committee for a minimum of three consecutive meetings. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • IDT team (DON/Designee) will monitor weekly to ensure any issues are addressed and refer any issues to the QA committee. • DON/designee will conduct audits of this process weekly X 8 weeks then monthly X 1 month, using the weekly floor statistic sheet in the weekly IDT team meeting. • Any errors found in the audits will be reported by DON/Designee to the QA committee until four consecutives of compliance has been reached and DON will adjust as necessary to ensure continued compliance.	

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Resident #8 received rehabilitation services for two days: 1/4/2022 and 1/6/2022.

January 8-13, 2023: There was no rehabilitation services documented.

January 14-20, 2023: There was documentation rehabilitation services were attempted for Resident #8 for one day: 1/19/2023.

On 1/17/2023 at 11:18 a.m., Resident #8 was observed lying in the bed with her eyes closed with right and left hands contracted into a fist and both elbows were flexed positioning the hands toward the upper body. There were no hand rolls observed in the right or left hand of Resident #8. The right foot and left foot were observed flexed toward the mattress of the bed with no splints on her lower extremities.

On 1/18/2023 at 3:49 p.m. during an interview with Nurse Aide (NA) #1, she stated was not aware how the facility was addressing Resident #8's contractures and placed pillows behind Resident #8 when positioning the resident.

On 1/19/2023 at 11:05 a.m. during an interview with the Director of Therapy, she said Resident #8 received therapy services until 8/16/2022, and upon discharge from therapy services, she was placed on a maintenance program for range of motion and splint application, which was conducted jointly by the rehabilitation technician, who worked in the therapy department, and the Nursing Department. She stated the former Director of Nursing would have received a copy of the rehabilitation orders for the nursing staff, and the nursing staff was responsible for conducting splint application and passive range of motion for Resident #8 when the rehabilitation technician was not scheduled to work. In a follow-up

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interview on 1/20/2023 at 9:21 a.m., the Director of Therapy stated the rehabilitation technician had been scheduled to work a couple days per week since September 2022.

On 1/19/2023 at 1:09 p.m. during an interview with Nurse #1 (who was assigned to Resident #8), he said the therapy department provided the nursing department rehabilitation orders for residents needing rehabilitative services after discontinuation of therapy services. The nursing department would re-write the rehabilitation orders to reflect on the Medication Administration Record for nursing staff to perform the rehabilitation services. He said the therapy department showed the nursing staff how to conduct passive range of motion and how to apply the splints as needed for residents with rehabilitation orders. He further stated Resident #8 was not care planned for rehabilitative services for her contractures, and he had not been shown by therapy how to apply splints or how to conduct passive range of motion for Resident #8.

On 1/19/2023 at 2:29 p.m. during an interview with Nurse #2, she stated she was not aware Resident #8's splint application and passive range of motion was the responsibility of the nursing staff. She stated therapy was applying Resident #8's splints for a while, and rehabilitative services would have been placed on Resident #8's Medication Administration Record if nursing responsible for conducting the rehabilitation services.

On 1/19/2023 at 4:42 p.m. during an interview with the Director of Nursing, she stated therapy provided rehabilitation orders for residents to the

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F 688	Continued From page 17 Director of Nursing when nursing staff needed to provide rehabilitation services, and Resident #8 had been receiving rehabilitative services when the rehabilitation technician was scheduled to work. She stated she had learned that day (1/19/2023) from the Director of Therapy that nursing staff should had been applying splints and conducting PROM on Resident #8 when the rehabilitation technician was not scheduled to work, and she was working on identifying nursing staff to train that would be responsible for performing rehabilitation services to Resident #8. She stated therapy provided the rehabilitation orders to the former Director of Nursing and was unsure why the rehabilitation orders were not re-written as a nursing order and communicated to the nursing staff through the Medication Administration Record to ensure Resident #8 PROM and splint application was conducted as ordered.	F 688		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.	F 809		1/20/23

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F 809	Continued From page 18 §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, consultant Registered Dietitian (RD) interview, and record review, the facility failed to serve a nourishing snack at bedtime when the time between dinner and breakfast was greater than 14 hours for residents residing on 2 of 2 resident hallways (100 Hall and 300 Hall). The findings included: A review of the facility's "Brook Stone Living Center Meal Times" indicated the food line start times were scheduled as follows: -The meal line for the 300 Hall was scheduled to begin at 4:45 PM for Dinner and at 7:15 AM for Breakfast (indicative of a 14 hour and 30 minute time span between the two meals); -The meal line for the 100 Hall Cart 1 was scheduled to begin at 4:50 PM for Dinner and at 7:30 AM for Breakfast (indicative of a 14 hour and 40 minute time span between the two meals); -The meal line for the 100 Hall Cart 2 was scheduled to begin at 5:00 PM for Dinner and at 7:45 AM for Breakfast (indicative of a 14 hour and 45 minutes time span between the two meals); An interview was conducted on 1/18/23 at 4:48 PM with the facility's Dietary Manager. When asked about the time between meals, the Dietary Manager indicated she noticed the extended time span between the residents' Dinner and Breakfast meals when she started working at the	F 809	Issues: • Meal times on the halls were slightly outside the 14 hour max span of time. Main dining rooms times were within 14 hours. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • All residents had the potential to be affected. • New dietary manager was hired week before the survey and she fixed the meal times and gave a copy of the new times to the surveyors while they were in the field. How the facility will identify other residents having the potential to be affected by the same deficient practice: • All residents had the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • Meal times were adjusted and given to the surveyors before they left the facility to ensure that there was no more than 14 hours between meals. Correct on or before 1/20/2023. • Any changes in mealtimes will have to be approved going forward by the	

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F 809	Continued From page 19 facility in January 2023. She explained she had written down her concern and had planned to bring up her concern to management at the next staff meeting. To the Dietary Manager's knowledge, there were not any concerns voiced by the residents. The Dietary Manager indicated the snack offered to residents at bedtime was not a high protein snack and was not considered a nourishing snack. The evening snack included item selections of cookies or chips. An interview was conducted on 1/18/23 at 5:15 PM with the consultant Registered Dietician (RD). When asked about the facility's meal schedule allowing greater than 14 hours to elapse between a substantial evening meal and breakfast the following day, the RD stated she was unaware there was greater than 14 hours between meal and indicated the Dinner time would be moved. The RD stated an example of a nourishing snack was a snack that included carbohydrates and at least 10 grams of protein such as half a sandwich and a carton of milk. The RD further indicated, the residents had not been offered a nourishing snack at bedtime and had been provided with snack such as cookies and chips. An interview was conducted on 1/18/23 5:24 PM with the Administrator. During the interview, the failure of the facility to provide meals within a time span specified by the regulations was discussed. The Administrator indicated the meal times were staggered to give staff time to get the meal trays down the hallway to the residents. The Administrator further indicated he was unaware there was more than 14 hours between Dinner and Breakfast the following day. When asked, the Administrator reported his expectation was that no more than 14 hours would elapse between the	F 809	Administrator. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • Dietary Manger will monitor mealtimes and spot check to ensure mealtimes are properly adhered to. • Any resident complaints about meals and specifically timing of meals will be bought up during the morning meetings when concerns and grievances are discussed. • Any reported issues will be bought up to the QA committee for discussion. • This monitoring will be ongoing without end date to ensure compliance.	

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F 809	Continued From page 20 Dinner and Breakfast meals.	F 809		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to	F 867		2/16/23

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adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse

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F 867	Continued From page 22 resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and	F 867	Facilty was cited in areas that had been cited and has implemetned individaul	

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F 867	Continued From page 23 Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the recertification survey of 10/06/21 and focused infection control survey of 12/22/20. The deficiencies were in the areas of Accuracy of Assessments (F641), Activities of Daily Living (ADL) Care Provided for Dependent Residents (F677), and Infection Prevention and Control (F880). The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross-referenced to: F641 Based on record review and staff interviews, the facility failed to accurately complete the Minimum Data Set (MDS) for discharge, and anticoagulant (blood thinning medication) use for 3 of 18 residents whose MDS assessments were reviewed (Resident #48, Resident #26, and Resident #30). During the recertification survey of 10/06/21, the facility was cited for failure to accurately code the MDS for weight loss, anticoagulants, and indwelling catheter. F677 Based on observations, record review, resident and staff interviews, the facility failed to provide hair care for 1 of 1 dependent resident reviewed for activities of daily living (Resident #20). During the recertification survey of 10/06/21, the	F 867	POC's for each of the areas that had received tags. The intervetions are as follows for each tag: 641 Issues: • The facility failed to accurately code an Admission Minimum Data Set for resident #48, #26,AND #30. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • The facility modified resident #48 to reflect discharge home on discharge assessment on 12/23/22 and retransmitted on 01/20/23. • The facility modified resident #48 to reflect discharge as “home on discharge assessment on 12/23/2022 and retransmitted on 01/20/23. • The facility modified resident #30 assessment reflected that resident did not receive anticoagulant(blood thinner) on 12/16/2022 and resubmitted on 01/20/23. • The facility modified resident #26 assessment reflected that resident did not receive anticoagulant(blood thinner) on 12/23/22 and resubmitted on 01/20/23. How the facility will identify other residents having the potential to be affected by the same deficient practice: • An audit of all current residents on anticoagulants was completed by the DON/or Designee to ensure accurate MDS coding. Any alterations identified will be corrected/modified as appropriate.	

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F 867	Continued From page 24 facility was cited for failure to provide nail care for resident who was dependent on facility staff for ADLs. F880 Based on observation, record review and staff interviews, the facility failed to follow the manufacturer's guidelines for cleaning and disinfection of a blood glucose meter which was stored in the medication cart after use for 1 of 5 residents observed (Resident #22) during a medication pass on 1/18/23 at 4:10 PM The blood glucose meter was stored in the medication cart and was not designated as an individual resident meter. During the focused infection control survey of 12/22/20, the facility failed to follow Centers for Disease Control and Prevention (CDC) recommended use of Personal Protective Equipment (PPE) for collecting COVID-19 nasopharyngeal specimens while within 6 feet of residents and staff. An interview on 1/20/23 at 2:50 PM with the Director of Nursing revealed she believed the repeat deficiencies were caused by staffing changes.	F 867	• Starting 1/23/2023 Minimum Data Set Nurses and Corp MDS consultant reviewed 30 days of discharge residents to ensure accuracy of coding discharge home. No additional concerns identified. • Starting 1/23/2023 Minimum Data Set Nurses and Corp MDS reviewed current resident discharges to ensure accuracy of coding for anticoagulants. To ensure completeness of all patients on anticoagulants, facility will obtain list from pharmacy. No additional concerns identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • The DON/assign Designee provided education to MDS staff on accuracy of coding MDS and review of current anticoagulant orders. • DON or designee will audit 5 discharge assessments weekly to ensure discharge assessments are coded accurately. If less than 5 discharge in the week we will look at 100% of discharges assessments. These audits will start on 1/20/2023. Audits will be for previous calendar week. • DON or designee will audit 5 admission assessments weekly to ensure assessment for height are coded accurately. If less than 5 admissions in a week we will review 100% of the admission assessments. These audits will start on 1/20/2023. Audits will be for previous calendar week.	

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F 867	Continued From page 25	F 867	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • The corporate DON or Corp MDS consultant will audit new MDS's weekly until we have four consecutive weeks of 100% compliance with coding of discharges and anticoagulants. • DON or Designee 5 per week or 100% if less than five audits will continue for another 4 weeks past after compliance has been reached to ensure new residents are coded properly. • Any errors found in the audits will be reported to the QA committee until 60 days of compliance has been reached and DON will adjust as necessary to ensure continued compliance. 677 Issues: • Surveyor reported resident had not had her hair washed for an extended period of time. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • Resident #20 hair was washed the day the surveyor team reported this. • Facility disagreed with surveyor assessment because documentation and interviews indicate information in contradiction to the narrative in the 2567. • Resident has oily hair and often looks oily the day after being washed. How the facility will identify other residents having the potential to be affected by the	

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F 867	Continued From page 26	F 867		

same deficient practice:
• All patients in the facility that require assistance with ADL care and more specifically bathing and showering.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
• Education with competency verification has been provided to the facility certified nursing assistant staff regarding performing bathing assistance on 01/31/2023.
• All residents care plans will be reviewed to ensure they are properly care planned for the appropriate bathing and showering schedule. Review will be completed by 2/16/2023.
• DON or designee will conduct audits of ADL care and documentation weekly until 100% compliance on bathing or documenting refusals for a period of four weeks starting 1/31/2023.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
• Departments heads will be asked to bring to DON or designees' attention if they see residents in need of personal care.
• DON or designee will conduct audits of ADL care and documentation weekly until 100% compliance on bathing or documenting refusals for a period of four weeks.
• Any errors found in the audits will be reported to the QA committee until four consecutives of compliance has been reached and DON will adjust as

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F 867	Continued From page 27	F 867	necessary to ensure continued compliance. 880 Issues: • Surveyor reported that nursing staff followed proper cleaning procedure except the correct drying time after disinfecting glucometer. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • Root cause analysis indicated that through the pandemic that we have used multiple different types of wipes and that they had different times that they were required to dry. Based on availability of supplies these wipes used to clean the glucometers changed from time to time. • Dry times were assumed to be the same for all types of wipes when manufacture specs had specific guidelines to dry times. • Nurses have been in serviced on appropriate dry times for the wipes we are currently using. How the facility will identify other residents having the potential to be affected by the same deficient practice: • All patients in the facility that require blood glucose monitoring are at risk for this practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 867	Continued From page 28	F 867	• Education with staff on dry times according to manufacturer's specification was done before the survey team left the building on 01/18/2023 for staff that was working that day. Additional more formal education was done with all staff on 1/31/2023 and 2/3/2023. • To ensure this is not an issue going forward facility also implemented the practice of having a separate glucometer for each resident that requires glucose monitoring which should eliminate potential for practice to continue as there would be sufficient drying times for each device before next use. New Glucometer should be in place by 2/16/2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • Director of Nursing or designee will complete 5 competency questioning audits of licensed and certified staff weekly for 4 weeks and then 5 competency questioning audits monthly for 4 months to determine if staff respond appropriately to infection control practices related to blood glucometer handling. • DON or designee will conduct cart audits for four weeks to ensure each resident requiring blood glucose monitoring has their own glucometer on the cart. • Any errors found in the audits will be reported to the QA committee until four consecutives of compliance has been reached and DON will adjust as necessary to ensure continued compliance.	

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F 867	Continued From page 29	F 867	Facilty will continue to monitor all QA related items and report any issues to the QAPI committee as concerns arise in addition to the interventions above.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		2/24/23

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F 880	Continued From page 30 (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow the manufacturer's guidelines for cleaning and disinfection of a blood glucose meter which was	F 880	Issues: • Surveyor reported that nursing staff followed proper cleaning procedure except the correct drying time after	

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F 880	Continued From page 31 stored in the medication cart after use for 1 of 5 residents observed (Resident #22) during a medication pass on 1/18/23 at 4:10 PM The blood glucose meter was stored in the medication cart and was not designated as an individual resident meter. Findings included: Review of the facility policy 'Obtaining a Fingerstick Glucose Level' revised in October 2011 read, in part, to clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. The blood glucose meter manufacturer's instructions for cleaning and disinfecting dated 9/2019 indicated the blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. A list of Environmental Protectional Agency (EPA) wipes were recommended on the cleaning instructions. Additional instructions were to read the manufacturer's instructions for the use of the wipes. The wipes container which was located on top of the medication cart read in part to disinfect nonfood contact surfaces to thoroughly wet surface, allow treated surface to remain wet for two minutes and let air dry. These wipes were an EPA-registered germicidal wipe and approved for bloodborne pathogen use. An observation on 1/18/23 at 4:12 PM of Nurse	F 880	disinfecting glucometer. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: • It is the policy of this facility to accurately and safely provide infection prevention and control, including the provision of establishing and maintaining an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. • Glucometer cleaning/disinfecting: Root Cause Analysis was conducted on 01/31/2023 and completed 02/02/2023 to identify the root cause of 1) failure of the license staff knowing how to allow surface to remain treated after cleaning the glucometer. The Root Cause Analysis was led by the Director of Nursing, Infection Preventionist, ADON. The Results of the Root Cause Analysis were reviewed by the QAPI Committee on 02/02/2023 were incorporated into the facility plan of correction. • The facility uses Brook Stone living and manufacturer Policies that address when staff are to clean/disinfecting of glucometer. A copy of Brook stone living center policy (Revised 2/2023) was reviewed with the licensed staff on 01/31/2023 and 02/02/2023 with in-service education completed by the facility ADON. Additional License staff not present on 01/31/2023 and 02/02/2023 will receive in-service education by the	

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F 880	Continued From page 32 #3 revealed she gathered necessary supplies, went into Resident #22's room and obtained his blood sugar. She exited the room and returned to the medication cart in the hall. Nurse #3 was observed to remove a wipe from the container and wipe the glucose meter. She was observed to wipe the blood glucose meter for approximately 20 seconds and placed it on a tissue on top of the medication cart. When asked how long she was supposed to clean the meter she stated, '30 seconds-ish' and then let it air dry. An interview on 1/19/23 at 11:08 AM with the Director of Nursing (DON) confirmed there were no residents with bloodborne pathogen diagnoses at the facility. She stated that the disinfecting contact time for the blood glucose meter should be two minutes. She stated the staff have been trained and she did not know why the nurse didn't follow policy. The DON stated that the facility had one glucometer for resident use since she had been there and did not know why each resident did not have their own personal glucometer. An interview on 1/20/23 at 9:56 AM with the Administrator revealed that blood glucose meters should be disinfected according to the manufacturer's instructions.	F 880	Infection Preventionist by 02/10/2023. An attestation statement by the Infection Preventionist verifying completion of in-service training will be completed by 02/10/2023. • Nurses have been in serviced on appropriate dry times for the wipes we are currently using. How the facility will identify other residents having the potential to be affected by the same deficient practice: • All patients in the facility that require blood glucose monitoring are at risk for this practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • Education with staff on dry times according to manufacturer's specification was done before the survey team left the building on 01/18/2023 for staff that was working that day. Additional more formal education was done with all staff on 1/31/2023 and 2/2/2023. • To ensure this is not an issue going forward facility also implemented the practice of having a separate glucometer for each resident that requires glucose monitoring which should eliminate potential for practice to continue as there would be sufficient drying times for each device before next use. New Glucometer should be in place by 2/16/2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: • The Director of Nursing or designee will monitor for compliance by observing	

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F 880	Continued From page 33	F 880	blood sugar checks to ensure staff use the resident's individual glucometer and that the glucometers are cleaned according to manufacturer guidelines. The Director of Nursing or designee will audit 5 observations of blood sugar checks per week x 4 weeks and then 5 observations of blood sugar checks per month x 3 months DON or designee will conduct cart audits for four weeks to ensure each resident requiring blood glucose monitoring has their own glucometer on the cart. • Any errors found in the audits will be reported by DON/Designee to the QA committee until four consecutives of compliance has been reached and DON will adjust as necessary to ensure continued compliance.	