STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/10/23 through 04/14/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 4Y5R11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/10/23 through 04/14/23. Event ID# 4Y5R11. The following intakes were investigated NC00199813, NC00199659, NC00199543, NC00199552, NC00199356, NC00197783, NC00197705, NC00197640, NC00196319, NC00195961, NC00195584 and NC00195013. 8 of the 30 complaint allegations resulted in deficiency.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with resident and staff, the facility failed to ensure dependent residents could access a light switch located behind their beds for 6 of 6 residents reviewed for accommodation of needs (Resident #6, #8, #11, #18, #76, and #83). A. Resident #8 was admitted to the facility on	F 558	* Corrective action for Residents 6, #8, #11, #18, #76 and #83 are schedule to occur on or before 5-12-23 by an outside contracted electrician by adding a pull cord/switch to the existing behind the bed lighting system which will allow the residents to turn their behind the bed light on and off at their desire without having to	5/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/05/2023

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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10/14/21.

Review of Resident #8's medical records revealed she had moved to her current room on 01/31/23.

The quarterly Minimum Data Set (MDS) dated 03/14/23 assessed Resident #8 with intact cognition. The MDS indicated walking between locations inside the room did not occur for Resident #8 during the assessment period.

During an observation conducted on 04/10/23 at 11:32 AM, the switch for the light behind Resident #8's bed located on the wall approximately 3 feet from the floor and around 5-6 feet from Resident #8's bed without a cord attached. Resident #8 was unable to reach the switch from the bed if needed.

An interview was conducted with Resident #8 on 04/10/23 at 11:36 AM. She stated she was bed bound and non-ambulatory. She did not have any control of the lights behind her bed as she could not reach the switch on the wall from her bed without the switching cord. She had to rely on nursing staff to control the light for her each time and it was very inconvenient to her.

B. Resident #18 was admitted to the facility on 03/24/23 and had been in her current room since admission.

The admission MDS dated 03/31/23 assessed Resident #18 with intact cognition. The MDS indicated walking between locations inside the room did not occur for Resident #18 during the assessment period.

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ask for assistance. Electrical switches and pull cords ordered by Administrator on 5-5-23.

* A room observation round was conducted on 5-4-23 by the maintenance director and it was determined that all the resident rooms (200 hall) that were part of the remodel a year and a half ago are affected by this same alleged deficient practice. All are being scheduled to be addressed by the contracted electrician such that the residents in these affected rooms will have increased accessibility to the lighting behind the bed. All the affected rooms on the 200 hall will be addressed and the behind the bed lighting will have pull cords installed such that the resident can operate it from the bed. This will be completed by 5-12-23: however, if through the audits or daily room rounds, issues with the lighting system are identified, they will be addressed by the maintenance director and this will be ongoing. Repairs will be monitored for completion by the Administrator and/or maintenance director (if contracted out).

* Measures/Systematic Changes include: 1) Education provided to the Maintenance staff by the Administrator regarding the necessity of the residents having accessibility to control the lighting in the room . Education provided 5-8-23 2) Education to all staff on the importance of reporting any issues with the behind the bed lighting systems in resident rooms to the maintenance staff. This education was presented and completed by the Staff

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F 558	Continued From page 2 During an observation conducted on 04/12/23 at 8:55 AM, the switch for the light behind Resident #18's bed located on the wall approximately 3 feet from the floor and around 5-6 feet from Resident #18's bed without a cord attached. Resident #18 was unable to reach the switch from the bed if needed. An interview was conducted with Resident #18 on 04/12/23 at 9:11 AM. She stated she was bed bound and the switch for the light behind her bed did not have a cord attached to it. The switch was too far for her to reach from her bed if needed. She had to ask the staff to control the light each time as needed. She was concerned about falling if she tried to access the switch from her bed. She added it was very inconvenient for her especially when she woke up in the middle of the night at times. C. Resident #76 was admitted to the facility on 10/19/22. Review of Resident #76's medical records revealed she had moved to her current room since 01/30/23. The significant change in status MDS dated 02/06/23 assessed Resident #76 with moderately impaired cognition. The MDS indicated walking between locations inside the room did not occur for Resident #76 during the assessment period. During an observation conducted on 04/12/23 at 10:17 AM, Resident #76's bed was lowered, the switch for the light behind her bed located on the wall approximately 3 feet from the floor and around 6-7 feet from her bed without a cord attached to it. Resident #76 was unable to reach	F 558	Development Coordinator and/or Unit Managers by 5-12-23. Any staff not present for educational sessions will receive the education upon returning to work by the SDC or UM. 3) Maintenance will repair/address lighting issues identified by staff on the day of notification. 4) Maintenance Repair notebook placed at 100 hall and 200 hall nurses stations for the staff on off hours to be able to communicate issues to the maintenance staff. Maintenance staff will check this daily (M-F) and address listed issues. This starts 5-8-23 * The maintenance director will conduct an audit in which resident room behind the bed lighting systems will be audited for proper function and resident accessibility by the residents in the following cadence: 5 resident rooms 3 times a week for 4 weeks, then 5 resident rooms 2 times a week for 4 weeks, and then 5 resident rooms once a week for 4 weeks. The maintenance director will present the findings of these audits to the QAPI committee meeting monthly for a period of at least 3 months. The QAPI committee may make adjustments to the plan if deemed necessary to ensure compliance. \ * Completion date will be 5-12-23	

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F 558	Continued From page 3 the switch from the bed if needed. Interview with Resident #76 on 04/12/23 at 10:19 AM revealed she was bed bound and non-ambulatory. She stated the switch for the light behind her bed was inaccessible from her bed as it did not have a cord attached. She had to trigger the call light each time when she needed to control the light and it was very inconvenient to her. She never tried to reach the switch from her bed as she was afraid of falling. She expected to have full control of the light behind her bed all the times. During a joint observation conducted with Nurse Aide (NA) #1 and Nurse #1 on 04/12/23 at 2:40 PM, the lights behind the bed for Resident #8, #18, and # 76 remained inaccessible from their bed. Both nursing staff acknowledged that the switches on the wall were unreachable for these residents from their bed. During an interview conducted on 04/12/23 at 2:49 PM, NA #1 stated she was aware of accessibility issues for some residents' light behind the bed on the 200 Hall. She tried to minimize risk of falling by encouraging residents to trigger call light whenever they needed to control the light behind the bed. During an interview with Nurse #2 on 04/12/23 at 2:54 PM, she explained she did not notice the light switches behind Residents #8, #18, and #76's beds were unreachable. Otherwise, she would have reported the issues to maintenance staff for repair. She stated all the lights behind residents' bed should be accessible by the resident.	F 558		

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During an interview conducted on 04/12/23 at 3:02 PM, Nurse #1 stated she did not notice the light switches behind Resident #8, #18, and #76's beds were inaccessible from their bed. She explained these residents always used the ceiling light and never voiced accessibility concerns to her so far. She added the light behind resident's bed should always be accessible.

During an interview conducted with the Maintenance Manager on 04/12/23 at 3:11 PM, he explained when the contractor renovated the rooms on 200 Hall a few months ago, they might have designed the rooms without considering the physical ability and needs of population under skilled nursing care. He acknowledged that the control switches for the light behind the bed for these residents were inaccessible from their bed. It could increase falling risks when resident tried to reach the switch from the bed. He stated all the lights behind bed should be assessable. Resident should always have full control of the light behind their bed.

During an interview conducted on 04/13/23 at 9:05 AM, the Director of Nursing (DON) stated it was her expectation for all the lights behind resident's bed to be accessible by the residents.

An interview was conducted on 04/14/23 at 3:44 PM with the Administrator. She expected nursing staff to be more attentive to residents' home and report repair needs to Maintenance Manager in a timely manner. It was her expectation for all the dependent residents to have accessibility and full control of the light behind their bed.

D. Resident #6 was admitted to the facility on 3/24/20.

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A quarterly Minimum Data Set for Resident #6 dated 1/6/23 revealed she was cognitively intact. The resident was dependent on staff for transfers, walking did not occur during the assessment period.

An observation was made of Resident #6's room on 4/10/23 at 2:25 PM. The switch for the lights behind Resident #6's bed was located on the wall approximately 3 feet from the floor and about 5-6 feet from Resident #6's bed, and there was no cord attached for the resident's use. Resident #6 could not reach the light switch from her bed.

During an interview on 4/10/23 at 2:30 PM Resident #6 revealed she could not reach any of the light switches in the room and if she wanted the lights off or on, she would have to call staff for assistance. She stated if she had a cord, she could control the lights herself.

E. Resident #11 was admitted to the facility on 8/25/22.

A quarterly Minimum Data Set for Resident #11 dated 3/10/23 revealed she was cognitively intact. The resident required extensive assistance for transfers and was unable to walk independently in her room.

An observation was made of Resident #11's room on 4/10/23 at 2:52 PM. The switch for the lights behind Resident #11's bed was located on the wall approximately 3 feet from the floor and about 5-6 feet from Resident #11's bed, and there was no cord attached for the resident's use. Resident #11 could not reach the light switch from her bed.

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During an interview on 4/10/23 at 2:55 PM Resident #11 revealed she was unable to reach the light switch to control the lights behind her bed, staff had to do it for her. If she wanted her lights on, she had to activate her call light and wait for staff to come. She stated if she had a cord, or something attached to her bed she could turn the lights on herself.

F. Resident #83 was admitted to the facility on 2/13/23.

An admission Minimum Data Set for Resident #83 dated 3/20/23 revealed he was cognitively intact. He required supervision to walk in the room and had an active diagnoses of falls.

An observation was made of Resident #83's room on 4/10/23 at 3:42 PM. The switch for the lights behind Resident #83's bed was located on the wall approximately 3 feet from the floor and about 5-6 feet from Resident #83's bed, and there was no cord attached for the resident's use. Resident #83 could not reach the light switch from his bed.

During an interview on 4/10/23 at 3:45 PM Resident #83 revealed he could not reach the switch to turn on the behind his bed without getting up. In order to turn the lights behind his bed on or off he would have to get up to his wheelchair and go to the wall to use the light switch. He stated this was inconvenient and it would be better if there was a way for him to operate the light from his bed.

During an interview conducted on 04/12/23 at 2:49 PM, NA #1 stated she was aware of the accessibility issues regarding the light switches for some of the residents on 200 Hall. She tried to

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minimize the risk of falling by encouraging residents to activate their call light whenever they needed to use the light behind the bed.

During an interview with Nurse #2 on 04/12/23 at 2:54 PM, she explained she did not notice the light switches behind the residents' beds on the 200 hall were unreachable. Otherwise, she would have reported the issues to maintenance staff for repair. She stated all the lights behind the residents' beds should be accessible for the resident.

During an interview conducted on 04/12/23 at 3:02 PM, Nurse #1 stated she did not notice the light switches behind the 200 hall residents' beds were out of reach. She added residents should be able to operate the lights behind their bed.

During an interview conducted with the Maintenance Manager on 04/12/23 at 3:11 PM, he explained when the contractor renovated the rooms on the 200 Hall a few months ago, they designed the rooms without considering the physical ability and needs of the residents. He acknowledged that the control switches for the lights behind the bed for these residents were inaccessible from their bed. He stated all the lights behind the beds should be accessible. Residents should always have full control of the light behind their bed.

During an interview conducted on 04/13/23 at 9:05 AM, the Director of Nursing (DON) stated it was her expectation for all the lights behind resident's beds to be accessible by the residents.

An interview was conducted on 04/14/23 at 3:44 PM with the Administrator. She expected nursing

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F 558	Continued From page 8 staff to be more attentive to the residents' environment and repair needs should be reported to the Maintenance Manager in a timely manner. The Administrator stated all the dependent residents should have accessibility and full control of the lights behind their bed.	F 558		
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	F 561		5/12/23

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by:
Based on record review, observations, resident and staff interviews, the facility failed to honor a resident's bathing preference for 1 of 4 residents reviewed for choices (Resident #19).

Findings included:

Resident #19 was admitted to the facility on 05/10/19. Her diagnoses included hemiplegia (paralysis on one side of the body) affecting the left non-dominant side and low back pain.

The annual Minimum Data Set (MDS) dated 03/24/23 revealed Resident #19 had intact cognition and displayed no behaviors or rejection of care. The MDS further revealed Resident #19 had an impairment on one side of the upper and lower extremities, required total staff assistance with bathing and it was very important for her to choose between a shower or bed bath.

Review of the Shower Sheets and Nurse Aide (NA) bathing documentation reports provided by the facility for Resident #19 revealed the following:
February 2023: Partial or complete bed baths were documented as provided on 02/01/23, 02/04/23, 02/05/23, 02/06/23, 02/08/23, 02/09/23, 02/10/23, 02/12/23, 02/13/23, 02/14/23, 02/16/23, 02/19/23, 02/20/23, 02/21/23, 02/22/23, 02/23/23, 02/24/23, 02/25/23, 02/26/23, 02/27/23 and 02/28/23. A shower was documented as provided on 02/02/23.

March 2023: Partial or complete bed baths were documented as provided on 03/01/23, 03/02/23, 03/03/23, 03/04/23, 03/05/23, 03/06/23, 03/08/23, 03/10/23, 03/11/23, 03/12/23, 03/13/23, 03/14/23,

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* The alleged deficient practice regarding failure to promote self-determination through support of resident choice regarding bathing for Resident #9 was corrected on 4-14-23 as the resident's preference for showers twice a week versus bed baths was added to her care plan as well as communicated to the direct care staff by the Director of Nursing (DON) and updated on the shower schedule which is maintained by the Minimum Date Set (MDS) Coordinator.

* A full audit of all current residents was completed by the Registered Nurse (RN) Charge Nurse on 4-21-23 to identify other potential issues of this same nature. All residents were asked their preference for bathing. Identified changes in preference were updated on resident care plan and shower schedule (by the MDS Coordinator) by 5-12-23.

* Systematic Changes to prevent further occurrences of this alleged deficient practice include: 1) All nursing staff to be educated on the importance of Self-Determination and honoring resident preferences.
This will be completed by the Staff Development Coordinator (SDC) by 5-12-23 for all current staff. New staff will receive this education upon hire by the SDC. Any staff not present for this education will be educated on their first day back at work by the SDC or Unit Manager (UM) 2) Upon admission, the Unit Manager will review bathing

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03/15/23, 03/16/23, 03/19/23, 03/20/23, 03/21/23, 03/22/23, 03/23/23, 03/27/23, 03/28/23, 03/29/23, 03/31/23. There were no showers documented as provided.

April 2023: Partial or complete bed baths were documented as provided on 04/01/23, 04/02/23, 04/03/23, 04/06/23, 04/08/23, 04/09/23, and 04/10/23. There were no showers documented as provided as of 04/11/23.

Review of the staff progress notes for February 2023 to April 2023 revealed no entries indicating Resident #19 refused a shower or bed bath when offered by staff.

The Activities of Daily Living (ADL) care plan, last reviewed/revised on 04/05/23, revealed Resident #19 required extensive to total assistance with ADL related to left upper and lower hemiparesis and included an intervention initiated on 06/24/22 that noted Resident #19 preferred a shower on Mondays before supper and a bed bath on Thursdays before supper.

An observation and interview was conducted with Resident #19 on 04/10/23 at 11:09 AM. Resident #19 was lying in bed wearing a clean nightgown with no obvious body odor. Her face, neck and hands were clean; however, her thin hair was pulled back from her face and appeared greasy. Resident #19 stated she was supposed to receive bathing assistance on Mondays and Thursdays each week and while she had received bed baths, she had not received a shower in approximately 2 months.

A follow-up observation and interview was conducted with Resident #19 on 04/13/23 at

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preferences with the resident or Responsible Party. 3) Bathing preferences for new admits will communicated to the MDS Coordinator by the Unit Manager.
4) Bathing preferences for new admits will be added to the shower schedule by the Minimum Data Set (MDS) Nurse upon discovery. 5) Quarterly, resident bathing preferences will be reviewed with the resident/RP by the Social Worker (SW)who will then communicate preference changes to the MDS Coordinator. The MDS coordinator will update the Care Plan and the shower schedule. 6) The shower schedule will be overseen by the MDS Nurse and kept at the 100 and 200 hall nurses stations so that all direct care staff have access to the shower schedule at all times. 7) If/when residents express to a staff member that a desired change in bathing preferences is the case, the staff member communicates those changes to the MDS Nurse so that the changes can be care planned and added to the shower schedule.

* To ensure compliance, UMs will conduct bathing preference audits with residents (at random) in the following cadence: 3 residents a day, 3 days a week, for 4 weeks, then 3 residents a day, 2 times a week, for 4 weeks, and then 3 residents, once a week, for 4 weeks. These audits will be presented by the UMs to the QAPI team at the monthly meeting. The QAPI team may make adjustments to the plan if deemed necessary to achieve compliance. If during the audits, it is

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10:20 AM. Resident #19 was lying in bed in a clean nightgown with no obvious body odor. Her face, neck and hands were clean; however, her thin hair was pulled back from her face and appeared greasy. Resident #19 stated when staff gave her a bed bath, they only cleaned certain areas but did not wash her back or hair and she did not feel that it was a "true bath." Resident #19 clarified her preference was to receive one shower and one complete bed bath every week.

During an interview on 04/13/23 at 10:42 AM, NA #5 revealed she had only been working at the facility for less than 2 weeks and was assigned to provide care to Resident #19. NA #5 stated she had not given Resident #19 with a shower or bed bath on the days she had provided her care and was not sure what days Resident #19 was scheduled to receive showers.

During an interview on 04/13/23 at 2:41 PM, Nurse Aide #4 revealed she worked 16 hour shifts at the facility and was routinely assigned to provide care to Resident #19. NA #4 explained some days her assigned residents would get a partial bed bath which she described as washing the face, armpits, peri-area and other days a complete bed bath which she described as washing the resident head-to-toe and using a dry shampoo cap to clean the hair. NA #4 confirmed she provided Resident #19's with bed baths instead of showers. NA #4 could not recall why Resident #19 was not offered a shower and stated it was either because Resident #19 had refused or had just wanted a bed bath.

During an interview on 04/14/23 at 5:49 PM, the Director of Nursing (DON) stated residents preferences to the quantity, type and frequency of

identified that bathing preferences have changed, the UMs will communicate this to the MDS nurse so that the care plan and shower schedule can be addressed.

* Completion date: 5-12-23

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F 561	Continued From page 12 bathing assistance should be honored. The DON explained if residents refused bathing assistance when offered, NAs were to notify the nurse who would try to convince the resident and/or document their refusal. The DON was unaware Resident #19 had not received a weekly shower per her preference since 02/02/23 and stated she would have expected for staff to offer Resident #19 a shower as she preferred. During an interview on 04/14/23 at 3:44 PM, the Administrator stated she was not aware Resident #19 was not provided a weekly shower per her preference since 02/02/23 and would expect for staff to provide Resident #19 with the type of bathing she preferred.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		5/12/23

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F 582	Continued From page 13 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare Part A skilled services to 2 of 3 residents reviewed for beneficiary notification review (Residents #41 and #46).	F 582	* Corrective action for this alleged deficient practice regarding failure to provides residents # 41 and # 46 with the required Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) prior to their discharge from Medicare Part A	

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The Findings Included:

1. Resident #41 was admitted to the facility on 02/13/20.

Review of the medial record revealed a Notice of Medicare Non-Coverage (NOMNC) was discussed with and signed by Resident #41 on 03/21/23 which indicated Medicare Part A coverage for skilled services would end on 03/27/23. Resident #41 remained in the facility.

A review of the medical record revealed no evidence a SNF ABN was provided to Resident #41.

During an interview on 04/11/23 at 3:55 PM, the Social Worker (SW) confirmed she was responsible for issuing residents or their Responsible Party a NOMNC prior to Medicare Part A services ending but was not aware a SNF ABN was also required. The SW confirmed Resident #41 was not issued a SNF ABN.

During an interview on 04/12/23 at 9:39 AM, the Administrator stated she was unaware SNF ABNs were not being provided per regulatory guidelines prior to Medicare Part A services ending. The Administrator explained there had been a change in the Social Worker position and the current SW had not known to issue a SNF ABN in conjunction with a NOMNC.

2. Resident #46 was admitted to the facility on 05/27/22.

Review of the medial record revealed a Notice of Medicare Non-Coverage (NOMNC) was

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skilled services. Because this particular regulation has a time frame stipulation, corrective action is not possible

* All residents being covered by Medicare A and remaining in the facility have the potential to be affected by this same alleged deficient practice. The Social Worker (SW) reviewed all payor source changes from April 1, 2023- current (5-4-23) and there were three residents that could be affected. The Electronic Health Record (EHR) was audited by the Administrator on 5-4-23 and the SNF ABN had not been completed. SNF ABN should have been issued prior to discharge from skilled services and that time has passed. This cannot be corrected for these affected residents.

* Systematic changes include: 1) Education provided by the Regional Minimum Data Set (MDS) Nurse to the SW on 5-5-23 regarding the significance of this regulation. 2) Daily (M-F), the Business Office Manager will inform the SW of any upcoming payor source changes and the SW will then determine the proper timeframe for presenting the SNF ABN to the residents that are remaining in the facility. This information will be reviewed in the morning meeting daily (M-F). 3) Once the SNF ABN is presented and signed, the SW will upload the document into the EHR. Bullet points 2 and 3 will start 5-5-23.

* The Administrator will perform an audit weekly in which the EHR, for residents

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F 582	Continued From page 15 discussed with and signed by Resident #46 on 01/02/23 which indicated Medicare Part A coverage for skilled services would end on 01/06/23. Resident #46 remained in the facility. A review of the medical record revealed no evidence a SNF ABN was provided to Resident #46. During an interview on 04/11/23 at 3:55 PM, the Social Worker (SW) confirmed she was responsible for issuing residents or their Responsible Party a NOMNC prior to Medicare Part A services ending but was not aware a SNF ABN was also required. The SW confirmed Resident #46 was not issued a SNF ABN. During an interview on 04/12/23 at 9:39 AM, the Administrator stated she was unaware SNF ABNs were not being provided per regulatory guidelines prior to Medicare Part A services ending. The Administrator explained there had been a change in the Social Worker position and the current SW had not known to issue a SNF ABN in conjunction with a NOMNC.	F 582	discharged from Medicare A and remaining in the facility, for an appropriate and timely SNF ABN starting 5-5-23. The audit will follow this cadence: weekly for a period of 4 weeks and then monthly for a period of 3 months. The results of this audit will be presented by the Administrator at the monthly QAPI committee meeting. If necessary, the QAPI team may change/adjust the plan to ensure compliance. * Completion date will be 5-12--23	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		5/12/23

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F 584	Continued From page 16 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with residents and staff, the facility failed to repair a hole with jagged edges and splintered wood on the lower portion of a door in a shared bathroom (room 128); failed to repair holes in the bathroom linoleum floor (room 128); failed to repair the seal surrounding the base of the toilet that had a buildup of black colored debris in shared	F 584	* Corrective action is as follows: Room 128 door...door plate added on 4-21-23 to address small hole in door and jagged edges sanded by maintenance director. Walls in need of sheet rock repair or painting all have been patched as of 5-5-23 and will be sanded and painted by 5-12-23 by maintenance director. These	

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bathrooms with a strong odor resembling urine (rooms 124 and 128); failed to maintain clean and sanitary bathroom floors (rooms 110, 114, 116, 120, 128); failed to remove side rails from the floor (room 114); failed to maintain a clean and sanitary room divider curtain (room 110); failed to properly label and store personal care equipment in shared bathrooms (rooms 110, 116, 119, 120, 121); failed to maintain walls and baseboards in good repair (rooms 101-2, 114, 116, 120, and 124); failed to repair a loose fitting sink faucet (room 220); failed to maintain a toilet paper holder in good repair (room 110); failed to maintain functioning overhead lights in residents bathrooms (rooms 116 and 119); failed to maintain a functioning overhead light behind the bed (room 206) for 11 of 46 rooms reviewed for maintain a clean, safe, and homelike environment.

Findings included:

1. a. Observations conducted on 04/10/23 at 11:45 AM at 3:47 PM, and then on 04/12/23 at 10:49 AM revealed the bathroom door in room 128 had a hole at the bottom portion of the door. The edges of the hole were jagged with splintered wood. The bathroom floor was sticky with damaged areas of missing linoleum around the base of toilet and in front of the sink. A black colored buildup on the linoleum floor surrounded the base of the toilet and there was a strong urine like odor in the bathroom.

b. An observation conducted on 04/10/23 at 10:49 AM, and then on 4/14/23 at 2:34 PM revealed the bathroom in room 124 smelled like urine. The wall behind the toilet had a large area of discolored paint covering approximately half of

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rooms include rooms 124,114,116,120,and 101. Toilet paper holder was replaced by the maintenance director in room 110 on 4-26-23. Light bulbs in the bathrooms for rooms 116 and 119 were replaced by the maintenance director on 4-+27-23. The sink faucet/fixture was replaced in room 103 by the maintenance director on 5-5-23. The linoleum floor in the bath room for 128 will be replaced with tile and the seal surrounding the base of the toilet will also be replaced by the maintenance director by 5-12-23. The bathroom between 124 and 126 will have the sheetrock below the sink repaired, new baseboard put in, and the walls will also be painted by the maintenance director by 5-12-23.
Behind the bed lighting for room 206 resident #8 was repaired by the maintenance director on 5-5-23

The Director of Housekeeping (DOH) mopped and cleaned the sticky/soiled floors identified in the survey which included: bathroom of room 128, 120, 116, 110, and 114.
The DOH addressed and resolved the smell of urine in the bathroom of room 124 by deep cleaning the bathroom on 5-4-23. Disconnected bed rails in room 114 were removed and discarded by the DOH on 5-4-23. The stained privacy curtain in room 110 was removed and laundered and replaced on 4-14-23 by the DOH.

* A room by room audit was conducted by the maintenance director identifying

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the wall. The sheetrock below the sink was damaged and torn with approximately two 4-to-5-inch tears in the paper of the sheetrock and the rubber like baseboard did not completely adhere to the wall, which left a gap at the top of the baseboard at one corner of wall underneath the sink. A black colored buildup on the linoleum floor surrounded the base of the toilet and there was a strong urine like odor in the bathroom.

An interview with the Director of Housekeeping on 04/14/23 at 9:07 AM revealed housekeeping staff mopped resident rooms daily. He stated he was aware of some the floors in 200 hall resident rooms being sticky but now it was becoming an issue in 100 hall resident rooms. The Director of Housekeeping stated he felt the floors were sticky due to housekeeping staff either only mopping the rooms with water or putting too much cleaning chemical in the water and not wringing the mops out thoroughly. He explained he had done education with staff about applying the right amount of cleaning chemicals in mop water and he would provide additional education regarding the correct way mix mop water. He stated he expected the floors to be free of stains and not sticky.

An observation and interview were conducted on 04/14/23 at 2:34 PM with the Maintenance Director. There were no repairs made to address the condition of the bathrooms for room 124 and 128. The Maintenance Director explained he checked resident rooms for repairs after he was hired on 02/13/23 and was aware the bathrooms needed new flooring and the walls needed to be repainted. He observed the bathroom in room 124 and stated the damaged baseboard and sheetrock underneath the sink might have been

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sheetroock/painting issues, toilet paper holders in need or replacement, lighting issues/light bulbs needs to be replaced, loose faucets, and damaged flooring on 5-4-23. There were issues identified throughout the facility and a schedule has been developed in which all newly identified issues will be addressed by the maintenance director or subcontracted out if necessary. The identified environmental issues will be prioritized and placed on a calendar for repair and will be maintained and reviewed by the Maintenance Director and Administrator weekly. This will be ongoing. The DOH also completed a room to room audit in which he was observing for sticky/soiled floors and soiled/stained privacy curtains. This was completed by 5-3-23. Four additional rooms were identified as being sticky or soiled and these four floors were mopped and cleaned by the DOH on 5-3-23. No other disconnected bed rails were found in resident rooms by the DOH while checking the floors. Four soiled privacy curtains were also identified and removed, laundered and replaced by the DOH on 5-4-23 The DOH also checked for the smell of urine (like what was identified in the bathroom of 124) and there was one resident room that was found to have a strong odor. That room was deep cleaned on 5-4-23 and the central supply clerk assisted in cleaning out and organizing that room.

* Measures/ systematic changes include:
1) Education provided to the Maintenance Director and DOH by the administrator on

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caused by a leak and the flooring and toilet needed to be replaced and toilet resealed to prevent the urine like odors. He observed the discoloration on the wall and explained it looked like bleach was sprayed and stated the wall needed to be repainted. He observed the bathroom in room 128 and stated the bathroom floor and the toilet needed to be replaced and the toilet resealed to prevent the black colored buildup and urine like odors. For the hole with damaged and splintered wood on the bathroom door the Maintenance Director stated he would do a temporary fix and place a metal kick plate but eventually the door needed to be replaced. He was aware bathrooms needed repairs but didn't know about the hole in bathroom door and did rely on staff to report environment issue either written or verbally. He stated there were a lot of high priority projects to fix and indicated those repairs had kept him busy and away from the issues noted in rooms 124 and 128.

During an interview on 04/14/23 at 6:25 PM the Administrator explained for a couple of months the facility had no Maintenance Director and they had difficulty filling the position and relied on maintenance staff from a sister facility. The positions were filled, and they currently have two full time maintenance personnel. The Administrator revealed there was a list that included painting, replacing tile, fixing wiring, and plumbing and there were always ongoing maintenance issues in the facility, but it would be a while before the areas were fixed and fixing safety issues were a priority.

2. An observation of room 114-1 on 04/10/23 at 11:29 AM revealed quarter-sized bed rails were completely detached from the bed and were lying

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the relevance of this F tag and the details of the citation. This was done on 5-2-23. 2) All staff to be educated on the importance of communicating issues identified in this citation to the maintenance director or his assistant or the DOH. This education will be completed by 5-12-23 and presented by the Staff Development Coordinator (SDC) or Unit Manager (UM). Staff on vacation will receive this education upon return to work by SDC or UM. Newly hired staff will be educated on this during orientation and new agency staff will be educated on their first day here at the Facility by the SDC or UM. 3) Newly developed notebook/log for housekeeping and maintenance issues will be placed at the 100 and 300 hall nurses stations for all staff to use to communicate identified issues starting 5-8-23 4) Maintenance director and DOH will review the notebook daily (M-F) and addressed the listed issues. 5) At the end of each week, the administrator will review the log to ensure issues are being addressed starting 5-8-23.

* The Maintenance Director will conduct an audit starting in which he will check resident rooms for wall damage, loose fixtures, tile/linoleum floor damage, damaged toilet paper holders and loose baseboards. The cadence for these audits is as follows: 5 rooms, 3 times a week for 4 weeks, then 5 rooms 2 times a week for 4 weeks, and then 5 rooms weekly for 4 weeks. The results of these audits will be presented to the QAPI committee by the maintenance director for

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in the floor on either side of the bed. Additional observations of room 114-1 on 04/11/23 at 3:02 PM, 04/12/23 at 7:50 AM, 04/13/23 at 7:55 AM, and 04/14/23 at 8:29 AM revealed quarter-sized bed rails were completely detached from the bed and were lying on the floor on either side of the bed.

An interview with the Director of Nursing (DON) on 04/14/23 at 2:10 PM revealed the bed rails on the bed in room 114-1 were not being used and should have been removed from the room. She stated she did not know why the side rails were in the floor.

3. An observation of the toilet paper holder in the bathroom of room 110 on 04/10/23 at 10:47 AM revealed the toilet paper holder was rusty and hanging from the wall by 1 nail. Additional observations on 04/11/23 at 8:57 AM, 04/12/23 at 8:37 AM, 04/13/23 at 7:46 AM, and 04/14/23 at 8:32 AM revealed the toilet paper holder was rusty and hanging from the wall by 1 nail.

An interview with the Maintenance Director on 04/14/23 at 2:40 PM revealed he knew a lot of toilet paper holders were rusty but he was not aware of the toilet paper holder in the bathroom of room 110 only being held in place by 1 nail. He stated since he began employment in February 2023 there were a lot of pressing issues he had to address before addressing things like repairing or replacing toilet paper holders and he would address the toilet paper holders when possible.

An interview with the Administrator on 04/14/23 at 6:26 PM revealed she had not had a full-time Maintenance Director from December 2022 until February 2023, and a member of maintenance

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at least 3 months. The QAPI may suggest/make adjustments to this plan to ensure compliance.

The DOH will conduct an audit in which he will be checking resident rooms observing for: sticky floors, stained/soiled privacy curtains, and strong lingering urine odor. This audit will follow the following cadence: 5 rooms 3 times a week for 4 weeks, then 5 rooms 3 times a week for 4 weeks, and then 5 rooms weekly for 4 weeks. The DOH will present the results of this audit at the monthly QAPI committee meeting. This will continue for at least 3 months. The QAPI team may suggest adjustments to this plan to ensure compliance.

* Completion date: 5-12-23

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staff from a sister facility helped out during that period of time. She stated there were a lot of maintenance issues that needed to be addressed and the most pressing concerns had to be addressed first and then issues like the toilet paper holders would be addressed.

4. An observation of the room divider curtain of room 110 on 04/12/23 at 8:37 AM revealed the curtain contained 2 large brown stains. Additional observations of the room divider curtain of room 110 on 04/13/23 at 7:46 AM and 04/14/23 at 8:32 AM revealed the curtain contained 2 large brown stains.

An interview with the Director of Housekeeping on 04/14/23 at 9:07 AM revealed housekeeping staff checked room divider curtains daily and if there were any stains they notified him and he changed the curtain. He stated he was not aware of any stains to the room divider curtain in room 110.

An interview with the Administrator on 04/14/23 at 6:26 PM revealed she expected room privacy curtains to be clean.

5. a. An observation of the bathroom floor of room 120 on 04/10/23 at 11:49 AM revealed there were multiple dried stains in front of the toilet and the bathroom floor was sticky. Additional observations of the bathroom floor of room 120 on 04/11/23 at 2:59 PM, 04/12/23 at 8:13 AM, 04/13/23 at 8:09 AM, and 04/14/23 at 8:38 AM revealed there were multiple dried stains in front of the toilet and the bathroom floor was sticky.

b. An observation of the bathroom floor of room 116 on 04/11/23 at 3:04 PM revealed the

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bathroom floor was sticky. Additional observations of the bathroom floor of room 116 on 04/12/23 at 7:52 AM and 04/14/23 at 8:24 AM revealed the floor was sticky.

c. An observation of the bathroom floor of room 110 on 04/14 23 at 8:32 AM revealed the floor was sticky.

d. An observation of the bathroom floor of room 114 on 04/14/23 at 8:29 AM revealed the floor was sticky.

An interview with the Director of Housekeeping on 04/14/23 at 9:07 AM revealed housekeeping staff mopped resident rooms daily. He stated he was aware of some the floors in 200 hall resident rooms being sticky but now it was becoming an issue in 100 hall resident rooms. The Director of Housekeeping stated he felt the floors were sticky due to housekeeping staff either only mopping the rooms with water or putting too much cleaning chemical in the water and not wringing the mops out thoroughly. He explained he had done education with staff about applying the right amount of cleaning chemicals in mop water and he would provide additional education regarding the correct way mix mop water. He stated he expected the floors to be free of stains and not sticky.

An interview with the Administrator on 04/14/23 at 6:26 PM revealed she expected resident room floors to be clean and not sticky.

6. a. An observation of the shared bathroom of room 110 on 04/10/23 at 10:47 AM revealed an unlabeled container of deodorant was sitting on the sink, an unlabeled and uncovered bedpan

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F 584	Continued From page 23 was sitting on the toilet, and an unlabeled and uncovered bedpan was sitting in the floor beside the toilet. An observation of the shared bathroom of room 110 on 04/11/23 at 8:57 AM revealed an unlabeled container of deodorant was sitting on the sink and an unlabeled bed pan was in a plastic bag sitting on the floor beside the toilet. An observation of the shared bathroom of room 110 on 04/12/23 at 8:37 AM revealed an unlabeled container of deodorant was sitting on the sink and an unlabeled bedpan in a plastic bag was hanging from a handrail on the wall across from the toilet. An observation of the shared bathroom of room 110 on 04/13/23 at 7:46 AM revealed an unlabeled container of deodorant was sitting on the sink and an unlabeled and uncovered bedpan was sitting on the toilet. An observation of the shared bathroom of room 110 on 04/14/23 at 8:32 AM revealed an unlabeled container of deodorant was sitting on the sink and an unlabeled and uncovered bedpan was sitting on the toilet. b. An observation of the shared bathroom of room 116 on 04/10/23 at 11:36 AM revealed an unlabeled toothbrush was sitting in an unlabeled cup containing water on top of a shelf above the sink. Additional observations of the shared bathroom of room 116 on 04/11/23 at 3:04 PM, 04/12/23 at 7:52 AM, and 04/14/23 at 8:24 AM revealed an unlabeled toothbrush was sitting in an unlabeled cup containing water on top of a shelf above the sink.	F 584		

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c. An observation of the shared bathroom of room 120 on 04/10/23 at 11:49 AM revealed an unlabeled toothbrush and unlabeled razor were sitting on a shelf above the sink and an unlabeled comb was sitting on the sink. Additional observations of the shared bathroom of room 120 on 04/11/23 at 2:59 PM, 04/12/23 at 8:13 AM, 04/13/23 at 8:09 AM, and 04/14/23 at 8:38 AM revealed an unlabeled toothbrush and unlabeled razor were sitting on a shelf above the sink and an unlabeled comb was sitting on the sink.

d. An observation of the shared bathroom of room 119 on 04/11/23 at 2:51 PM revealed 2 unlabeled and uncovered bath basins were stacked inside each other and were sitting on top of a chest. Additional observations of the shared bathroom of room 119 on 04/12/23 at 8:04 AM, 04/13/23 at 8:12 AM, and 04/14/23 at 8:38 AM revealed 2 unlabeled and uncovered bath basins were stacked inside each other and were sitting on top of a chest.

e. An observation of the shared bathroom of room 121 on 04/10/23 at 3:22 PM revealed 2 unlabeled and uncovered bath basins were stacked inside each other and were sitting on the floor. The top bath basin contained 2 wadded up wash cloths. Additional observations of the shared bathroom of room 121 on 04/13/23 at 8:21 AM and 04/14/23 at 8:40 AM revealed 2 unlabeled and uncovered bath basins were stacked inside each other and were sitting on the floor. The top bath basin contained 2 wadded up wash cloths.

An interview with the Director of Nursing (DON) on 04/14/23 at 5:49 PM revealed all personal care

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equipment should be labeled and stored appropriately. She stated nurse aides (NAs) were responsible for labeling personal items, making sure bed pans were stored in a bag and not stored on the floor, and making sure bath basins were covered and not stacked inside each other. The DON stated administration did room rounds Monday through Friday to check for unlabeled personal items or items not stored correctly, but she felt that staff were not paying attention to the details.

7. a. An observation of the walls behind both beds in room 114 on 04/10/23 at 10:54 AM revealed multiple deep linear scrapes to the walls and a section of baseboard was missing to the wall beside 114-1. Additional observations of the walls behind both beds in room 114 on 04/11/23 at 3:02 PM, 04/12/23 at 7:50 AM, 04/13/23 at 7:55 AM, and 04/14/23 at 8:29 AM revealed multiple deep linear scrapes to the walls and a section of baseboard was missing to the wall beside 114-1.

b. An observation of the wall beside the bed in room 116-2 on 04/10/23 at 11:36 AM revealed multiple areas of exposed sheetrock. Additional observations of the wall beside the bed in room 116-2 on 04/11/23 at 3:04 PM, 04/12/23 at 7:52 AM, and 04/14/23 at 8:24 AM revealed multiple areas of exposed sheetrock.

c. An observation of the wall beside the bed in room 120-2 on 04/10/23 at 11:43 AM revealed multiple areas of exposed sheetrock. Additional observations of the wall beside the bed in room 120-2 on 04/11/23 at 2:58 PM, 04/12/23 at 8:12 AM, 04/13/23 at 8:07 AM, and 04/14/23 at 8:22 AM revealed multiple areas of exposed

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sheetrock.

An interview with the Maintenance Director on 04/14/23 at 2:40 PM revealed he knew a lot of the walls in resident rooms had deep scrapes in the walls or exposed sheetrock. He stated he was not aware of the missing baseboard in room 114. He stated since he began employment in February 2023 there were a lot of pressing issues he had to address before addressing things like repairing scrapes to walls, exposed sheetrock, or missing baseboards.

An interview with the Administrator on 04/14/23 at 6:26 PM revealed she had not had a full-time Maintenance Director from December 2022 until February 2023, and a member of maintenance staff from a sister facility helped out during that period of time. She stated there were a lot of maintenance issues that needed to be addressed and the most pressing concerns had to be addressed first and then issues like scraped walls, exposed sheetrock, or missing baseboards would be addressed.

8. a. An observation of the 3-light fixture above the sink in the bathroom of room 116 on 04/11/23 at 3:04 PM revealed only 1 light in the light fixture was working. Additional observations of the 3-light fixture above the sink in the bathroom of 116 on 04/12/23 at 7:52 AM and 04/14/23 at 8:24 AM revealed only 1 light in the fixture was working.

b. An observation of the 3-light fixture above the sink in the bathroom of room 119 on 04/10/23 at 11:57 AM revealed all 3 lights were on but barely produced any light. Additional observations of the 3-light fixture above the sink in the bathroom of

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119 on 04/11/23 at 2:51 PM, 04/12/23 at 8:04 AM, 04/13/23 at 8:12 AM, and 04/14/23 at 8:38 AM revealed all 3 lights were on but barely produced any light.

An interview with the Maintenance Director on 04/14/23 at 2:40 PM revealed he was not aware of only 1 light in the bathroom of room 116 working or of the bathroom lights in room 119 not working correctly. He stated that due to being pulled in so many different directions he relied on housekeeping or nursing staff to notify him with problems with light fixtures and he was not notified of any concerns with the light fixtures in those rooms.

An interview with the Administrator on 04/14/23 at 6:26 PM revealed she expected lights in resident bathrooms to be working correctly.

9. An observation made of room 101-2 on 04/10/23 at 10:47 AM revealed behind the head of the bed in the middle of the wall were 3 deep, vertical gouges with exposed sheetrock.

Additional observations made of room 101-2 on 04/11/23 at 12:33 PM and 04/13/23 at 3:22 PM revealed the condition of the wall remained unchanged.

An interview and tour was conducted with the Maintenance Director on 04/14/23 at 2:40 PM. The Maintenance Director revealed he knew a lot of the walls in resident rooms had deep scrapes in the walls and/or exposed sheetrock. He stated since he began employment in February 2023 there were a lot of pressing issues he had to address before addressing things like repairing scrapes to walls and exposed sheetrock.

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An interview with the Administrator on 04/14/23 at 6:26 PM revealed she had not had a full-time Maintenance Director from December 2022 until February 2023, and a member of maintenance staff from a sister facility helped out during that period of time. She stated there were a lot of maintenance issues that needed to be addressed and the most pressing concerns had to be addressed first and then issues like scraped walls and exposed sheetrock would be addressed.

10. An observation made of the shared bathroom in room 103 on 04/10/23 at 11:32 AM revealed the faucet on the sink was loose and moved easily from side to side exposing gaps where it attached to the sink base.

An observation of the shared bathroom in room 103 on 04/14/23 at 10:34 AM revealed the faucet had completely loosened and pulled out from the sink base but remained attached to the water hose.

An observation and interview was conducted with the Maintenance Director on 04/14/23 at 2:45 PM. The Maintenance Director stated he was not aware the sink faucet in bathroom 103 had loosened and could be pulled out from the base of the sink. He stated that was something that he should have been made aware of so that repairs could have been made.

During an interview on 04/14/23 at 6:26 PM, the Administrator revealed she had not had a full-time Maintenance Director from December 2022 until February 2023, and a member of maintenance staff from a sister facility helped out during that period of time. She stated there were a lot of

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F 584	Continued From page 29 maintenance issues that needed to be addressed and the most pressing concerns had to be addressed first but would have expected staff to notify maintenance of any emergent repairs needed. 11. Resident #8 was admitted to the facility on 10/14/21. Review of Resident #8's medical records revealed she had moved to her current room since 01/31/23. The quarterly Minimum Data Set (MDS) dated 03/14/23 assessed Resident #8 with intact cognition. An observation conducted on 04/10/23 at 11:32 AM revealed the light behind Resident #8's bed in Room 206-A failed to light up when the surveyor tried to switch it on repeatedly. During an interview conducted on 04/10/23 at 11:36 AM, Resident #8 did not know how long the light behind her bed had not been working. She had no choice but to use the ceiling light since it happened. She did not notify any nursing staff about the dysfunctional light so far. She preferred to use the light behind her bed as it would not cause any irritating glares. During a joint observation conducted with Nurse Aide (NA) #1 and Nurse #1 on 04/12/23 at 2:40 PM, the light behind Resident #8's bed remained dysfunctional. During an interview conducted on 04/12/23 at 2:49 PM, NA #1 stated she did not know the light behind Resident #8's bed was not working. She	F 584		

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explained Resident #8 always used the ceiling light and never complained about the broken light behind her bed.

During an interview conducted on 04/12/23 at 3:02 PM, Nurse #1 explained she did not notice the light behind Resident #8's bed was not working properly. She stated all the light in resident's room should always function properly.

During an interview conducted on 04/12/23 at 3:11 PM, the Maintenance Manager explained he depended on staff reporting for repair needs via work order. He checked the work order box located in nurse station at least once daily. In addition, he would walk through the facility at least once weekly to identify repair needs. He was unaware of the dysfunctional light in Room 206-A as staff did not report the issue in timely manner. He acknowledged that all the lights in resident's room should always be in good repair.

During an interview conducted on 04/13/23 at 9:05 AM, the Director of Nursing (DON) stated it was her expectation for all the lights to be in working condition all the times.

An interview was conducted on 04/14/23 at 3:44 PM with the Administrator. She expected nursing staff to be more attentive to residents' home and reported repair needs to maintenance manager as needed in timely manner to ensure all the lights remained in good repair all the times.

F 644 SS=D — Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) — F 644 — 5/12/23

§483.20(e) Coordination.
A facility must coordinate assessments with the

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F 644	Continued From page 31 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. §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 interviews with staff, the facility failed to request a resident with a newly diagnosed mental illness be reevaluated for a level II Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for PASRR (Resident #28). The findings included: Resident #28 was admitted to the facility on 09/22/20 with diagnoses including anxiety and depression. Review of Resident #28's current PASRR determination letter dated 06/12/21 revealed the resident remained a level I and determined no further screening was required unless a significant changed occurred to suggest a diagnosis of mental illness.	F 644	* Corrective action for the alleged deficient practice for Resident #28 was achieved by submitting a Pre Admission Screening and Resident Review (PASRR) on 5-4-23 by the Social Worker (SW). * All residents with a newly evident or possible serious mental disorder, intellectual disability or a related condition (for Level II residents) have the potential to be affected by this same alleged deficient practice. The Social worker (SW) will conduct an audit of all residents for a current diagnosis of a serious mental disorder, intellectual disability or a related condition and ensure that a current and appropriate PASRR is present. If any are identified in this audit as not being current or inappropriate, the SW will submit a new one. This audit will be conducted by	

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Review of Resident #28's current diagnoses revealed schizoaffective disorder was documented on 06/14/22.

Review of a hospital discharge summary dated 06/20/22 included schizoaffective disorder as a current diagnosis for Resident #28 and noted aripiprazole (an antipsychotic medication) was being used as a treatment and was included on the list of medications.

Review of the significant change of condition Minimum Data Set (MDS) dated 08/15/22 revealed Resident #28 was not currently considered by the state level II PASRR process to have serious mental illness.

An interview was conducted on 04/14/23 at 4:31 PM with the Social Worker (SW). The SW confirmed Resident #28's last PASRR determination was done on 06/12/21 and received a level I. The SW revealed she was not employed at the time of the hospital discharge and not aware Resident #28 needed a reevaluation for a level II PASRR. The SW stated the MDS Nurse would have more information on obtaining an evaluation for a level II PASRR when Resident #28 was newly diagnosed with a mental illness.

During an interview on 04/14/23 at 5:00 PM the MDS Nurse revealed it was the responsibility of the SW to request an evaluation for a level II PASRR when Resident #28 was newly diagnosed. She explained the SW wasn't employed at the time Resident #28 was diagnosed with schizoaffective disorder and indicated the request for a level II PASRR was not done by the previous SW and was missed.

F 644

comparing the Medical Diagnosis lists for all current residents with the current PASRR to ensure appropriateness of the PASRR This will be completed by 5-12-23 by the SW.

* Systematic changes include: 1) Education provided to the SW by the Regional Minimum Data Set (MDS) Nurse on 5-5-23 regarding the meaning/significance of this F tag. 2) Education provided to the contracted psychiatrist by the Director of Nursing (DON) on the communication process for when he identifies new diagnoses of serious mental disorder, intellectual disability or a related condition to the SW and MDS nurse who will make sure that the diagnosis is on the Medical Diagnosis list in the Electronic Health Record (EHR) by 5-12-23 3) Education provided to the Unit Managers (UM) and the Admissions Coordinator (AD) regarding the diagnoses that require this specific PASRR screening by 5-12-23. This will be completed by the DON on or before 5-12-23. 4) The AD will alert the DON, SW, and MDS nurse that a new PASRR might be necessary based on the hospital records and DX list upon reviewing the referral. 5) New medications (orders) and diagnoses will be reviewed daily (M-F) in the Clinical meeting by the DON, Assistant Director of Nursing (ADON), and MDS nurse. Findings pertaining to this regulation will be communicated to the SW so that a PASRR can be initiated. 6) SW will maintain a file for PASRRs so that the opportunity for expiration is nullified.

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F 644	Continued From page 33 During an interview on 04/14/23 at 6:08 PM, the Director of Nursing (DON) revealed it was the responsibility of SW to obtain PASRR referrals for residents. The DON stated a request to evaluate for new a PASRR should have been obtained when Resident #28 was diagnosed with a mental illness. During an interview on 04/14/23 at 6:25 PM, the Administrator explained the SW wasn't at the facility at time Resident #28 was diagnosed with a mental illness but would expect a request was made for a PASRR evaluation.	F 644	File will be complete by 5-12-23 and then kept current ongoing. * The SW will conduct an audit in which the Medical Diagnosis and the current PASRR are compared for appropriateness. The cadence for this audit will be as follows: 3 residents (at random) will be reviewed 3 times a week for a period of 4 weeks, then 3 residents will be reviewed 2 times a week for a period of 4 weeks, and then 3 residents will be reviewed weekly for a period of 4 weeks. The results of this audit will be presented monthly at the Quality Performance and Process Improvement (QAPI) by the SW for at least 3 months and possibly longer if necessary. The QAPI may make adjustments to the plan if deemed necessary to achieve compliance. * Completion date: 5-12-23	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, staff interviews, Pharmacist interview, and Physician interview the facility failed to provide care according to professional standards when the Physician failed to continue a resident's	F 658	* Corrective action for resident #83 was achieved on 4-20-23 when he received an Intra Muscular (IM) dose of Testosterone cypionate 200/mg/ml administered by his assigned nurse.	5/12/23

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testosterone injections that he needed for hormone replacement. This resulted in 1 of 1 resident missing monthly testosterone injections for more than 2 months. (Resident #83)

The findings included:
Resident #83 was admitted to the facility on 2/13/23 with diagnoses that included, hypopituitarism (a deficiency in 1 or more pituitary hormones), and kallmann syndrome (a condition characterized by absent or delayed puberty, and lack of or loss of sense of smell. This condition was treated with hormone therapy).

The admission Minimum Data Set for Resident #83 dated 2/20/23 revealed he was cognitively intact with no behaviors or rejection of care.

Review of a hospital discharge summary for Resident #83 dated 2/7/23 the section titled medication list included new, unchanged, and stopped medications. The discharge summary revealed Resident #83's medication Testosterone 200 milligram (mg)/milliliter (ml) intramuscular every 2 weeks as an unchanged medication.

Review of the medication administration record (MAR) for Resident #83 for the month of February 2023 revealed there was no order or administration for testosterone.

Review of a note dated 3/16/23 created by the Social Worker documented an email communication with Resident #83's community case manager that read in part: I am following up on the progress of Resident #83. I received your call regarding the testosterone needed that was previously ordered by his primary care provider. I have advised the medical team and it is being

F 658

* An audit was completed on 5-4-23 by the Director of Nursing (DON) for the time frame 4-1-23 through 5-4-23 to identify any additional medications missing due to not being available. No other issues were identified.

* Measures put into place or systemic changes include: 1) All licensed Nurses and Certified Medication Aides (CMA) to receive education provided by the Staff Development Coordinator (SDC) and/or Unit Manager (UM) regarding the facility policy "Unavailable Medications" by 5-12-23. Staff that did not receive this education by 5-12-23 will receive the education when they return to work by the SDC or UM. New agency staff will receive this education on their first day of work in the Facility by the SDC or UM. This policy notes in detail who is to be contacted and what action is to be taken. CMAs are to report any issues they have with unavailable medications to their supervising nurse so that appropriate action and communication can be implemented. 2) Missed medications will be reviewed in the Clinical meeting daily (M-F) by the administrative nursing team which includes the DON, UM, Assistant Director of Nursing (ADON), and Minimum Data Set (MDS) nurse starting 5-8-23. 3) Immediate corrective action will be taken by the DON or ADON if missing medications are identified in the Clinical Meeting starting 5-8-23 and re-education provided as necessary.

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reviewed.

Review of a physician progress note dated 3/20/23 revealed Resident #83 indicated he took testosterone injections monthly for kallmanns syndrome. The physician indicated he would order a dose of the medication followed by another dose in 1 month.

Physician orders for Resident #83 revealed an order for Testosterone Cypionate Intramuscular Solution 200 MG/ML, inject 200 mg intramuscularly one time only for kallman syndrome for 1 Day. Start Date: 3/21/2023 End Date: 3/22/23

Review of Resident #83's MAR for the month of March 2023 revealed the ordered dose of testosterone to be given on 3/21/23. The administration record did not indicate the dose was given but had an instruction to "see note".

Review of a MAR note dated 3/21/2023 and timed 7:45 PM revealed there was no text in the note. The note was created by Nurse #7.

Review of Resident #83's MAR for the month of April 2023 revealed there was no order or administration for testosterone.

During an interview on 4/10/23 at 3:09 PM Resident #83 revealed he usually takes monthly injections of testosterone related to a condition where his body does not produce the proper amount of testosterone. He stated he had been taking these monthly injections for 60 years and they were given to him by his primary care physician. He asked the nurses about the

* The UM will complete an audit of missed medications 3 times weekly for a period of 4 weeks, then twice weekly for a period of 4 weeks. and then once weekly for a period of 4 weeks. The UM will provide the audits to the DON who will in turn, present the results of the audit to the Quality Assurance and Process Improvement (QAPI) committee monthly for at least 3 months. The QAPI team may adjust the plan if deemed necessary in order to achieve compliance.

* Completion Date: 5-12-23

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medication, but he had been told it was not on his list or the facility did not have it. Resident #83 explained he was in the hospital in January 2023 before coming to the facility. He did not receive a dose of testosterone in the hospital in January, and he has not received any doses at the facility for February, March, or April. He revealed he was concerned about the number of doses he had missed. He was unsure if the medication was reordered from the hospital.

During an interview on 4/14/23 at 7:00 AM Nurse #7 revealed she was assigned to care for Resident #83 on 3/21/23, 7 PM shift. She recalled there was a dose of testosterone due for Resident #83 on that night, but it was not on the cart. She stated the medication was not available for her to administer. She further stated that she does not recall if she passed this on to the dayshift nurse, or if she called pharmacy to ask for the medication.

An interview with the Pharmacist on 4/14/23 at 9:29 AM revealed she could not find any past or pending prescriptions for testosterone injections for Resident #83. She explained that testosterone was a controlled substance, and it required the prescriber to send a hard copy of the prescription to the pharmacy. Other medications could be ordered directly through the facilities electronic medical record (EMR), but controlled substances could not. She could not find record of a prescription, so the testosterone was never prepared or sent for Resident #83. During the interview the Pharmacist logged into the facility EMR to view Resident #83's MAR. She revealed that on 4/13/23 the testosterone had been ordered again, but she did not have a hard script and it would not be visible to anyone at the

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F 658	Continued From page 37 pharmacy and would not be dispensed to the resident without a hard copy of the prescription. She stated when ordering this medication, the Physician should get a flag so that he would be aware that the medication was controlled and required a hard copy of the prescription to be sent to the pharmacy. During an interview on 4/14/23 at 10:01 AM the Director of Nursing revealed medications that were considered controlled substances needed to have a hard copy of the prescription of the medication sent to the pharmacy for the facility to receive the medication. She further revealed if a nurse did not have a medication for a resident they should follow up on the location of the medication. They can call and check with pharmacy. An interview with the Social Worker on 04/14/23 at 10:38 AM revealed on or around 3/16/23 she received a voicemail from a nurse navigator that follows Resident #83 outside of the facility. The voicemail was requesting the resident receive the testosterone doses he needed. The Social Worker stated she passed on this information to nursing leadership to notify the physician. During an interview on 4/14/23 at 4:20 PM the Physician revealed he initially did not order the testosterone injections for Resident #83 because he usually would not order that medication for his patients. He first saw Resident #83 on 2/16/23. The Physician stated the focus for that visit was the residents low blood pressures and he did not ask the resident why he was taking the testosterone injections. In a later visit Resident #83 explained to the Physician that he was taking testosterone as treatment for kallmann syndrome.	F 658		

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F 658	Continued From page 38 The Physician revealed kallmann syndrome was a diagnoses that testosterone should be prescribed for. He further revealed on 3/20/23 he ordered a one-time dose of the testosterone for Resident # 83. When he ordered the testosterone, he overlooked the need for a hard copy of the prescription. The Physician indicated the resident did not receive his February dose of testosterone because he was unaware of the reason he was taking the medication. He did not receive the March dose because he overlooked the need for a hard copy of the prescription. The Physician revealed that the number of missed doses should not have any significant impact on the resident. He further revealed if nursing was missing a medication for a resident, they should contact pharmacy and the physician if necessary.	F 658		
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, observations, and interviews with residents and staff the facility failed to provide dependent residents assistance with personal hygiene including oral care (Resident #2 and #47) and shaving (Resident #6) for 3 of 11 residents reviewed for activities of daily living. The findings included: 1. Resident #2 was admitted to the facility on 06/11/19. Her diagnoses included diabetes	F 677	* Corrective action for Resident #2 was achieved on 4-12-23 when his Certified Nursing Assistant (CNA) provided oral care. Corrective action for Resident #47 was achieved on 4/14/23 when CNA provided set up assistance for resident so that he could brush his own teeth. Corrective action was provided for Resident #6 when she received facial hair care by the CNA on 4-14-23. * All dependent residents were observed	5/12/23

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mellitus, cerebrovascular accident, and aphasia (a disorder affecting comprehension and communication).

Review of the significant change Minimum Data Set (MDS) dated 03/28/23 revealed Resident #2 was assessed as having severely impaired cognition with no rejection of care behaviors and needed extensive assistance with personal hygiene.

Review of the care plan revised on 03/24/23 revealed Resident #2 required extensive to total assistance with activities of daily living related to poor strength and severely impaired cognition. Interventions included provide AM and PM oral care.

An observation and interview with Resident #2 were conducted on 04/12/23 at 8:40 AM. When asked if she had her own teeth Resident #2 smiled to reveal several upper and lower teeth had a white colored build up surrounding the teeth and gums. Resident #2 stated she would let someone brush her teeth.

An observation and interview were conducted with Nurse Aide (NA) #2 on 04/12/23 at 3:26 PM. NA #2 revealed Resident #2 did not use the call light or make her needs known and staff anticipate care. NA #2 confirmed she was assigned to assist with personal hygiene but hadn't offered oral care because Resident #2 hadn't felt good and thought the resident wouldn't want anyone to bother her. NA #2 asked Resident #2 if she would like her teeth brushed. Resident #2 nodded her head to indicate yes and smiled to show her gums, the upper, and lower teeth continued to have a white colored buildup. NA #2

F 677

for oral care and unwanted facial hair on 5-3-23 and 5-4-23 by the Unit Managers (UM). There were 7 residents identified as being in seed of such services. UM addressed these needs with the assigned CNA and the care/services were offered and provided to all with the exception of 3 residents who refused oral care and 1 that refused to be shaved. The refusals were reported to the UM and Director of Nursing (Don) on that same day.

* Measures/systematic changes implemented include: 1) One on One education provided to Nurse Aide (NA) #2, NA #7, and NA #3 regarding this deficient practice on 5-5-23 by the Staff Development Coordinator (SDC). 2) Education regarding this citation/tag to all nursing staff provided by the SDC or UM to be completed by 5-12-23. Those not in attendance in any of the educational sessions will receive education by the SDC or UM upon returning to work and this will be ongoing. 3) Facial hair care to be offered/provided with showers/bathing by assigned CNA unless the need is otherwise identified starting 5-8-23 4) Oral care to be offer/provided to residents twice daily by the assigned CNA. 5) Oral and facial hair care/grooming refusals will be reported to the supervising nurse/Certified Medication Aide (CMA) and in turn to the UMs for review and discussion and then appropriately care planned if necessary. This starts 5-8-23. 6) Newly hired nursing staff will be educated on this plan during new hire orientation by the SDC or

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F 677	Continued From page 40 gathered supplies needed and provided oral care for Resident #2. Resident #2 was accepting of the oral care and followed NA #2's cues to keep her mouth open while the teeth were brushed and to swish and spit to rinse her mouth with water. The white colored buildup was easily removed by the toothbrush. 2. Resident #47 was admitted to the facility on 03/18/22. Resident #47's diagnoses included Huntington's disease, lack of coordination and dysphagia (difficulty swallowing). Review of the annual MDS dated 02/07/23 revealed Resident #47 was assessed as being cognitively intact and required extensive assistance with personal hygiene. The Care Area Assessment for dental revealed although Resident #47 was alert and oriented he was dependent on staff for oral hygiene. Review of the activities of daily living care plan revealed Resident #47 required total assistance with hygiene. Interventions included provide AM and PM oral care. During an interview and observation on 04/11/23 at 11:01 AM Resident #47 revealed his teeth were brushed by therapy on Monday, Wednesday, and Friday. Resident #47 teeth had a white colored build-up around the gums and upper and lower front teeth. Resident #47 stated NA staff didn't offer oral care or assist with brushing his teeth and he preferred his teeth were brushed daily. During an interview on 04/13/23 at 9:52 AM the Certified Occupational Therapy Assistant (COTA) revealed Resident #47 required assistance with brushing his teeth and needed someone to open	F 677	UM and new agency staff will be educated on their first day at this facility by the SDC or UM effective 5-8-23. * UM will completed an audit of dependent residents for the need for oral care and need for facial hair care (unwanted hair) according to the following cadence: 5 residents will be observed 3 times a week for a period of 4 weeks, then 5 residents will be observed twice a week for a period of 4 weeks, and then 5 residents will be observed weekly for a period of 4 weeks. The UM will present the audits to the Director of Nursing who will report the results of the audit to the Quality Assurance and Process Improvement (QAPI)committee monthly for a period of at least 3 months. The QAPI committee may make/suggest changes in the plan to achieve compliance. * Completion date: 5-12-23	

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and apply toothpaste on the toothbrush and was able to brush his own teeth. The COTA confirmed she had assisted Resident #47 with oral care on Monday, Wednesday, and Friday and encouraged him to brush his teeth.

During an interview on 04/14/23 at 1:49 PM Resident #47 stated today none of the NA staff offered to assist with oral care. Resident #47's continued to have a white colored buildup.

An interview was conducted on 04/14/23 at 1:53 PM with NA #3. NA #3 revealed she worked for agency staffing and wasn't very familiar with Resident #47 and hadn't assisted with oral care. NA #3 revealed Resident #47 was already up when she arrived on 04/14/23 and oral care was given in the morning when getting residents out of bed.

During an interview on 04/14/23 at 6:05 PM the Director of Clinical Services stated oral care was offered every morning and at bedtime and would expect the NA staff to assist residents with their oral hygiene.

An interview was conducted on 04/14/23 at 6:25 PM with the Administrator. The Administrator stated NA staff were expected to provide assistance and offer oral care to residents twice a day.

3. Resident #6 was admitted to the facility on 3/14/20 with diagnoses that included falls, neck pain, polyneuropathy (damage to the nerves outside of the brain and spinal cord), and depression.

A quarterly minimum data set for Resident #6

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dated 1/6/23 revealed she was cognitively intact and required extensive 1 person assist with personal hygiene.

The care plan for resident #6 revised on 3/22/23 revealed Resident #6 required extensive to total assistance with her activities of daily living (ADL) tasks related to globalized weakness. The interventions included provide assistance with ADLs only to the extent required.

During an observation and interview on 4/10/23 at 2:30 PM Resident #6 revealed that she would like to be shaved but she was not sure if the facility had any razors because she had not been shaved in a while. She stated she was unsure of how long it had been since she was last shaved. She pulled the hair on her chin and said "look". Resident #6 was observed to have hairs on her chin that were approximately 1 inch long.

During an observation and interview on 4/12/23 at 11:32 AM resident #6 revealed she had a bed bath that morning, but she was not shaved. Resident #6 was observed with hair on her chin.

An interview and observation were conducted on 4/12/23 at 3:10 PM with Nurse Aide (NA) #7. NA #7 revealed she was assigned to care for Resident #6 on that day 3/12/23 7 AM - 3 PM. She further revealed Resident #6 was total care for ADLs, she preferred bed baths over showers but otherwise did not refuse care. She stated she bathed Resident #6 on that day but did not notice she needed to be shaved. An observation was made of Resident #6 with NA #7. Resident #6 was observed with hair on her chin approximately 1 inch long. NA #7 stated that Resident #6 needed to be shaved but she did not notice it

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F 677	Continued From page 43 earlier. She said had she noticed the chin hair she would have shaved the resident. During an interview on 4/12/23 at 2:49 PM Nurse #6 revealed he was assigned to care for Resident #6. He stated Resident #6 was mostly dependent on staff for care and NA's were responsible for providing ADL care. Nurse #6 further stated resident's, male and female, should be shaved as needed. During an interview on 4/14/23 at 10:21 AM the Director of Nursing stated staff should offer to shave all residents on their shower days. If a resident does not shower it should still be offered on those days and as needed.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, staff interviews, and Physician interview the facility failed to follow the Physician's order to provide dressing changes to a resident's peritoneal catheter daily. This occurred for 1 of 1 resident reviewed for quality of care (Resident # 83).	F 684	* Corrective action for resident #83 was achieved when a new order for "left chest periotoneal dialysis site care to clean with alcohol and replace dressing with sterile gauze and cover with Opsite and change daily" and the first dressing change occurred on 4-15-23 by the assigned nurse. Wound Nurse who documented	5/12/23

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The findings included:

Resident #83 was admitted to the facility on 2/13/23 with diagnoses that included end stage renal disease, diabetes, and orthostatic hypotension.

The admission Minimum Data Set for resident #83 dated 2/20/23 revealed he was cognitively intact with no behaviors or rejection of care. Resident #83 was receiving hemodialysis.

Review of Resident #83's care plan updated on 4/5/23 revealed the resident was at risk for complications related to hemodialysis. The interventions included provide treatment to access site (chest) as ordered.

Review of Resident #83's Physician orders revealed the following:

Left chest peritoneal dialysis access - Monitor every shift for signs and symptoms of bleeding. every day and night shift 2/16/23.

Left chest peritoneal dialysis access site. Change dressing every day shift 2/17/23.

During an observation and interview on 4/10/23 at 3:42 PM Resident #83 revealed he received Tuesday, Thursday, and Saturday hemodialysis since residing at the facility. Before entering the facility, he was doing peritoneal dialysis at home, and he hoped to continue after he leaves the facility. He stated he was concerned that staff did not know how to care for his peritoneal dialysis catheter. Staff did not provide any care for the peritoneal catheter unless he requested it. He further stated if he asked staff to come provide

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performing a dressing change for resident #8 on the Treatment Administration Record (TAR) and did not in fact perform the dressing change was terminated on 4-13-23 by the Director of Nursing.

* The Director of Nursing (DON) will complete an audit comparing the ordered dressings too what was actually done based on resident interviews and observations (bandages). This will be completed by 5-12-23. Any issues identified in this audit will be addressed immediately by the DON or Unit Manager (UM).

* Measures/systematic Changes implemented include: 1) All licensed nurses, Certified Medication Aides (CMA) and Certified Nursing Assistants (CNA) will be educated on the Facility's Handbook information regarding inappropriate conduct and behavior including falsification of any nursing records. Falsification of medical records is a terminable offense. This education will be presented by the Staff Development Coordinator (SDC) or Unit Manager (UM) by 5-12-23. Newly hired nursing staff will be educated on this during orientation. New agency staff will receive this education on their first day in the facility by the SDC or UM. Staff not present for the educational sessions related to this citation will receive the education by the SDC or UM upon return to work (their first shift back). 2) Daily (M-F) in the Clinical Meeting, the administrative nursing team will review the

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care for the catheter a nurse would come and remove the old dressing and place a new dressing. The site was not being cleaned. The resident was observed to have a left chest peritoneal dialysis catheter covered with a transparent dressing. The catheter site appeared clean without any redness or drainage. The resident also had a right chest hemodialysis catheter that was dressed. He stated care was provided for that catheter at hemodialysis.

An interview was conducted on 04/12/23 at 11:22 AM, Nurse #1 revealed that she frequently cared for Resident #83 and was aware that he had a peritoneal dialysis catheter, but she did not provide care for it. The care for Resident #83's peritoneal dialysis catheter was provided by the wound nurse.

During an interview on 04/12/23 at 2:38 PM Nurse #6 revealed he was assigned to care for Resident #83 on 4/10/23, 4/11/23, and 4/12/23. He further revealed he did not provide care for Resident #83's peritoneal dialysis catheter. The care was provided by the wound nurse. He monitored the catheter daily and if he had a concern, he would let the wound nurse or physician know. He further stated that on that day he notified the wound nurse that the resident wanted his dialysis catheter sites covered so he could shower and that the dressing was lifting and needed to be changed.

During a second observation and interview on 4/12/23 at 3:42 PM Resident #83 revealed the last time the peritoneal dressing was changed was 3 or 4 days ago and staff only do it if asked. No dressings were changed today. He stated someone placed a plastic bag over it on that day

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Medication Administration Audit Report for the Treatment Administration Record for missed treatments. Any that are identified will be addressed immediately by the nursing admin team. 3) Education will also include the necessary step of documenting the date of the dressing change on the bandage. 4) Any dressing changes that are identified as not being performed as ordered should immediately be reported to the DON or UM and addressed.

* The Unit Managers will complete an audit ensuring that the dressing changes are being conducted as ordered. The cadence of this audit will be as follows: 3 residents will be observed 3 times weekly for a period of 4 weeks, then 3 residents for twice a week for 4 weeks, and then 3 residents weekly for 4 weeks. The results of this monitor will be presented to the Quality Assurance and Process Improvement (QAPI) committee by the DON. The QAPI committee may adjust the plan as necessary to achieve compliance.

* Completion date: 5-12-23

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F 684	Continued From page 46 so that he could shower. Resident #83 was observed with a clear plastic bag taped to his chest covering both catheters. An interview conducted with the Wound Nurse on 04/12/23 at 5:43 PM revealed she covered Resident #83's dialysis catheters on that day 4/12/23 so he could shower. She stated she changed his peritoneal dressing when it was due, but she was not sure of the ordered frequency. The Wound Nurse further stated sometimes the hall nurses will change the dressings. During a follow-up interview on 04/13/23 at 1:18 PM the Wound Nurse revealed she had reviewed the order for Resident #83's dressing changes and they should be done daily. She stated she completed the dressing change on the evening 4/12/23 after she read the order. She further stated when she completes Resident 83's dressing change she only changes the transparent dressing, "the order says change dressing, I'm not sure what else to do". She did not clarify the order with the Physician. The Wound nurse explained she was unsure when she last changed the dressing before 4/12/23. She said, "it was sometime last week". The treatment administration record (TAR) was reviewed with the wound nurse. She acknowledged that she signed off the TAR on 4/10/23, 4/11/23, and 4/12/23. She revealed although she signed off on the TAR on 4/10/23 and 4/11/23, she did not change the dressing. She further explained sometimes the hall nurse completed the dressing changes and then she will sign off on the TAR. "I sign it, but it doesn't mean I did it. Someone else may have changed the dressing". The Wound Nurse stated she was unsure who may have changed the dressing on	F 684		

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F 684	Continued From page 47 4/10/23 and 4/11/23. During an interview on 4/14/23 at 10:08 AM the Director of Nursing (DON) revealed Resident #83's dressings should be changed by the Wound Nurse and the physician's order should be followed. The DON stated she was not aware of the TAR being signed off by staff when they did not complete the care. She further stated the TAR should only be signed off when the care was completed, and by the staff member that completed the care. An interview was conducted on 4/14/23 at 4:20 PM. The Physician stated Resident #83's peritoneal catheter dressing should be changed as ordered and if staff had questions about any order, they should call the physician for clarification.	F 684		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		5/12/23

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F 761	Continued From page 48 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure medication for 6 of 6 residents observed for medicated creams and/or medicated powders at the bedside (Resident #26, Resident #80, Resident #24, Resident #20, Resident #38, and Resident #44). Findings included: 1. Resident #26 was admitted to the facility 02/28/20 with multiple diagnoses including diabetes. The quarterly Minimum Data Set (MDS) dated 01/24/23 revealed Resident #26 was cognitively intact. Review of the medical record revealed no documentation that Resident #26 had been assessed for self-administration of medication. Review of Resident #26's medical record revealed no physician orders for antifungal powder or cream containing miconazole nitrate 2% or zinc oxide cream 20% (a skin protectant). An observation of Resident #26's room on 04/10/23 at 11:53 AM revealed he had two 3	F 761	* The Unit managers (UM) removed medicated creams and powders from the rooms of residents #26, #80, #24, #20, #38, and #44 on 5-5-23 and placed these items in the treatment cart. * The Certified Nursing Assistant (CNA)/Central Supply Clerk (CSC) completed a room by room check on 5-5-23 removing any medicated creams or powders stored at bedside. Additional residents were identified with these items at bedside. The CNA/Central Supply Coordinator individually labeled all items and placed them in a ziplock bag prior to the Unit Manager (UM) placing them in the treatment car. * 1) The Staff Development Coordinator (SDC) will educate all nursing staff on the facility policy regarding "Medication Storage in the Facility" and "Bedside Medication Storage" by 5-12-23. Newly hired staff will be educated on this during orientation by the SDC . New Agency staff will be educated by the SDC or Unit Manager (UM) on their first day of work in the facility. Staff not present in the	

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ounce (oz) bottles of antifungal powder containing miconazole nitrate 2% sitting on the windowsill of his room and one 3 oz bottle of antifungal powder containing miconazole nitrate 2% sitting on his overbed table.

An observation of Resident #26's room on 04/11/23 at 2:52 PM and 04/12/23 at 8:00 AM revealed 2 bottles of antifungal powder containing miconazole nitrate 2% and a tube of antifungal cream containing miconazole nitrate 2% was sitting on the windowsill and 1 bottle of antifungal powder was sitting on his overbed table.

An observation of Resident #26's room on 04/13/23 at 8:14 AM and 04/14/23 at 8:38 AM revealed two 3 oz bottles of antifungal powder containing miconazole nitrate 2% and one 2 oz tube of zinc oxide 20% cream were sitting on the windowsill.

An interview with the Vice President of Clinical Operations and Quality Assurance/Process Improvement (QAPI) on 04/14/23 at 4:49 PM revealed Resident #26 had not been assessed for self-administering medication and the antifungal cream, zinc cream, and antifungal powder should not have been left in his room since they were medicated. She stated if medications were left at the bedside there should be a physician order for the medications to be left at the bedside and she confirmed Resident #26 did not have an order to have the medications at his bedside.

An interview with the Director of Nursing (DON) on 04/14/23 at 5:49 PM revealed Resident #26 should have had a physician order to have medicated cream and powder in his room.

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educational sessions related to this citation will receive education upon return to work by the SDC or UM. 2) Residents identified as being appropriate to have medicated creams/powders at bedside will be assessed and care planned as such by the MDS nurse and UM. These items will be kept in a locked area for safety reasons. 3) Any medicated creams/powders found at bedside that are not stored behind a lock or in the room of a resident that is not assessed to have these items at bedside will be taken to the supervising nurse and reported to the UM. 4) Residents that are assessed to have medicated creams/powders at bedside will be reassessed quarterly by the UM to ensure safety.

* The UM will complete an audit of proper labeling and storage of medicated creams/powders by observing the rooms of residents on the following cadence: 3 resident rooms 3 times a week for 4 weeks, then 3 resident rooms 2 times a week for 4 weeks, and then 3 resident rooms weekly for 4 weeks for at least 3 months. The UM will present the results of this audit to the QAPI committee monthly. The QAPI may make adjustments to the plan to achieve compliance.

* Completion date: 5-12-23

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F 761	Continued From page 50 2. Resident #80 was admitted to the facility 12/30/22 with multiple diagnoses including hypertension (high blood pressure). Review of the quarterly Minimum Data Set (MDS) dated 02/28/23 revealed Resident #80 was cognitively intact. Review of the medical record revealed no documentation that Resident #80 had been assessed for self-administration of medication. Review of Resident #80's medical record revealed no physician orders for antifungal powder containing miconazole nitrate 2% or zinc oxide cream 20% (a skin protectant). An observation of Resident #80's room on 04/10/23 at 11:36 AM and on 04/12/23 at 7:52 AM revealed a 3 ounce (oz) bottle of antifungal powder containing miconazole nitrate 2% was sitting in the windowsill. An observation of Resident #80's room on 04/14/23 at 8:24 AM revealed a 3 oz bottle of antifungal powder containing miconazole nitrate 2% and a tube of zinc oxide 20% were sitting in the windowsill. An interview with the Vice President of Clinical Operations and Quality Assurance/Process Improvement (QAPI) on 04/14/23 at 4:49 PM revealed Resident #80 had not been assessed for self-administering medication and the zinc cream and antifungal powder should not have been left in her room since they were medicated. She stated if medications were left at the bedside there should be a physician order for the medications to be left at the bedside and she	F 761		

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confirmed Resident #80 did not have an order to have the medications at her bedside.

An interview with the Director of Nursing (DON) on 04/14/23 at 5:49 PM revealed Resident #80 should have had a physician order to have medicated cream and powder in her room.

3. Resident #24 was admitted to the facility 04/30/19 with multiple diagnoses including heart failure and anemia.

The quarterly Minimum Data Set (MDS) dated 03/10/23 revealed Resident #24 was cognitively intact.

Review of the medical record revealed no documentation that Resident #24 had been assessed for self-administration of medication.

Review of Resident #24's medical record revealed no physician orders for antifungal powder containing miconazole nitrate 2%.

Observations of Resident #24's room on 04/10/23 at 10:41 AM and 04/14/23 at 8:32 AM revealed a 3 ounce (oz) bottle of antifungal powder containing miconazole nitrate 2% was in a bath basin sitting on her chest of drawers beside her bed.

An interview with the Vice President of Clinical Operations and Quality Assurance/Process Improvement (QAPI) on 04/14/23 at 4:49 PM revealed Resident #24 had not been assessed for self-administering medication and the antifungal powder should not have been left in her room since it was medicated. She stated if medications were left at the bedside there should

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F 761	Continued From page 52 be a physician order for the medications to be left at the bedside and she confirmed Resident #24 did not have an order to have the medications at her bedside. An interview with the Director of Nursing (DON) on 04/14/23 at 5:49 PM revealed Resident #24 should have had a physician order to have medicated powder in her room. 4. Resident #20 was admitted to the facility 02/23/22 with multiple diagnoses including heart failure. The significant change Minimum Data Set (MDS) dated 03/05/23 revealed Resident #20 was cognitively intact. Review of the medical record revealed no documentation that Resident #20 had been assessed for self-administration of medication. Review of Resident #20's medical record revealed no physician orders for antifungal powder containing miconazole nitrate 2%. An observation of Resident #20's room on 04/13/23 at 7:46 AM revealed a 3 ounce (oz) bottle of antifungal powder containing miconazole nitrate 2% in a bath basin sitting on the chest of drawers beside her bed. An interview with the Vice President of Clinical Operations and Quality Assurance/Process Improvement (QAPI) on 04/14/23 at 4:49 PM revealed Resident #20 had not been assessed for self-administering medication and the antifungal powder should not have been left in her room since it was medicated. She stated if	F 761		

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medications were left at the bedside there should be a physician order for the medications to be left at the bedside and she confirmed Resident #20 did not have an order to have the medications at her bedside.

An interview with the Director of Nursing (DON) on 04/14/23 at 5:49 PM revealed Resident #20 should have had a physician order to have medicated powder in her room.

5. Resident #38 was admitted to the facility 02/08/18 with multiple diagnoses including non-Alzheimer's dementia.

The annual Minimum Data Set (MDS) dated 03/08/23 revealed Resident #38 was moderately cognitively impaired.

Review of the medical record revealed no documentation that Resident #38 had been assessed for self-administration of medication.

Review of Resident #38's medical record revealed no physician orders for antifungal cream containing miconazole nitrate 2%.

An observation of Resident #38's room on 04/14/23 at 8:40 AM revealed a tube of antifungal cream containing miconazole nitrate 2% sitting in a bath basin on the chest of drawers beside her bed.

An interview with the Vice President of Clinical Operations and Quality Assurance/Process Improvement (QAPI) on 04/14/23 at 4:49 PM revealed Resident #38 had not been assessed for self-administering medication and the antifungal powder should not have been left in her room

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since it was medicated. She stated if medications were left at the bedside there should be a physician order for the medications to be left at the bedside and she confirmed Resident #38 did not have an order to have the medications at her bedside.

An interview with the Director of Nursing (DON) on 04/14/23 at 5:49 PM revealed Resident #38 should have had a physician order to have medicated powder in her room.

6. Resident #44 was admitted to the facility on 10/11/19 with multiple diagnoses that included end-stage renal disease and diabetes.

The quarterly Minimum Data Set (MDS) dated 01/13/23 revealed Resident #44 had intact cognition.

Review of Resident #44's medical record revealed no documentation he had been assessed for self-administration of medication.

Review of Resident #44's medical record revealed no physician orders for antifungal powder or cream containing miconazole nitrate 2% (used to treat fungal or yeast infections of the skin) or zinc oxide 20% (skin protectant).

An observation of Resident #44's room on 04/11/23 at 8:20 AM revealed two 2 ounce (oz.) bottles of antifungal powder containing miconazole nitrate 2%, one 3.75 oz tube of antifungal cream containing miconazole nitrate 2% and two 2 oz. tubes of zinc oxide 20% cream were all stored in an open plastic container sitting on top of his nightstand.

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F 761	Continued From page 55 Additional observations of Resident #44's room on 04/12/13 at 12:08 PM and 04/13/23 at 9:00 AM revealed the two 2 oz. bottles of antifungal powder containing miconazole nitrate 2%, one 3.75 oz. tube of antifungal cream containing miconazole nitrate 2% and two 2 oz. tubes of zinc oxide 20% cream were all stored in an open plastic container sitting on top of his nightstand. During an interview on 04/14/23 at 4:49 PM, the Vice President of Clinical Operations and Quality Assurance Process Improvement (QAPI) revealed Resident #44 had not been assessed for self-administering medications and the antifungal cream, zinc oxide cream, and antifungal powder should not have been left in his room since they were medicated. She stated if medications were left at the bedside, there should be a physician order and confirmed Resident #44 did not have a physician order for the medicated powders and creams to be left in his room. During an interview on 04/14/23 at 5:49 PM, the Director of Nursing stated Resident #44 should have had a physician order to have medicated creams and powders left in his room.	F 761		
F 867 SS=E	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:	F 867		5/12/23

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§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 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.

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F 867	Continued From page 57 §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 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).	F 867		

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F 867	Continued From page 58 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 interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint survey and recertification survey conducted on 3/3/22 and 6/1/22. Six of the seven repeat deficiencies were originally cited on the 6/1/22 recertification survey under the areas of Resident Rights (F561 and F584), Comprehensive Resident Centered Care Plan (F658), Quality of Life (F677), Quality of Care (F684), and Infection Control (F880). One of the seven repeat deficiencies was originally cited on the 3/3/22 complaint survey under the area of	F 867	* On 5-8-23, the Medical Director was notified by the Administrator of the repeat citations and the F 867 citation as well as the plans to correct the cited issues. * On 5-5-23, the Interdisciplinary Team (IDT) conducted an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss findings of repeat citations including F tags: 561, 584, 658, 677, 684, and 880. and the necessary corrective action to ensure the facility has an effective QAPI program in place to prevent repeat citations. This	

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Resident Rights (F558). These repeat deficiencies during the 3 federal surveys show a pattern of the facility's inability to sustain an effective QAA Program.

The findings included:

This citation is cross referenced to:

F 561: Based on record review, observations, resident and staff interviews, the facility failed to honor a resident's bathing preference for 1 of 4 residents reviewed for choices (Resident #19).

During the Recertification and Complaint survey completed on 6/1/22 the facility failed to accommodate a resident's request to be assisted out of bed at their preferred time of day and provide residents with their preferred number of showers per week for 5 of 8 sampled residents.

F 584: Based on observations and interviews with residents and staff, the facility failed to repair a hole with jagged edges and splintered wood on the lower portion of a door in a shared bathroom (room 128); failed to repair holes in the bathroom linoleum floor (room 128); failed to repair the seal surrounding the base of the toilet that had a buildup of black colored debris in shared bathrooms with a strong odor resembling urine (rooms 124 and 128); failed to maintain clean and sanitary bathroom floors (rooms 110, 114, 116, 120, 128); failed to remove side rails from the floor (room 114); failed to maintain a clean and sanitary room divider curtain (room 110); failed to properly label and store personal care equipment in shared bathrooms (rooms 110, 116, 119, 120, 121); failed to maintain walls and baseboards in good repair (rooms 101-2, 114, 116, 120, and

F 867

was presented by the Vice President of Clinical Operations and QAPI.

* On 5-5-23, the Regional Director of Nursing provided education to the Interdisciplinary Team (IDT) on maintaining an effective QAPI program to prevent repeat citations. Effective 5-12-23, the Facility IDT will meet weekly for twelve (12) weeks to review results of ongoing monitoring tools to ensure the current plan is effective. Changes will be made to the plan if compliance is not being maintained.

* The Regional Director of Nursing and/or Nursing will attend QAPI meetings weekly for 4 weeks then, monthly for 2 months to validate the effectiveness of the facility QAPI program and it's ongoing compliance with preventing repeat citations and make recommendations to the facility IDT as appropriate to maintain compliance with QAPI activities.

* Completion date: 5-12-23

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F 867	Continued From page 60 124); failed to repair a loose fitting sink faucet (room 220); failed to maintain a toilet paper holder in good repair (room 110); failed to maintain functioning overhead lights in residents bathrooms (rooms 116 and 119); failed to maintain a functioning overhead light behind the bed (room 206) for 11 of 46 rooms reviewed for maintain a clean, safe, and homelike environment. During the Recertification and Complaint survey completed on 6/1/22 the facility failed to replace stained ceiling tiles for 1 of 4 halls, failed to maintain walls in good repair for 3 of 4 halls, failed to maintain room entry doors and bathroom doors in good condition, failed to maintain sanitary bathing rooms on 2 of 4 halls, failed to replace missing closet doors and drawer fronts on 2 of 4 halls, and failed to replace a leaking toilet on 1 of 4 halls. F 658: Based on observations, record review, resident interview, staff interviews, Pharmacist interview, and Physician interview the facility failed to provide care according to professional standards when the Physician failed to continue a resident ' s testosterone injections that he needed for hormone replacement. This resulted in 1 of 1 reviewed resident missing monthly testosterone injections for more than 2 months. (Resident #83) During the Recertification and Complaint survey completed on 6/1/22 the facility failed to provide care according to professional standards when a Medication Aide administered a medication used to control and relieve symptoms of acute diarrhea without a physician ' s order for 1 of 2 sampled residents.	F 867		

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F 867	Continued From page 61	F 867		

F 677: Based on record review, observations, and interviews with residents and staff the facility failed to provide dependent residents assistance with personal hygiene including oral care (Resident #2 and #47) and shaving (Resident #6) for 3 of 11 residents reviewed for activities of daily living.

During the Recertification and Complaint survey completed on 6/1/22 the facility failed to provide nail care, oral care, and facial hygiene for 2 of 7 dependent sampled residents.

F 684: Based on observations, record review, resident interview, staff interviews, and Physician interview the facility failed to follow the Physician ' s order to provide dressing changes to a resident's peritoneal catheter daily. This occurred for 1 of 1 resident reviewed for quality of care. (Resident # 83)

During the Recertification and Complaint survey completed on 6/1/22 the facility failed to prevent a resident who was at risk for aspiration from using straws for 1of 1 sampled resident.

F 880: Based on observations, record review, and staff interviews the facility failed to implement infection control for hand hygiene when 2 of 2 facility staff (Nurse Aide #6 and Nurse Aide #2) did not remove their gloves and perform hand hygiene after providing incontinence care for 2 of 2 residents observed for incontinence care (Resident #33 and Resident #46); and when 1 of 1 facility staff (Nurse Aide #6) handled soiled linen without gloved hands and failed to place soiled linen in a bag before removing it from a resident room and placing it in the soiled linen hamper for 1 of 2 residents observed for incontinence care

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F 867	Continued From page 62	F 867		

(Resident #33).

During the Recertification and Complaint survey completed on 6/1/22 the facility failed to implement their infection control policies and the Center for Disease Control and Prevention recommended practices when 1 of 3 staff members failed to wear full personal protective equipment while providing care to a resident on enhanced droplet precautions, and 1 of 1 staff member failed to perform hand hygiene during wound care for 1 of 2 residents reviewed.

F 558: Based on observation, record review and interviews with resident and staff, the facility failed to ensure dependent residents could access a light switch located behind their beds for 6 of 6 residents reviewed for accommodation of needs (Resident #6, #8, #11, #18, #76, and #83).

During the Complaint survey completed on 3/3/22 the facility failed to provide a wheelchair that was the correct size to accommodate 1 of 3 sampled residents.

During an interview on 4/14/23 at 7:06 PM the Administrator revealed that their QAA committee met monthly. During this meeting the committee reviews their current process improvements, falls, smokers, potential and past survey issues. She stated the repeat environmental citation was related to the number of items they needed to correct and repair. They had consistently been working on repairs and renovations, but things often come up that take priority and it interrupted their progress. The Administrator revealed the other repeat citations were related to the amount of new staff they had, but training was ongoing. They also continued to use many agency staff

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F 867	Continued From page 63 while trying to increase their facility staff. She explained agencies did not always send the same individuals; therefore, they did not have consistency with their agency staff. This made it harder to educate and monitor the performance of agency staff.	F 867		
F 880 SS=E	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	F 880		5/12/23

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F 880	Continued From page 64 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. §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 review, and staff interviews the facility failed to implement infection control for hand hygiene when 2 of 2 facility staff	F 880	* On 4-25-23, NA #6 was re-educated by the Unit Manager (UM) regarding infection control and handwashing during	

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F 880	Continued From page 65 (Nurse Aide #6 and Nurse Aide #2) did not remove their gloves and perform hand hygiene after providing incontinence care for 2 of 2 residents observed for incontinence care (Resident #33 and Resident #46); and when 1 of 1 facility staff (Nurse Aide #6) handled soiled linen without gloved hands and failed to place soiled linen in bag before removing it from a resident room and placing it in the soiled linen hamper for 1 of 2 residents observed for incontinence care (Resident #33). Findings included: Review of the facility's policy titled "Hand Hygiene" revised 10/29/20 read in part as follows: "All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. "Hand hygiene" is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Additional considerations-The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (putting on) gloves, and immediately after removing gloves." The Hand Hygiene Table indicated conditions for performing hand hygiene including "before applying and after removing personal protective equipment (PPE), including gloves; when, during	F 880	incontinence care. The Unit Manager (UM) completed a Competency Assessment for Perineal Care Male/Female on 4-25-23 for Nurse Aide (NA) #6. The NA #6 also successfully completed Handwashing Competency on 5-5-23 with the UM. NA #2 was re-educated on infection control and handwashing. The UM completed the Competency Assessment for Perineal Care Male/Female on 4-25-23. NA #2 successfully completed Handwashing Competency on 4-25-23 with the UM. * The Facility recognizes that all residents are at risk for infection if the staff fail to implement infection control practices for hand hygiene: therefore, a facility-wide observation on all three shifts will be conducted by 5-12-23 on hand hygiene during incontinence care by the UM and Infection Control Preventionist (ICP). * 1) The ICP will complete education to all Certified Nursing Assistants on the facility policy of Hand Hygiene, Perineal Care Male/Female Competency as well as the Handwashing and Perineal Care Male/Female skills checklist by 5-12-23. 2) When education needs are identified, that will be provided immediately through verbal coaching and demonstration by the ICP or UM. 3) Newly hired CNAs will receive this education during orientation as well as the checklists for competency and new agency will receive this education and complete the checklists on	

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F 880	Continued From page 66 resident care, moving from a contaminated body site to a clean body site; and after assisting with personal body functions (e.g., elimination)." The facility's policy titled "Infection Prevention and Control Program" last revised 08/2022 read in part as follows: "All staff shall use PPE according to established facility policy governing the use of PPE. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room." 1. A continuous observation of Nurse Aide (NA) #6 on 04/12/23 from 2:45 PM to 2:55 PM revealed NA #6 provided incontinence care to Resident #33. With gloved hands, NA #6 used her right hand to clean stool with a resident care wipe and placed the wipe in a trash bag, removed the soiled brief and placed it in a trash bag, removed the soiled bed pad and placed it toward the foot of Resident #33's bed, applied a fresh bed pad and clean brief, applied barrier cream to Resident #33's bottom with her right hand, removed her right glove and replaced her right glove, fastened Resident #33's brief, pulled up Resident #33's pants, and removed both of her gloves. NA #6 lowered Resident #33's bed with the bed control, handed Resident #33 a baby doll, pulled up Resident #33's bed cover, and pinned the call light to Resident #33's bed cover. NA #6 picked up the soiled incontinent pad and carried it to the soiled linen hamper in the hall. NA #6 did not remove her gloves and perform hand hygiene after removing stool and before applying barrier cream; did not perform hand hygiene before donning a clean pair of gloves and touching Resident #33's clean brief and pants; did not perform hand hygiene after removing her gloves	F 880	their first day at the facility. 4) Any CNAs not present in the educational session related to this citation will be educated by the SDC or UM on their first day back at work. * The ICP will complete an audit of staff performance of handwashing during incontinent care for 3 CNAs 3 times a week for 3 weeks, then for 3 CNAs 2 times a week for 4 weeks, and then 3 CNAs weekly for 4 weeks. The ICP will present the results of this audit to the Quality Assurance and Process Improvement (QAPI) committee monthly for at least 3 months. The QAPI committee will make adjustments to the plan if necessary to achieve compliance. * Completion date: 5-12-23 * Completion date: 5-12-23	

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and before touching Resident #33's bed control, baby doll, bed cover or call light; did not wear gloves when removing a soiled bed pad from Resident #33's room and placing it in the soiled linen; and did not place soiled linen in a bag before carrying it to the soiled linen hamper.

An interview with NA #6 on 04/12/23 at 2:55 PM revealed she thought she removed her right glove after wiping stool and before applying barrier cream. She stated she only changed the right glove because she was using the left glove as a "clean glove" and the right glove as a "dirty glove". NA #6 stated she had been trained to do hand hygiene after removing soiled gloves and before applying clean gloves and did not on 04/12/23 because she was nervous. She stated she should have placed the soiled bed pad in a trash bag and taken it to the soiled linen hamper contained in a trash bag, but she did not have any trash bags with her. NA #6 explained she did not put gloves on when bringing the bed pad to the soiled linen hamper because she thought she was not supposed to wear gloves in the hallway.

An interview with the Infection Preventionist (IP)/Staff Development Coordinator on 04/14/23 at 3:12 PM revealed NA #6 should have removed her soiled gloves and performed hand hygiene after wiping stool and then applied clean gloves before applying barrier cream. She stated after the barrier cream was applied NA #6 should have removed her soiled gloves, performed hand hygiene, and completed care. The IP/Staff Development Coordinator stated soiled linen should be placed in a trash bag before being carried out of a resident room and a soiled bed pad should not be touched without wearing gloves.

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An interview with the Director of Nursing (DON) on 04/14/23 at 5:49 PM revealed NA #6 should have removed her soiled gloves and performed hand hygiene after wiping stool, put on a clean pair of gloves, applied barrier cream, removed the soiled gloves, performed hand hygiene, and then completed care. She stated the soiled bed pad should have been placed in a trash bag when removed from the room and soiled linen should not have been touched with bare hands.

2. Review of the facility's Hand Hygiene policy revised 10/29/20 read in part: "All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub. Conditions for performing hand hygiene: after handling items potentially contaminated with body fluids, secretions, or excretions during resident care; when moving from a contaminated body site to a clean body site."

An observation and interview were conducted during incontinence care on 04/13/23 at 10:40 AM with Nurse Aide (NA) #2. NA #2 gathered supplies and washed her hands with soap and water then donned a pair of gloves. NA #2 removed the front part of the brief and noted Resident #46 had a bowel movement. NA #2 used premoistened wipes to clean the front peri area then requested Resident #46 roll to his side and continued to wipe stool from the resident's buttocks. While wearing the same gloves NA #2 grabbed a bottle of peri cleanser and a bottle of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345174	A. BUILDING ______ B. WING ______	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE HEALTH AND REHABILITATION	91 VICTORIA ROAD ASHEVILLE, NC 28801

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F 880	Continued From page 69 skin cleansing soap and wet washcloths she used to complete incontinence care and remove stool. When finished and wearing the same gloves NA #2 applied a clean brief, grabbed the privacy curtain to move it out of the way, grabbed the closet curtain to move it out of the way, removed a pair of clean shorts from the closet she used to dress Resident #47 then tucked a lift pad underneath the resident. After the lift pad was placed NA #2 removed her gloves and used alcohol-based hand rub to sanitize her hands. NA #2 confirmed she didn't remove her gloves after wiping bowel movement before she touched other items and surfaces in Resident #46's environment and stated if she saw her gloves were visibly soiled, she would have removed them and performed hand hygiene. During an interview on 04/14/23 at 3:14 PM the Infection Preventionist/Staff Development Coordinator stated NA #2 should have removed her gloves and performed hand hygiene before touching supplies, bottles, and other surfaces that included curtains and clothing. An interview was conducted on 04/14/23 at 6:09 PM with the Director of Clinical Services. The Director of Clinical Services stated it wasn't proper infection control practice for the NA to continue to wear the same gloves from the start to finish of incontinence care and would expect hand hygiene was performed after contact with bowel movement. An interview was conducted on 04/14/23 at 6:25 PM with the Administrator. The Administrator stated she would expect the NA would remove gloves and perform hand hygiene after cleaning a dirty site before moving to a clean area.	F 880		

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	345174	A. BUILDING ______ B. WING ______	C **04/14/2023**

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