STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495334	A. BUILDING _____ B. WING _____	C 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HEALTH & REHAB CENTER	26181 PARKSLEY ROAD PARKSLEY, VA 23421

(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 Medicaid/Medicare abbreviated survey was conducted on 03/10/21 through 03/12/21. No corrections are required for Emergency Preparedness compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 124 bed facility was 102 at the time of the survey. The survey sample consisted of 36 current resident reviews and 5 closed records.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/10/2021 through 03/12/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 2 complaints were investigated during the survey. The census in this 124 certified bed facility was 102 at the time of survey. The survey sample consisted of 36 current Resident reviews and 5 closed record reviews.	F 000		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 574	RECEIVED APR 07 2021 VDH/OLC	

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

Lisa Waltenbaugh — Administrator — 3-25-21

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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E 000	Initial Comments An unannounced Medicaid/Medicare abbreviated survey was conducted on 03/10/21 through 03/12/21. No corrections are required for Emergency Preparedness compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 124 bed facility was 102 at the time of the survey. The survey sample consisted of 36 current resident reviews and 5 closed records.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/10/2021 through 03/12/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 2 complaints were investigated during the survey. The census in this 124 certified bed facility was 102 at the time of survey. The survey sample consisted of 36 current Resident reviews and 5 closed record reviews.	F 000		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 574	F574 Required Notices and Contact Information 1. Facility obtained a new larger print poster made to show the contact information for the Office of Licensure and was placed on each wing in addition to the front lobby. 2. Education provided to the Resident Council, including the President, regarding location of the posted contact information.	

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Lisa Letterman

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F 574	Continued From page 1 personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of	F 574	3. With each monthly Resident Council, education will be provided to remind residents where the contact information is posted. 4. Administrator or designee will randomly ask 4 residents from each unit to ensure they know the location of the contact	

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F 574	Continued From page 2 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: 574-C The facility staff failed to ensure postings of State Agencies were in large enough font, positioned well and accessible to facility residents. FACILITY Resident Council 03/11/21 11:39 AM Resident council was at 10:30 am and voiced concerns about missing clothing, snacks at night are not substantive even for the diabetic-I went to the A Wing refrigerator and found crackers and nabs- and Toni WARD, LPN stated that snacks are given with their meals at 5:00 p.m., but she works 7:00 am to 7:00 p.m.. I will tell Tanya and see if she can check the kitchen. The diabetic in the group (Vera Kerry on B wing said she gets crackers and has awaken	F 574	information weekly x4. All audit information will be forwarded to QAPI for review and revision as needed 5. 04/09/2021	

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F 574	Continued From page 3 sweating due to low blood sugar. The President stated crackers with no drink-would like fruit, yogurt, or something else. They do not offer?? Been having Council meetings even during the Pandemic. No aware of survey results-where located, not aware on Ombudsman or our office if need to contact. The Administrator does not comeback to tell you about missing items investigation, it is the employee from the laundry that says, "We could not find it." The facility staff failed to ensure State office numbers to include Office of Licensure and Certification (OLC) were posted in a conspicuous area, appropriately positioned and with a font that is large enough to be read by residents.	F 574		
F 677 SS=E	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 observations, clinical record review, staff and resident interviews, the facility staff failed to provide personal hygiene to include full body showers and or whirlpools with hair washing for 4 of 41 residents (#64, #52, #19 and #53) in the survey sample. The findings include: 1. Resident #64 was not receiving personal hygiene to include showers and hair shampoos since 12/25/20.	F 677	F677 ADL Care Provided for Dependent Residents 1. Residents #64, #52, #19 and #53 were all given showers including having their hair washed. 2. Facility completed a 100% audit of current residents to ensure showers are scheduled 2x weekly. 3. Education by DON or designee for nursing department regarding shower schedules and procedures.	

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F 677	Continued From page 4 Resident #64 was admitted to the facility on 8/23/19 with diagnoses that included stroke with right sided weakness, tremors and swallowing problems, Bell's Palsy, lymphedema, high blood pressure and type 2 diabetes and neuropathy. The most recent Minimum Data Set (MDS) assessment was an Annual dated 1/25/21 and coded Resident #64 with a 15 out of a possible score of 15 which indicated the resident was intact with the skills needed for daily decision making. The MDS assessed the resident to not reject care. The resident was assessed totally dependent on one staff for dressing, personal hygiene and bathing. Resident #64 required extensive assistance of one staff for bed mobility, transfer, eating and toilet use. The resident was coded not steady and only able to stabilize herself with staff assistance for moving from seated position, moving off the toilet and surface to surface transfer. The resident was assessed impaired on both sides of upper extremity in range of motion. The resident was assessed to use a wheelchair. Resident #64 was assessed frequently incontinent of bowel and bladder. The care plan dated 8/23/19 identified self-care deficit and that Resident #64 required assistance with Activities of Daily Living (ADL). The goal set by the staff was that the resident's ADL needs would be met. Some of the approaches the staff would implement to accomplish this goal included assist with ADLs, dressing, grooming, toileting, feeding and oral care. On 3/10/21 at 12:15 p.m., Resident #64 was observed in her wheelchair in her room. She stated she could not remember the last time she	F 677	4. Unit Managers or designee will audit Mon- Fri each week to ensure showers are given, x3 months. All audit information will be forwarded to QAPI for review and revision as needed. 5. 04/09/2021	

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F 677	Continued From page 5 had a shower and her hair washed, "It has been months. I only get hand baths." She stated even though she wore a wig, she still would love to have her hair washed and it had been months. Strands of her natural hair was observed at the nape of her neck from under her wig. There was no record of showers or documentation that the resident's hair had been washed since 12/25/20 when droplet precautions for COVID-19 were discontinued. On 3/12/21 at 10:20 a.m., the Director of Nursing (DON) presented the aforementioned documentation that indicated the resident was off transmission based precautions on 12/25/20, thus the aides could have restarted showers for Resident #64. On 3/12/21 at 12:05 p.m., this surveyor and the Administrator went to the resident's room at which time, without any prompting, Resident #64 asked the Administrator if she could make sure her hair was washed and showers resumed. The Administrator stated as long as a resident was not on transmission based precautions, they could be given a shower and their hair shampooed. She reassured the resident her showers and shampoos would resume. On 3/12/21 at 3:40 p.m., during the debriefing with the Administrator, Director of Nursing (DON) and the Regional Corporate Nurse, no further information was provided prior to survey exit. 2. Resident #52 was not receiving personal hygiene to include showers and hair shampoos since 12/22/20. Resident #52 was originally admitted to the nursing facility on 10/2/19 with diagnoses that	F 677		

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F 677	Continued From page 6 included chronic obstructive pulmonary disease (COPD), muscle weakness, difficulty walking and type 2 diabetes mellitus. The most recent Minimum Data Set (MDS) assessment was dated 1/12/21 and coded Resident #52 with a 15 out of a possible score of 15 which indicated the resident was intact with the skills needed for daily decision making. The MDS assessed the resident to not reject care. The resident was assessed to need supervision and support from one staff for bathing and personal hygiene. She was coded occasionally incontinent of urine and frequently incontinent of bowel. The care plan dated 1/27/21 identified the resident with ADL self care performance deficit related to limited mobility and required assistance with ADLs. The goal set by the staff for the resident included the resident would maintain her current level of function and resident needs would be met. Some of the approaches the staff would implement to accomplish this goal included assist with ADLs, dressing, grooming, toileting, feeding and oral care. On 3/10/21 at 12:15 p.m., Resident #52 was observed in her wheelchair in her room. She stated she was told because of the Pandemic only "wash-ups" could be done and once she was set up, she washed herself, but would love to restart her whirlpool and have her hair washed. She stated, "I would feel so much better if I could get my whirlpools back and I would love my head washed. Even though I am bald on top, my head is a part of my body and it should be washed too." She wore a wig and gray hair was visible around the edges of the wig.	F 677		

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F 677	Continued From page 7 There was no record of showers or documentation that the resident's hair had been washed since 12/22/20 when transmission based precautions were discontinued. On 3/12/21 at 10:20 a.m., the Director of Nursing (DON) presented the aforementioned documentation that indicated the resident was off transmission based precautions on 12/22/20, thus the aides could have restarted whirlpools for Resident #52. On 3/12/21 at 12:05 p.m., this surveyor and the Administrator went to the resident's room at which time, without any prompting, Resident #52 asked the Administrator if she could make sure her hair was washed and whirlpools resumed. The Administrator stated as long as a resident was not on transmission based precautions, they could be given a shower/whirlpool and their hair shampooed. Resident #52 asked the Administrator if she was sure she could have her whirlpools and her hair washed. The resident wanted to know if she needed to provide the hair shampoo. The Administrator reassured the resident that the facility would provide shampoo and her whirlpools would resume. On 3/12/21 at 3:40 p.m., during the debriefing with the Administrator, Director of Nursing (DON) and the Regional Corporate Nurse, no further information was provided prior to survey exit. 3. Resident #19 was not receiving personal hygiene to include showers since 2/18/21.	F 677		

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F 677	Continued From page 8 Resident #19 was admitted to the facility on 04/22/2018. Diagnoses included but were not limited to, Muscle Weakness, Pain in joints and Pain in hands. Resident #19's Minimum Data Set (an annual assessment) with an Assessment Reference Date of 11/07/20 coded Resident #19 with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #19 as requiring supervision of 1 person for bed mobility, and eating. Limited assistance of 1 person with dressing. Extensive assistance of 1 for personal hygiene. 1 person physical assistance with bathing. Independence with transfers. Careplan: The careplan reads that Resident #19 has a Self care deficit. -refuses teds at times, refuses showers. Goals: Residents needs will be met with regard to adl's through next review. Interventions: Break tasks down so that adl's are easier for resident to perform and encourage resident participation while performing adl's. During the tour on 03/11/21 9:39 AM Resident #19 was observed lying in bed. She was asked if she was taking baths and what days were her showers scheduled. She stated, "They don't give me any showers. I want to start taking showers. CNA (Certified Nurse's Aide) #3 walked in. Resident #19 stated "I feel like I have sand in my socks." CNA #3 replied, "I'm getting ready to give you care now. What do you want a bath or shower." Resident #19 replied. "A shower." A review of the B-Wing shower book on 3/11/21 showed Resident #19, should receive showers on	F 677		

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F 677	Continued From page 9 Monday and Thursdays during the 7A-3P Shower List. The shower list reads: Every resident is to be offered a shower, if they refuse, put refused. This is completed daily. The shower list shows that Resident #19 did not receive any showers for the months of February and March. Resident should have received showers on the following days during 7A-3P shift. The January shower list is not available per LPN #2. The list for February was only available from 2/18/21 - 2/27/21. Scheduled days were Mondays and Thursdays 7 AM-3 PM no showers were given on the following scheduled dates: 2/18, 2/22 and 2/25, 3/01, 3/04 and 3/08/21. On 3/11/21 at 9:53 AM an interview was conducted with LPN (Licensed Practical Nurse) #2 concerning Resident not receiving any showers. She stated, The DON (Director of Nursing) said everyone that has been vaccinated on this unit can receive a shower." On 03/11/21 at 10:23 AM CNA #3 was seen transporting resident #19 via wheel chair to the shower room. On 3/12/21 at 10:15 am an interview was conducted with Resident #19 concerning her getting her scheduled shower today. She was asked how did taking the shower make her feel. She stated, "Wonderful." I haven't had a shower in a while. I get a bed bath everyday. My feet are feeling better today. No sand but sore today." 4. Resident #53 was not receiving personal hygiene to include showers and hair shampoos since 2/20/21. Resident #53 was admitted to the facility on	F 677		

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F 677	Continued From page 10 01/12/21. Diagnoses included but were not limited to, Chronic Kidney Disease Stage 4 and Muscle Weakness. Resident #53's Minimum Data Set (an Admission assessment) with an Assessment Reference Date of 1/17/21 coded Resident #53 with a BIMS (Brief Interview for Mental Status) score of 3 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #53 as requiring extensive assistance of 1 person with dressing, and personal hygiene. Requires extensive assistance of 2 persons for bed mobility. Requires 1 person physical assistance with eating. Requires total dependence with bathing. On 03/11/21 at 10:12 AM Resident #53 was seen ambulating in the hallway with OSM #2 (Physical Therapist) her hair appeared matted and uncombed. A review of the B-Wing shower book shows Resident #53, should receive showers on Wednesdays during the 7A-3P Shower List. The shower list reads: Every resident is to be offered a shower, if they refuse, put refused. This is completed daily. The shower list shows that Resident #53 did not receive any showers for the months of February and March. Resident should have received showers on the following days during 7A-3P shift on Wednesday and Saturdays. The January shower list is not available per LPN #2. The list for February was only available from 2/18/21 - 2/27/21. Scheduled shower days were Wednesdays and Saturdays 7 AM-3 PM no showers were given on the following dates: 2/20, 2/24, 2/27, 3/03, 3/06, 3/10/21.	F 677		

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F 677	Continued From page 11 Careplan: Reads that Resident #53 has a self-care deficit relating to disease processes and needs assistance with ADLs (Activity of Daily Living). Goal: Resident needs will be met. Interventions: Assist with activities of daily living, dressing, grooming, toileting, feeding, oral care. On 03/12/21 at 9:49 AM an interview was conducted with LPN #2 concerning Resident #53 receiving showers on Wednesday and Saturdays. She stated, " It should be initialed in the book when completed. Lately they haven't been documenting on the ADL sheets. On 03/12/21 at 9:55 AM an interview was conducted with CNA #6 concerning Resident #53. She stated, "I don't have her most of the time. She's not my normal. Showers are given on 3 different shifts. If a resident refuses showers we tell the nurse and she documents in the chart and we put an R (for Refusal) and initial in the book. On 3/12/21 at 9:59 AM an interview was conducted with LPN #3 concerning Residents not receiving showers. She stated, "No one told me they refused showers. When they were on isolation they weren't allowed to leave their rooms. Resident #53 was on isolation on the C unit for 3 weeks. She was admitted on 1/12/21 to 1/26/21 and came to this unit on 1-26-21." On 3/12/21 at 10:12 AM an interview was conducted with Resident #53 concerning her receiving showers. She stated, "I don't think I can get showers because of this thing (pointing to peg tube). My hair itches. Can you say something to them? It (her hair) hasn't been washed since Christmas."	F 677		

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F 677	Continued From page 12 On 03/11/21 at 12:34 PM the DON was interviewed concerning Residents not receiving their showers. She stated, "Unless the person is on isolation people should be getting showers. On 3/11/21 at 3:00 PM a phone call was made to Resident's daughter to request a resident representative interview. She stated that her sister was the RP (Responsible Party) for her mom but they both were concerned that their mother was not receiving showers or getting her hair washed. The daughter was reassured by surveyor that the issue would be investigated. On 3/12/21 at 12:30 PM an interview was conducted with CNA #3 concerning resident receiving showers. She stated, "We had COVID-19 and they (Residents) were on isolation. Most of the time they do get a shower if they want it. We have shampoo bags. We wash their hair as often as needed. I will ask if you want your shower I ask them if they want their hair washed. I will use the shower cap. Policy: Resident Bath/Showering/Scheduling Policy. Effective: 1/01/2008. Last Revision Date: 02/01/2021. Reads: Residents will be bathed or showered according to their preferences in order to maintain healthy hygiene and skin condition. (A). Each Resident will be asked about his/her bathing preference upon admission (type of bath, preferred days and times). (B). Each resident will be scheduled to receive bathing a minimum of two times per week unless they prefer less frequent baths or state regulation requires more frequent bathing. (C). The facility will develop and maintain a bathing/shower schedule for each unit. (D). At the beginning of the shift the Charge Nurse will review the bathing schedule for that	F 677		

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F 677	Continued From page 13 day and shift with the nursing assistants. (E). When the bath or shower is complete the nursing assistant will document the activity on the shower sheet or in point of care section of the electronic record. (G). A shower sheet will be completed for each bath/shower given. (H). If the bath/shower cannot be given or the resident refuses, the nursing assistant will promptly report this to the Charge Nurse. Policy: Morning Care/AM Care. Effective: January 2011. Last Revision Date: 6/15/2020. Morning Care will be offered each day to promote resident comfort, cleanliness, grooming and general wellbeing. Residents who are capable of performing their own personal care are encouraged to do so but will be provided with setup assistance if needed. Showers and baths are scheduled three times weekly or more or less often according to resident preference. Procedure: Assemble supplies: Basin, soap/shampoo, comb/brush, lotion, oral care supplies, nail care supplies, linen, garments, incontinent supplies if needed. #5. Provide bath/shower as indicated. #13. Brush/comb hair. On 03/12/21 at 1:22 PM an interview was conducted with the DON and the Administrator concerning the above Residents not receiving their showers. No comments were made.	F 677	F686 Treatment/SVS to Prevent/Heal pressure Ulcers 1. Resident #64 was provided a new wheelchair cushion on 3/12/21. Residents wound was reassessed by the physician on 03/23/2021.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		

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F 686	Continued From page 14 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, observations, staff and resident interviews and facility documentation, the facility staff failed to accurately assess and provide effective pressure relief while in sitting in a wheelchair to prevent pressure ulcers for 1 of 41 residents (Resident #64) in the survey sample. The findings include: Resident #64 was admitted to the facility on 8/23/19 with diagnoses that included stroke with right sided weakness, tremors and swallowing problems, Bell's Palsy, lymphedema, high blood pressure and type 2 diabetes and neuropathy. The most recent Minimum Data Set (MDS) assessment was an Annual dated 1/25/21 and coded Resident #64 with a 15 out of a possible score of 15 which indicated the resident was intact with the skills needed for daily decision making. The MDS assessed the resident to not reject care. The resident was assessed totally dependent on one staff for dressing, personal hygiene and bathing. Resident #64 required extensive assistance of one staff for bed mobility, transfer, eating and toilet use. The resident was coded not steady and only able to stabilize herself	F 686	2. Facility will complete 100% audit for appropriate pressure-reducing cushion in wheelchairs and replace with appropriate cushion as needed. 3a. Education by DON or designee for nursing department and therapy department on appropriate pressure reducing devices for residents at risk for pressure ulcers. 3B. Education for DON, ADON, Wound Nurse on assessing and identifying types of wounds.	

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F 686	Continued From page 15 with staff assistance for moving from seated position, moving off the toilet and surface to surface transfer. The resident was assessed impaired on both sides of upper extremity in range of motion. The resident was assessed to use a wheelchair. Resident #64 was assessed frequently incontinent of bowel and bladder. The resident was coded with weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was on a therapeutic, mechanically altered diet. The resident's height and weight was recorded as 5 ft. 3 in and 105 lbs. Based on the Braden Scale formal assessment instrument and clinical assessment, Resident #64 did not have any current pressure ulcers/injuries, but was coded at risk for them. The assessment indicated the resident had pressure reducing devices for the chair and bed, nutrition or hydration interventions and applications of ointments and medications other than feet for skin and ulcer/injury treatments. The care plan dated 8/23/19 to current identified that the resident was at risk for impaired skin integrity related to decreased mobility, incontinence, diabetes and cognition. The goal the staff set for the resident was that the area would show improvement and be free of signs and symptoms of infection. Some of the approaches the staff would take to accomplish this goal included elevate heels, monitor and report to physician redness, swelling, local warmth, tenderness, discharge and elevated temperature, nutritional status, skin prep per orders, turn and reposition as indicated and wheelchair cushion. Resident #64 was care planned for COVID-19 virus on 12/15/20 and droplet precautions/isolation ordered.	F 686	4. Unit managers or designee will audit wheelchairs for proper pressure-relieving cushions Mon-Fri x 1 month, then weekly x 4 weeks. 4B.DON will audit wound assessments to ensure accurate coding is done weekly x 3 months. All Audit information will be forwarded to QAPI for review and revision as needed 5. 04/09/2021	

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F 686	Continued From page 16 On 3/10/21 at 12:15 p.m., Resident #64 was observed in her wheelchair, sitting on a black cushion. She possessed a constant tremor of both arms, hands, as well as facial twitches of eyes and lips. The condition of the cushion was not visible during this observation. The resident stated she had been up in the chair since "around 9:30 a.m." The resident stated she got up in the morning and usually laid down and was changed before dinner. She stated the nursing staff did not routinely lift, stand or reposition her while she was in the chair. Certified Nursing Assistant (CNA) #8 placed the resident in bed at 4:00 p.m. "for a rest before dinner." The cushion had a plastic cover and observed creased and dipped in the center with an obvious warped bubbled appearance rips along the edges. Sacral wound pressure ulcer observation: On 3/11/21 at 12:32 p.m., Licensed Practical Nurse (LPN) #8 (wound care nurse) accompanied by LPN #7 transferred Resident #64 to bed to provide treatment to a sacral pressure ulcer. The area was described by LPN 8 as a *Stage III with slough (slough is soft necrotic/dead tissue), .9 cm (centimeters) length by (x) .5 cm width. The wound was cleansed with normal saline followed by Santyl (topical debridement) and covered with a boarded dressing. LPN #8 stated she was the nurse to stage wounds due to her training and LPN #7 covered in her absence. LPN #8 also stated she performed wound care treatments on Wednesdays and Thursdays with the licensed nurse's to provide treatments the remaining days. LPN #8 said the physician took her description of wounds and recommendation for treatment, but if wounds require the physician to observe, she will	F 686	4b. DON will audit wound assessments to ensure accurate coding is done weekly x 3 months. All Audit information will be forwarded to QAPI for review and revision as needed 5. 04/09/2021	

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F 686	Continued From page 17 either take a picture and send it to the physician or if necessary, he or she will come in. LPN #8 stated the sacral pressure ulcer was facility acquired and when asked about the etiology of the wound she responded, "She got this pressure area from sitting up in her wheelchair too long, but she has a cushion." The resident spoke up and said, "I thought I was going to get a new cushion, this one bends in the middle." The cushion was the same one as observed the previous day in the wheelchair. LPN #7, stated the resident's wheelchair cushion was called a "non-specific" cushion which indicated it was a basic wheelchair cushion. Review of physician's orders dated 8/17/20 verified that a "non-specific" cushion to wheelchair. *Stage III involves the full thickness of the skin and may extend into the subcutaneous tissue layer; granulation tissue and epibole (rolled wound edges) are often present. At this stage, there may be undermining and/or tunneling that makes the wound much larger than it may seem on the surface (Information retrieved on 3/15/21 from document Prevention and Treatment of Pressure Ulcers/Injuries, third edition, European Pressure Ulcer Advisory Panel, National Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance third edition, p. 40, 2019). Right foot wound observation: The LPN #8, wound care nurse, and LPN #7 prepared to perform wound care to the right heel. LPN #7 proceeded to pull up Resident #64's right pant leg when she observed significantly greater swelling of the right leg/foot than the left, pitting edema. LPN 7 stated, "(Resident #64's name) we have to take these socks off and find something looser." When the existing dressing was	F 686		

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F 686	Continued From page 18	F 686		

removed, an inflamed reddened area was observed on the resident's medial heel with an open area. The resident said she did not feel anything was there. LPN #8 did not hesitate to state the right heel was a diabetic ulcer and appeared to be a "divit" on the sole of the resident's foot the previous day (3/10/21). She said a divit was like an open "dent" and it was first identified on 3/4/21, but "today I may be leaning more towards a *Stage II because it is more towards the bony prominence? It could still be a diabetic ulcer." She stated they needed to keep pressure off the area and would have the resident leave her shoes off for a few days. They stated, "Her diabetic shoes have been ordered which will give her more room and avoid any pressure to her heels." LPN#8 was asked to provide professional documentation to support that this area on the resident's bony prominence of the medial heel was a diabetic ulcer and not the result of edema and pressure from a malfitting tight shoe. The documentation was not provided prior to survey exit. *A Stage II is a Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed without slough. May also present as an intact or open/ruptured serum-filled blister (information retrieved on 3/15/21 from document Prevention and Treatment of Pressure Ulcers/Injuries, third edition, European Pressure Ulcer Advisory Panel, National Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance third edition, p. 39, 2019).

The resident was observed back up in her wheelchair on 3/11/21 at 1:15 p.m. for the lunch meal. The shoes remained off. On 3/11/21 at 2:38 p.m., Resident #64 stated she thought she got a new cushion, but the one she had was dipped in

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F 686	Continued From page 19 the center and "it was not what I thought I was going to get." She said she was not able to push up on the arms of the wheelchair to reposition her lower body and buttocks without help, but the staff did not reposition her while in the wheelchair and that was why she wanted a more comfortable cushion. The resident was observed in the wheelchair at 4:05 p.m. The first documentation by the Unit Manager (UM) LPN #6 of the sacral wound was dated 2/27/21 as 1 cm (length) by 1 cm (width) and 0.1 cm depth, no drainage, pink wound bed, no odor, pink periwound and in house acquired. The physician was notified and treatment included hydrocolloid dressing every three days and that the resident was made aware of "small open area on bony area of coccyx". On 3/10/21 at 2:40 p.m., the UMLPN #6 stated she and other nurses can describe wounds and get an order for treatment, but unless it was a Registered Nurse (RN) only the wound care nurse (LPN#8) staged wounds and Resident #64's sacral area was staged the next time LPN #8 worked four days later on 3/3/21 with the same measurements, but the woundbed had deteriorated with 100% slough (unstageable due to inability to visualize woundbed to Stage the wound) with a concave base. Physician order changed to treat the wound with Santyl after cleansing with normal saline once a day. The first documentation of the right heel was dated 3/4/21 as 1.0 cm x 1.4 cm and 0.1 depth with no drainage and periwound appearance pink. Treatment was "to cleanse diabetic ulcer to right heel with normal saline, apply wound gel and cover with a dry dressing." On 3/10/21 at 2:40 p.m., UMLPN #6 stated the right heel did not look	F 686		

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F 686	Continued From page 20 like it did on 3/11/21, but I am thinking now this maybe a Stage II. She documented the following: "Assessed resident's right heel and performed dressing change to heel. Since assessment one day prior, diabetic ulceration is larger by 0.3 (in length) towards bony prominence, with heel red and soft, indicating pressure involvement. Bilateral legs with noted pitting edema above sock line that also wasn't present with previous assessment. Larger socks applied after dressing change. MD was notified and treatment to continue as ordered...Area remains a diabetic ulceration, but is exacerbated by pressure indicated by the heel being soft and red...Resident was asked to keep shoes off for a couple of days. Resident agreed." On 3/12/21 at 10:20 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON). They stated the resident requested a new cushion for her wheelchair and they were sure she received one recently from the Occupational Therapist (OT). They also stated that the resident preferred to stay up in her wheelchair, but thought she was able to "reposition herself", which was the opposite of the MDS assessment, care plan and the resident's statements. Additionally, the resident stated she was unable to reposition herself in the wheelchair without staff assistance. The DON stated UMLPN#6 said the appearance of the right heel on 3/11/21 changed from its appearance on 3/10/21 and that she was considering wound to be a Stage II at the recommendation of the surveyor. It was shared with the Administrator and the DON that no recommendations were given to the nursing staff and that UMLPN#6 and LPN#8 were vacillating back and forth as to whether to continue to assess the right heel ulcer origination	F 686		

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F 686	Continued From page 21 as diabetic or pressure from the resident's shoes, exacerbated by edema. The DON stated she did not know what LPN#8 was referring to using the word "divit" to describe the heel wound. On 3/12/21 at 12:05 p.m., this surveyor and the Administrator went to the resident's room to check out the wheelchair cushion. The Administrator examined the condition of the cushion and stated, "This cannot be the new cushion, torn and worn on the edges. Maybe the CNA placed the new one in another resident's chair." Without any prompting, Resident #64 voluntarily stated, "I thought I was getting a new cushion. This one dips so much in center." The Administrator also recognized the resident's right leg edema. The resident stated she kept her shoes off because of the swelling unless she had to go out of her room. On 3/12/21 at approximately 2:50 p.m., the Administrator, DON and OT stated there was nothing wrong with the original cushion, but it was replaced because the resident felt it was "worn out." The OT stated she examined the resident's cushion and said, "I looked at the cushion that you all saw and it did not look like that when I gave it to her on 3/1/21. It was falling apart, so I took that one off and gave her another one. Maybe because the resident is incontinent, it bubbled and started to shred like that from urine. Also, these cushions are used and are kept outside in our storage unit, which makes them exposed to different temperature and atmospheric conditions." The OT stated there was nothing wrong with the resident's original cushion. OT presented the resident's original *"Vive" cushion, opened it and stated that it was 1-1/2 inch foam around to equal 3 inches, 16 x 18	F 686		

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F 686	Continued From page 22 cushion with gel. The cushion dipped in the middle and the gel was no longer expanded, but flattened. She stated subsequent cushions for the resident were similar with same type gel insert. *The following information was accessed on 3/15/21 from the Vive website (dated 2021) https://www.vivehealth.com/products/wheelchair-cushions-gel Effective Support: With a gel core, premium foam layer, a waterproof seal and topped off with a luxuriously soft cover, the 3" thick cushion will relieve back and tailbone pain from sciatica and other conditions. Distribute pressure evenly: The liquid gel core redistributes your weight away from high pressure areas like the tailbone and the coccyx where painful sores could develop. Supportive height quality foam: The premium foam layer will not flatten under your weight so that you will sit comfortably day after day. On 3/12/21 at 3:30 p.m., Resident #64 was observed in bed and a smaller cushion, with gaps on each side, was in the seat of the wheelchair that did not conform to the wheelchair and was sunken in the middle. The resident stated she just laid down and "I have not had a chance to see if this one is better." On 3/12/21 at approximately 3:40 p.m., during debriefing with the Administrator, DON and Regional Corporate Nurse they stated the resident preferred to sit up in the wheelchair instead of getting back into the bed despite encouragement by the staff in case her husband	F 686		

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F 686	Continued From page 23 visits or calls. They said an air mattress overlay was placed on the bed 3/9/21 and an air mattress replacement ordered. They reiterated that the initial wheelchair cushion 8/17/20 was traded out for another cushion at resident's request for more comfortable cushion on 3/1/21, and replaced again on 3/12/21 due to the recently issued cushion falling apart, however, all cushions were used cushions. They also restated they thought the resident was able to reposition herself, but would encourage more off-loading to bed. Select a seat and seating support surface that meets the individual's need for pressure redistribution with consideration to body size and configuration, effects of posture and deformity on pressure distribution, mobility and lifestyle needs (information retrieved on 3/15/21 from document Prevention and Treatment of Pressure Ulcers/Injuries, third edition, European Pressure Ulcer Advisory Panel, National Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance third edition, p. 24, 2019). The following information was obtained on 3/15/21 from an article dated 2014 https://www.ncbi.nlm.nih.gov/books/NBK333136/ Heel pressure ulcers are localized injury to the heel as result of pressure sometimes in association with other factors. The heel is at the back of the foot, extending from the Achilles tendon around the plantar surface, it covers the apex of the calcaneum bone. It is a common site for pressure ulcer development. The lower limb can be subject to disease processes such as ischemia, edema, structural changes (due to fractures or bone disorders) and neuropathy, all of which affect the development and healing of heel pressure ulcers. Prevention is key, but once	F 686		

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F 686	Continued From page 24 a heel pressure ulcer has developed, pressure must be relieved from the heels to prevent further damage.	F 686	F761 Label/Store Drugs Biologicals 1. No resident affected. 2. Facility will audit all medication carts and medication storage rooms for expiration date on medications. 3. Education by DON or designee for licensed nurses re: proper medication storage including expiration date of medications and disposal of expired medications.	
F 761 SS=D	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. §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, staff interviews and facility documentation review the facility staff failed to remove expired medication from 1 of 6 medication carts (A-Wing).	F 761		

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F 761	Continued From page 25 The findings included: On 03/11/2021 at 9:02 a.m., during a medication pass observation outside of room 03-B on A Wing, Licensed Practical Nurse (LPN) #1 was observed pouring 2 tablets in medication cup from a bottle labeled Sodium Bicarbonate 5 gr (Grain) - 325 mg. (Milligram). Per inspection of the bottle it was observed that 03/22 was written in black ink on the bottle cap. When asked what 03/22 indicated, LPN #1 stated, "This is when we opened it." Per further inspection of bottle an expiration date of 06/20 and Lot number 182027 was observed. When asked what do you check for when preparing to give medications, LPN #1 stated, "Check the name, correct dose and expiration date." When asked what is the expiration date on the bottle, LPN #1 stated, "06/20." When asked if the medication was expired, LPN #1 stated, "Yes." LPN #1 removed the Sodium Bicarbonate tablets from the medication cup. LPN #1 stated, "I'm not going to give the Sodium Bicarbonate to the resident." When asked should you give expired medication to a resident, LPN #1 stated, "No ma ' am." When asked what is the process when a medication is expired and you do not administer, LPN #1 stated, "I will check to see if there is some more in the store room and give." On 03/12/2021 at approximately 12:30 p.m., a copy of the Administration of Medication Policy and Procedure was requested. On 03/12/2021 at approximately 2:00 p.m., a copy of the facility policy, Disposal/Destruction of Expired or Discontinued Medication, was received.	F 761	4a. Unit managers or designee will audit medication carts weekly x 3 months for expired drugs. 4B. Unit manager or designee will audit medication storage rooms weekly to ensure no expired medication is found weekly x 3 months and randomly as needed. All audit information will be forwarded to QAPI for review and revision as needed. 5. 04/09/2021	

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F 761	Continued From page 26 The Director of Nursing was made aware of the finding during a briefing on 03/12/2021 at approximately 3:00 p.m. When asked what are your expectations of nurses when administering medications, Director of Nursing stated, "To check the expiration date." No further information was provided. The facility policy titled - Disposal/Destruction of Expired or Discontinue Medication Applicability: This policy 8.2 sets forth procedures relating to medication disposal and destruction. Procedure: 4. Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	F 791		

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F 791	Continued From page 27 §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interviews, and clinical record review, the facility's staff failed to act on replacing missing dentures after they were know not to be in the resident's possession for 1 of 41 residents (Resident 4), in the survey sample. The findings included: Resident #4 was originally admitted to the facility	F 791	F791 Routine/Emergency Dental Srvcs 1. Resident #4 has a scheduled dental appointment for denture replacement on 05/04/2021 @ 4pm. 2. Facility will audit current residents for missing dentures and or dental issue and schedule consults as needed.	

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F 791	Continued From page 28 11/5/2017 and had never been discharged. The resident has never been discharged from the facility. The current diagnoses included; dementia, a-fib, and breast cancer. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/10/20 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired for daily decision making. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bathing and dressing, limited assistance of one person, with bed mobility, transfers, and personal hygiene, supervision with one person assistance with walking in room, supervision after set-up with eating. Section "L" Oral/Dental was coded for no dental concerns. On 3/10/20, at approximately 2:10 p.m., an interview was conducted with Resident #4. Resident #4 stated I have one concern, my weight loss; My daughter stated she doesn't want me to loose anymore weight. The resident further stated I try to eat and I eat what I want but I'm still losing weight. Resident #4 denied swallowing or chewing problems but she had no teeth and or dentures (upper or lowers) currently in use. The resident stated she had dentures but they were lost a while ago. The resident also stated she would like to have replacement dentures but she didn't know how to get them. On 3/10/20, at approximately 8:10 p.m., an interview was conducted with Resident #4's daughter. The daughter stated her mother's	F 791	3a. Education by DON or designee for nursing department regarding dental services and care and notification of social services for any missing dentures for replacement. 3b. Education by the Administrator for Social Services to follow up on scheduling for dental concerns.	

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F 791	Continued From page 29 lower denture plate had been missing since shortly after receiving a replacement set of dentures and staff was aware of it because an attempt was made to modify the consistency of her foods to accommodate for the loss of the lower dentures. Resident #4 further stated the chopped food diet was not well received by the resident and she began to eat less therefore; the staff changed the diet back to regular texture but still no arrangements were made to replace the second case of missing dentures. During the midday meal on 3/11/20, the resident consumed only a magic cup and a chocolate ice cream sundae. The soup, sliced beef with gravy, mashed potatoes and vegetable were not touched. An interview was conducted with Licensed Practical Nurse (LPN) #3 on 3/11/21 at approximately 12:10 p.m. LPN #3 stated some residents has an order on the Medication/Treatment record to apply and remove appendages such as dentures, hearing aids, eyeglasses but Resident #4 wasn't one of those residents. LPN #3 further stated Resident #4 managed her own and was known to leave her dentures on the meal tray or hide them from herself but she would have the assigned Certified Nursing Assistant (CNA) assist the resident to locate the missing teeth. An interview was conducted with the Social Worker on 3/11/2021, at approximately 1:25 p.m. The Social Worker stated she had not been alerted that Resident #4's dentures were missing but she would follow-up on the concern. After speaking to the resident's daughter and staff the Social Worker reported she arranged for a dental	F 791	4. Unit managers or designee will audit residents for follow up with missing dentures or dental issues weekly x 3 months. All audit information will be forwarded to QAPI for review and revision as needed. 5. 04/09/2021	

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F 791	Continued From page 30 consult and notified the staff to arrange transportation for replacement dentures. The Social Worker stated the resident's daughter stated the dentist the resident saw previously is no longer in practice in the area and she had no preference or recommendation of which dentist to use, asking that the facility set up an appointment with whoever other residents in the facility typically sees. The above information was shared with the Administrator and Director of Nursing on 3/12/21 at approximately 1:45 p.m. The Director of Nursing stated she had recently spoken with Resident #4's daughter and she didn't mention the resident's dentures were missing.	F 791	**F880** 1. No resident cited for this deficiency. 2. All residents are at risk to be affected by this deficient practice. CNAS on isolation unit received immediate education 3. Education by the DON or designee for facility staff to include all departments on guidelines for PPE and hand hygiene for entering/exiting isolation rooms.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		

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F 880	Continued From page 31 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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	F 880	4. Audit by the department managers and unit managers Mon-Fri via direct observation to ensure staff entering/exiting isolation rooms are donning/doffing appropriate PPE and performing hand hygiene and that staff on other units are washing hands appropriately when passing and collecting trays weekly x3 months and then randomly. All audit information will be forwarded to QAPI for review and revision as needed. 5. 04/09/2021	

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F 880	Continued From page 32 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to follow infection control practices while picking up meal trays from quarantine rooms on the C-Wing. The findings included: On 3/10/21 at 1:45 p.m., observations were made of CNA (Certified Nursing Assistant) #1 collecting meal trays from C-Wing, hallway (C-17 through C-22); the quarantine unit. All rooms on the quarantine unit had signage in front of each room documenting the following: "Droplet-Contact Precautions" "Perform hand hygiene, Wear mask before entering the room, Gown before entering the room, Gloves before entering the room, eye protection before entering the room." At 1:50 p.m., CNA #1 was observed entering room C-20 wearing an N95 mask and face shield. CNA #1 failed to don a gown and gloves prior to entering the room. At 1:51 p.m., CNA #1 left room C-20, placed the meal tray on the cart and entered room C-22 without sanitizing her hands. CNA #1 also failed to don a gown and gloves prior to entering room C-22. CNA #1 was then observed leaving room C-22 without sanitizing her hands. CNA #1 placed the meal tray on the cart and entered room C-21 without sanitizing hands. CNA #1 also failed to don a gown and	F 880		

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F 880	Continued From page 33 gloves prior to entering C-21. At 1:54 p.m., CNA #1 was observed leaving room C-21 without sanitizing her hands. CNA #1 then placed the meal tray on the cart, went directly to the clean linen cart and grabbed a wash cloth. CNA #1 did not sanitize her hands prior to touching the clean linen cart. CNA #1 was then observed going back into room C-21 without a gown and gloves in place. At 1:55 p.m., CNA #1 was observed leaving room C-21 and then sanitized her hands. On 3/12/21 at 10:00 a.m., an interview was attempted with CNA #1. She could not be reached. On 3/12/21 at 10:03 a.m., an interview was conducted with CNA #2, another nursing aide on the quarantine unit. When asked the process of picking up meal trays for residents on quarantine (Droplet) precautions; CNA #2 stated that when picking up meal trays she is supposed to put on a gown, gloves, and have her N95 mask and shield already in place. CNA #2 stated that she will grab the meal tray and then set the tray on the sink so she can doff her gown and gloves prior to exiting the room. CNA #2 stated that she will then either wash or sanitize her hands and then leave the room. CNA #2 stated that hands must be sanitized prior to picking up another meal tray. This writer made her aware of some staff not donning gowns and gloves prior to entering the quarantine rooms when picking up meal trays on Wednesday during lunch. CNA #2 stated that sometimes, "Not going to lie, sometimes I forget because we are not providing care; just grabbing the tray real quick." Also made aware of staff not sanitizing or washing hands prior to leaving room and before picking up another tray. CNA stated that staff were supposed to sanitize hands in	F 880		

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F 880	Continued From page 34 between each room. On 3/12/21 at 12:52 ASM #1 was made aware of above concerns. When asked if she expected staff to don gown and gloves when picking up meal trays for residents on the quarantine unit, ASM #1 stated that she did. When asked if she expected staff to sanitize hands between each room, ASM #1 stated that she did or after the meal trays were dropped off on the meal cart. Policy titled, "Handwashing in the Kitchen," documents in part, the following: "When to wash hands ...Before distributing trays/meals to resident." Policy titled, "Droplet Precautions,"- intended to prevent transmission of pathogens spread through close respiratory or mucous contact with respiratory secretions ...c. Gloves, gown, eye protection are worn adhering to Standard Precautions guidelines ...F) Handle resident-care equipment and instructions /devices, laundry, dishware, or eating utensils and environment cleaning with Standard Precautions unless more stringent disinfection is indicated ..."	F 880		