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	495141	A. BUILDING _____ B. WING _____	09/02/2021

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E 000	Initial Comments An unannounced Emergency Prepredness survey was conducted 8/31/2021 through 9/2/2021. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/31/21 through 9/2/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 105 certified bed facility was seventy-eight at the time of the survey. The survey sample consisted of eighteen current resident reviews and two closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		9/24/21

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

Electronically Signed | 09/24/2021

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide dignity for one of twenty residents in the survey sample, Resident #53. Resident #53, without clothing and wearing only an incontinence brief was visible to other residents and staff on her living unit. The findings include: Resident #53 was admitted to the facility on 7/31/18 with diagnoses that included Huntington's	F 550	F000 This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or con F550 To remain in compliance with all federal and state regulations, the center has	

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F 550	Continued From page 2 disease, COVID-19, myopia, anxiety, mood disorder, insomnia, cognitive communication deficit, major depressive disorder, gastroesophageal reflux disease, peptic ulcer disease, osteoarthritis and hypertension. The minimum data set (MDS) dated 7/27/21 assessed Resident #53 with severely impaired cognitive skills and as totally dependent upon staff for dressing and transfers. On 8/31/21 at 3:20 p.m., Resident #53 was observed in her room in a Broda specialized wheelchair with protective floor mats surrounding the chair. The resident had on no clothing other than an incontinence brief. Her upper body including her breasts and legs were exposed. The resident was visible from the hallway as the door to the resident's room was open. The resident was repeatedly moving back and forth in the Broda chair and had constant, spastic movements of her arms/hands. The resident's roommate (Resident #28) was in bed at the time of the observation. There was no privacy curtain installed in the room. Another resident on the unit was observed ambulating in the hallway outside Resident #53's room. On 9/1/21 at 10:20 a.m., Resident #53 was observed in the Broda chair in her room again without any clothing other than an incontinence brief. The resident's chair was positioned at the end of the roommate's bed with protective floor mats surrounding the chair. A hospital gown was observed in the floor beside the Broda chair. The resident's roommate was in bed at the time of the observation. The resident's breasts, upper body and legs were exposed and visible from the hallway.	F 550	taken or will take the actions set forth in the following plan of correction. 1)Resident #53 clothing received from laundry and resident dressed in onsie due to self removal of clothing. 2)Residents that remove their own clothes have the potential to be at risk for being visible to other residents and staff on their living units. 3)The staff will be reeducated regarding resident dignity and ensuring properly dressed. 4)Residents will be monitored during care keeper rounds, discussed in morning meeting and reviewed in weekly QAPI for 3 months. 5)Date of completion is September 24, 2021.	

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On 9/1/21 at 10:45 a.m., the certified nurses' aide (CNA #1) that routinely cared for Resident #53 was interviewed. CNA #1 stated Resident #53 stripped her clothes off "all the time." CNA #1 stated, "She [Resident #53] figures a way to take them off." CNA #1 stated she had tried shirts and a gown but the nothing stayed over her due to her constant movements and jerking. CNA #1 stated she had been told to check on the resident frequently and try to keep her covered but she was not sure what else to do and the resident stayed mostly exposed. CNA #1 stated the resident stayed in her room due to COVID-19 and there was no privacy curtain in her room.

On 9/1/21 at 10:50 a.m., the licensed practical nurse (LPN #2) caring for Resident #53 was interviewed. LPN #2 stated, "She does not like clothes." LPN #2 stated she was aware the resident was exposed but nothing they put on her stayed in place because of the constant movements. LPN #2 stated she put a sheet over her this morning but it did not stay in place. LPN #2 stated, "She comes out of a shirt or gown." LPN #2 stated the resident was on another unit prior to coming onto the COVID-19 unit and she thought staff used "onesies" as clothing. LPN #2 stated the resident used to be in a private room with floor mats but she had a roommate on the COVID-19 unit. When asked about why the "onesie" was not on the resident, LPN #2 stated she had not seen the onesies since the resident came to the COVID unit and "they were hard to keep clean." LPN #2 stated Resident #53 and her roommate (Resident #28) required assistance with activities of daily living. LPN #2 stated she was not sure if a privacy curtain could be mounted in their room. Resident #53 was still exposed and in the Broda chair at the end of the

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F 550	Continued From page 4	F 550		

roommate's bed at the time of this interview. LPN #2 did not attempt to cover the exposed resident in any manner.

On 9/1/21 at 10:55 a.m., Resident #53 was observed in the Broda chair in her room without any clothing other than an incontinence brief. Another resident walking on the unit stopped in the doorway to Resident #53's room, looked in and then continued walking up the hallway.

On 9/1/21 at 1:54 p.m., the director of nursing (DON) was interviewed about Resident #53 exposed and without clothing. The DON stated that the resident previously tried to remove clothing and the onesies had "worked pretty well" but the resident still pulled at any type of clothing. The DON stated the removing of clothes was a recent problem and had been worse since the resident was moved to the quarantine unit. The DON stated the resident had always pulled at clothing but had not completely removed them until the room change.

On 9/2/21 at 8:18 a.m., the social worker (LPN #3) that worked with Resident #3 on her previous living unit was interviewed. LPN #3 stated "onesies" were used with the resident on the previous unit. LPN #3 stated the resident did not like anything restricting her but the onesies had been the best intervention to prevent exposure. LPN #3 stated, "We need to find her stuff." LPN #3 stated Resident #53's clothing "got mixed up" when she moved from the standard unit to the quarantine unit. LPN #3 stated she thought her clothing, including the onesies, went to laundry when she was diagnosed with COVID-19.

On 9/2/21 at 8:40 a.m., the laundry supervisor

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(other staff #1) and day shift laundry employee (other staff #2) were interviewed about Resident #53's clothing including the "onesies." The laundry supervisor stated when residents were diagnosed with COVID, their clothing was sent to laundry for washing/sanitizing. The laundry supervisor stated clothing sent to the laundry was usually processed the same day and returned to the units. The laundry employee stated Resident #53's clothing, including the onesies came to laundry when the resident moved to the quarantine unit. The laundry employee stated the resident's clothing had been washed and stored in a container in the laundry area. When asked why the clothing was not returned to the resident, the laundry employee stated she was not going on the COVID unit and nobody from the quarantine unit had requested the resident's clothing. The laundry employee stated Resident #53's clothing included seven "onesies."

Resident #53's clinical record documented the resident was diagnosed with COVID-19 and moved to the designated COVID-19 quarantine unit on 8/24/21.

Resident #53's plan of care (revised 8/2/21) documented the resident had spastic/involuntary jerking movements due to Huntington's disease and required assistance with activities of daily living including dressing and transfers. The care plan made no mention of the resident removing clothing, issues with privacy or exposure and included no use of the "onesies." The plan documented, "...Will at times scoot buttocks or rock to the edge of chair...unable to express needs...chooses to sleep in clothes, refusing to remove at bedtime. Will at times refuse to go to bed at night until early morning..." Interventions

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F 550	Continued From page 6 to manage behaviors included intervene prior to behaviors, notify physician if behaviors interfere with daily living, diversion activities and psychiatric services for medication management. The plan of care documented the resident required assistance for activities of daily living. Interventions to maintain functioning included, providing care as needed allowing as much independence as possible, encourage choices, report changes in physical functioning ability and provide dressing assistance as needed. This finding was reviewed with the administrator and director of nursing during a meeting on 9/1/21 at 3:00 p.m.	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		9/24/21

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F 583	Continued From page 7 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and clinical record review, the facility staff failed to ensure privacy during personal care for one of twenty residents in the survey sample, Resident #50. Staff provided incontinence care for Resident #50 with the door open and no use of the privacy curtain. The findings include: Resident #50 was admitted to the facility on 7/17/21 with diagnoses that included pulmonary embolism, COVID-19, diabetes, bipolar disorder, chronic kidney disease, atrial fibrillation, hypertension, anemia and dysphagia. The minimum data set (MDS) dated 7/26/21 assessed Resident #50 as cognitively intact, frequently incontinent of bowel/bladder and requiring extensive assistance of two people for toileting and hygiene. On 9/1/21 at 10:25 a.m., certified nurses' aides (CNA #1 and CNA #2) were observed from the hallway providing incontinence care and a brief	F 583	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. 1)Staff providing care to resident #50 were immediately reeducated regarding privacy during incontinence care. 2)Residents that receive incontinence care by clinical staff have the potential to be affected by this practice. 3)Clinical staff will be reeducated regarding privacy during incontinence care. 4)Residents will be monitored during care keeper rounds, discussed in morning meeting and review in weekly QAPI for 3 months. 5)Date of completion September 24, 2021.	

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change for Resident #50. The door to the resident's room was open and there was no privacy curtain pulled around the bed. The resident's roommate was in bed at the time of the observation. Resident #50 was uncovered from the waist down with her buttocks and peri-area visible as the CNAs turned and cleaned the resident. The door to the room directly across the hall from Resident #50's room was also open with two male residents in view of the resident.

On 9/1/21 at 10:40 a.m., CNA #1 was interviewed about the lack of privacy during Resident #50's brief change. CNA #1 stated the privacy curtain was supposed to be pulled around the bed prior to providing care. CNA #1 stated she knew she was supposed to provide privacy but it had been a "bad morning."

On 9/1/21 at 1:10 p.m., the director of nursing (DON) was interviewed about the lack of privacy for Resident #50. The DON stated pulling the privacy curtain for care was a standard of practice and residents should always have privacy during personal care.

On 9/2/21 at 10:30 a.m., the DON stated whenever performing personal care, staff were expected to pull the privacy curtain around the resident and shut the window blinds and/or door if necessary to ensure privacy.

The facility's standard of practice (identified by the administrator as Lippincott Manual of Nursing Practice 8th edition) included on pages 382 and 384 in steps for fecal/urinary incontinence care, "Provide privacy."

Resident #50's plan of care (revised 8/6/21)

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F 583	Continued From page 9 documented the resident required assistance with activities of daily living due to poor mobility and obesity. Interventions for completion of activities of daily living included assist resident as needed and provide thorough skin care after incontinence. This finding was reviewed with the administrator and director of nursing during a meeting on 9/1/21 at 3:00 p.m.	F 583		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		9/24/21

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F 657	Continued From page 10 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of twenty residents in the survey sample, Resident #26 and #25. Resident #26's care plan was not revised with problems, goals and interventions regarding a significant weight loss. Resident #25's care plan was not revised to include non-drug interventions for pain. The findings include: 1. Resident #26 was admitted to the facility on 3/23/21 with diagnoses that included hypothyroidism, vitamin deficiency, bradycardia, polyneuropathy, gastroesophageal reflux disease, hypertension, history of myocardial infarction, cerebral infarction with dysphagia, COPD (chronic obstructive pulmonary disease), peripheral vascular disease, hemiplegia and COVID-19. The minimum data set (MDS) dated 6/28/21 assessed Resident #26 with severely impaired cognitive skills, requiring extensive assistance of one person for eating and having a significant weight loss of 5% or more in last month. Resident #26's clinical record documented the resident was assessed with a significant weight loss of 5.5% on 4/26/21 with weight on 3/31/21 of 110 lbs. (pounds) and 104 lbs. on 4/26/21. The record documented a physician's order dated 4/28/21 for addition of 2-cal supplement three times per day.	F 657	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. 1)MDS coordinators reviewed the comprehensive care plans for resident #25 and #26. Resident #25 care plan revised to include non-drug interventions for pain. Resident #26 care plan revised with problem, goals and interventions regarding a significant weight loss. 2)Residents with pain and weight loss have the potential to be affected by this practice. An audit of pain and weight loss care plans will be completed of current residents. 3)MDS, RD and nurses will be reeducated on updating residents care plans regarding pain and weight loss. 4)MDS will monitor care plans scheduled weekly for non-drug interventions for pain and interventions regarding significant weight loss. Will be reviewed weekly in QAPI for 3 months. 5)Date of completion September 24, 2021.	

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The resident's weight on 6/3/21 was 105 lbs. An order was entered on 6/3/21 for fortified foods, dysphagia-mechanical soft diet, two whole milks with each meal and maximum assistance with meals.

On 7/15/21, an order was entered requiring monthly weights and a multivitamin was started on 7/28/21.

The registered dietitian's (RD's) note dated 8/11/21 documented, "...Regular, Dysphagia Soft PO intakes: >75% of all meals...Nutrition Interventions: fortified foods, 120 cc Medpass TID, whole milk with all trays Sig wt [significant weight] change: -8.49% x 3 months...Triggered for significant wt [weight] loss x 3 months...Spoke with RN [registered nurse] who reports ongoing good po [oral] intakes. All meals documented as > 75% consumed...Weights continue to trend down steadily. Nutrition interventions in place..."

Resident #26's plan of care (revised 6/25/21) documented the resident was on a pureed diet with thickened liquids and had not been updated regarding the resident's significant weight loss. Interventions listed were, "Diet as ordered" and Monitor meal consumption daily." There was no mention of the mechanical soft diet, 2-cal supplement, fortified foods, maximum assistance for meals or the whole milk with each meal. The nutrition section of the care plan had not been revised since 3/31/21.

On 9/1/21 at 2:51 p.m., the registered nurse (RN #4) responsible for MDS and care plans was interviewed about Resident #26's nutrition plan. RN #4 stated the weight committee followed the resident and the RD usually revised the nutrition

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portion of the care plan as needed. RN #4 stated the RD entered a progress note on 8/11/21 about the resident's status but the care plan had not been revised about the weight loss.

This finding was reviewed with the administrator and director of nursing during a meeting on 9/1/21 at 3:00 p.m.

2. Resident #25 was admitted to the facility on 6/22/21 with diagnoses that included right lower leg fracture, rheumatoid arthritis, lupus, gastroesophageal reflux disease, osteoporosis, dysphagia, cardiomyopathy with defibrillator, atrial fibrillation, hypertension, chronic kidney disease, anxiety, obesity, fibromyalgia, depression, COVID-19 and opioid dependence. The minimum data set (MDS) dated 6/25/21 assessed Resident #25 as cognitively intact and as frequently experiencing pain.

Resident #25's clinical record documented a physician's order dated 6/25/21 for oxycodone 20 milligrams every 4 hours as needed for pain.

The resident's medication administration record (MAR) for August 2021 documented 37 doses of oxycodone administered as needed for leg and generalized pain rated from 2 to 10 (scale of 0 = no pain, 10 = worst pain). Nursing notes documented non-drug interventions of repositioning, encouragement to be out of bed and therapy exercises but listed these as frequently refused by the resident.

Resident #25's plan of care (revised 6/25/21) documented the resident required pain management due to ankle fracture, lupus and rheumatoid arthritis. Interventions to maintain

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F 657	Continued From page 13 comfort included administer medication, assess pain using numeric scale and evaluate pain medication effectiveness. The care plan made no mention of any non-drug interventions for comfort or pain reduction. On 9/1/21 at 10:50 a.m., the licensed practical nurse (LPN #2) caring for Resident #25 was interviewed about the care plan for pain. LPN #2 stated the resident requested as needed oxycodone almost daily for leg and generalized pain. LPN #2 stated repositioning, encouragement to get out of bed and therapy exercises were offered as non-drug interventions but the resident frequently refused them. LPN #2 stated the resident preferred to stay in bed and was non-compliant with requests to move frequently. LPN #2 stated she was not sure what was on the care plan about pain. On 9/1/21 at 2:51 p.m., the registered nurse (RN #5) responsible for MDS and care plans was interviewed about Resident #25's plan regarding pain and non-drug interventions. RN #5 stated the nurses offered and attempted repositioning and encouragement to get out of bed prior to the oxycodone. RN #5 stated the resident's plan of care had not been updated regarding non-drug interventions for pain relief. This finding was reviewed with the administrator and director of nursing during a meeting on 9/1/21 at 3:00 p.m.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		9/24/21

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F 684	Continued From page 14 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 observation, clinical record review, and staff interview, the facility staff failed to follow hospital discharge instructions for one of 20 residents in the survey sample, Resident 62. The facility failed to ensure Resident #62's hospital discharge orders/instructions to follow up with the resident's PCP (primary care physician) were followed. Findings include: Resident #62 was admitted to the facility on 09/10/20. Diagnoses for Resident #62 included, but were not limited to: dementia, high blood pressure, chronic kidney disease, and hypothyroidism. The most current full MDS [minimum data set] assessment was an annual assessment dated 06/21/21. This MDS assessed the resident with a cognitive score of 3, indicating the resident had severe impairment in daily decision making skills. Resident #62 was observed multiple times throughout the survey process on 08/31/21 through 09/02/21. The resident was in her room, on the isolation (COVID) unit, in bed with bilateral knees drawn up toward her abdomen. The resident was in a "low" bed. The resident was in the bed during all observations.	F 684	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. 1)Resident #62 was seen by her primary care physician. 2)Residents admitted from the hospital are at risk of discharge instructions not being followed. 3)Nurses will be reeducated to ensure hospital discharge instructions to see primary care physicians for follow up completed. 4)Admission and readmission charts to be brought to morning meeting to check for any follow up primary care physicians orders and placed on physician list. Will review in weekly QAPI for 3 months. 5)Completion date September 24, 2021	

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During the resident's clinical record review on 09/01/21, the records revealed that Resident #62 was found on the floor in her room on 07/16/21 laying on her lefts side. According to nursing progress notes, their was no apparent injury. On 07/18/21 (two days after the resident's fall) it was documented in the resident's nursing notes that she was crying out in pain when staff were providing care for her and assisting with positioning changes. An X-ray was obtained on 07/18/21. The X-ray impression revealed, "possible hairline subcapital fracture of the proximal femur." The X-ray also documented that a repeat hip series and a CT (computed tomography) scan was recommended for definitive diagnosis. On 07/19/20 the resident was sent to the hospital for a scan, per above recommendations and physician's order. The CT documented, "Acute left greater trochanteric fracture with some mild avulsion..."

On 07/20/21, the resident was discharged from the hospital back to the facility. The hospital discharge instructions documented for the resident to follow up with the resident's PCP in 5 days.

Resident #62's clinical records were reviewed and there was no evidence of a 5 day PCP follow up.

There were no physician progress notes following Resident #62's discharge from the hospital until 08/18/21. This progress note documented, "...Re-certification visit follow up of GERD [gastro-esophageal reflux disease]...patient is alert and oriented x 1...independent of transfers and ambulation...does require assistance for

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F 684	Continued From page 16 ADL's [activities of daily living]...needed tramadol for chronic leg discomfort...tele-medicine was provided from a remote location...full physical exam could not be performed due to COVID 19 isolation...therapy to evaluate and treat as indicated to reduce fall risk and improve overall quality of life..." The resident's CCP [comprehensive care plan] documented, "...observe resident when walking for balance issues and assist as necessary [09/10/20]...functional deficit related to: left femur fracture [07/20/21]...monitor and report changes in physical functioning ability...monitor and report changes in ROM [range of motion] ability [07/20/21]...rehab services as ordered..." The DON [director of nursing] and the administrator were made aware of the above information on 09/02/21 at approximately 10:00 AM. No further information and/or documentation was provided to evidence that Resident #62 had the 5 day PCP follow up after a fall with fracture, as recommended and ordered upon discharge from the hospital on 07/20/21.	F 684		
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.	F 761		9/24/21

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F 761	Continued From page 17 §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 a medication pass and pour observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure drugs and biologicals were labeled during a medication pass and pour observation for one of 4 residents in the medication pass, Resident #20. The facility failed to ensure Resident #20's insulin pen had a pharmacy label. Findings include: Resident #20 was admitted to the facility originally on 04/01/19. Diagnoses for Resident #20 included, but were not limited to: high blood pressure, anxiety, Alzheimer's dementia, hyponatremia, psychotic disorder, schizophrenia, and diabetes mellitus. The most current MDS (minimum data set) was a	F 761	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. 1)The insulin pen for resident #20 was destroyed and replaced with a new pharmacy labeled insulin pen. 2)Residents that use insulin pens are at risk of being affected by this practice. 3)Nurses reeducated on ensuring insulin pens are labeled with the pharmacy label. 4)Weekly audit of insulin pens for proper labeling to be reviewed in weekly QAPI for 3 months. 5)Date of completion September 24,	

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5 day medicare assessment. This MDS assessed the resident with a cognitive score of 11, indicating the resident had moderate impairment in daily decision making skills.

During a medication pass and pour observation on 09/01/21 at 8:15 AM, LPN (Licensed Practical Nurse]) #1 prepared medications for Resident #20. The medications included, but were not limited to: Levemir (insulin) FlexTouch Solution Pen-injector. The Levemir insulin pen did not have a pharmacy label at all. The insulin pen had the first three letters of the resident's last name written with a permanent marker on the insulin pen. The insulin pen also had a round sticker on the insulin pen that documented a space to put a date when the pen was opened, a date to discard the pen and a space for initials (for the person opening the insulin pen). This label was completely blank, there was no open date, no discard date and no initials.

LPN #1 administered 36 units of Levemir insulin using the pen.

At approximately 8:30 AM, LPN #1 was asked about the label. The LPN stated, "It should be labeled." The LPN stated, "It should be dated when opened."

At approximately 2:00 PM, a policy and procedure was requested from the DON [director of nursing] for medication labeling.

A policy titled, "Medications and Medication Labels" documented: "...Medications are labeled in accordance with currently accepted professional principles...to promote safe medication use...Each prescription medication will

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F 761	Continued From page 19 be labeled to include: Resident's name...specific directions for use, including route of administration...medication name...name, address, and telephone number of dispensing pharmacy, prescription number, accessory/precautionary labels indicating storage requirements and special procedures...example: "Shake well"...dispensing pharmacist initials...the nurse shall place a "date opened" sticker on the medication if one is not provided by dispensing pharmacy and enter the date opened..." At approximately 3:30 PM, the administrator, DON [director of nursing], and ICP [infection control preventionist] were made aware of the above information in an end of day meeting with the survey team. No further information and/or documetnation was presented prior to the exit conference on 09/02/21 at 12:15 PM.	F 761		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure physician ordered laboratory services were obtained for one	F 770	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in	9/24/21

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F 770	Continued From page 20 of 20 residents, Resident #6. The findings include: Resident #6 was admitted to the facility on 4/25/2014 with diagnoses that include type 2 diabetes, dementia with behavioral disturbance, hypertension, hyperlipidemia, muscle weakness, bipolar disorder, mood disorder, depression, and anxiety. The most recent minimum data set (MDS) dated 08/25/2021 was a quarterly assessment and assessed Resident #6 as severely cognitively impaired for daily decision making with a score of 7 out of 15. On 09/01/2021, Resident #6's electronic clinical record was reviewed. Observed on the physician's order report were the following laboratory orders: "Dilantin Q3 (every 3) months: Jan, Apr, July, Oct. Start Date: 8/16/2018. Depakote Q3 (every 3) months: Jan, Apr, July, Oct. Start Date 8/6/2018." A review of Resident #6's electronic clinical record did not include the July laboratory results for the Dilantin and Depakote levels. A review of the Lab Administration record for the month of July did not document any labs were drawn nor a refusal from Resident #6. On 09/01/2021 at 9:15 a.m., the licensed practical nurse (LPN #3) was interviewed regarding the location of the laboratory results. LPN #3 stated the results could be find in the resident's paper (hard copy) chart and pending or upcoming laboratory orders could be found in the white [Lab Name] binder. A review of Resident #6's paper (hard copy) chart	F 770	the following plans of correction. 1)Labs have been obtained for resident #6. 2)Residents requiring labs are at risk of being affected by this practice. 3)Reeducate nurses that all ordered labs are to be drawn and any refusals documented. 4)Weekly lab orders will be audited for completion and any refusals documented. Will review in weekly QAPI for 3 months. 5)Date of completion September 24, 2021.	

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F 770	Continued From page 21 and the white laboratory binder did not include laboratory results or pending orders for the above referenced physician orders. On 09/01/2021 at 11:51 a.m., the director of nursing (DON) was asked about the missing laboratory results. The DON stated, "he (Resident #6) may have refused the labs. I will follow-up and let you know." On 09/01/2021 at 3:00 p.m., these findings were discussed during a meeting with the administrator, DON, and infection control nurse. The DON was asked who was responsible for drawing the labs. The DON stated, "it varies, it can be the nurse or the lab. The lab says they have an acquisition for the order, but they believe the resident refused. They are looking for documentation of his refusal." The DON was advised a review of the clinical record did not document Resident #6 refusing any labs for the month of July. On 09/02/2021 at 9:23 a.m., the administrator stated the lab was not able to locate any documentation that Resident #6 refused to have the labs drawn. No additional information was provided to the survey team prior to exit on 09/02/2021.	F 770		
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	F 880		9/24/21

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a 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.

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F 880	Continued From page 23 (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 a medication pass and pour observation, staff interview, clinical record review and facility document review, the facility staff failed to to don gloves for insulin administration, and failed to perform appropriate hand washing after resident contact on one of three nursing wings, A wing (COVID 19 unit); and failed to follow infection control practices during incontinence care for one of 20 residents, Resident #50. Findings include: 1. During a medication pass and pour observation on 09/01/21 at 8:15 AM, LPN (Licensed Practical Nurse) #1 prepared medications for Resident #20. The medications	F 880	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. 1)Clinical staff on the covid unit were reeducated regarding glove use and hand hygiene when giving insulin to resident #20 and when providing incontinence care to resident #50. 2)All residents that receive insulin and incontinence care are at risk of being affected by this practice. 3)Reeducate clinical staff on proper glove use and hand hygiene when giving insulin	

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F 880	Continued From page 24 included, but were not limited to: Levemir [insulin] FlexTouch Solution Pen-injector. LPN #1 adjusted the insulin pen to the prescribed number of units and took the prepared medications to the room of Resident #20. LPN #1 entered the room, went to the resident's bedside and administered the insulin in the resident's abdomen. LPN #1 did not have on gloves. LPN #1 administered the remainder of medications and then disposed of the medicine cup and water cup in the trash can near the sink. LPN #1 then turned on the water, got some soap and washed her hands for approximately 3 seconds, took some paper towels and wiped her hands and turned off the water. LPN #1 then left the room and went to the medication cart with the insulin pen. LPN #1 disposed of the insulin needle in the sharps container, reapplied the cap and put the insulin pen back into the medication cart. LPN #1 did not wipe the insulin pen off prior to putting it back into the medication cart. LPN #1 then proceeded to begin preparation for the next resident. LPN #1 was then made aware of the above observations and lack of hand washing. LPN #1 stopped what she was doing, went over to the nursing desk and got some hand sanitizer and cleansed her hands. When asked if gloves should be worn during insulin administration and how insulin pens should be handled after use, LPN #1 stated, "Probably so, it's something we should do, I should have, I was a little nervous." At approximately 2:00 PM, a policy and procedure was requested from the DON (director of nursing)	F 880	and incontinence care to residents. 4)Random audits of 10 employees a week during insulin administration and /or incontinence care will be conducted and reviewed weekly in QAPI for 3 months. 5)Date of completion September 24, 2021.	

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ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

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for hand washing/wearing gloves and infection practices for medication administration.

A policy titled, "Subcutaneous Insulin" documented, "...perform hand hygiene...determine correct amount of insulin...prepare syringe/pen and safety needle...dial correct dose on pen...Put on gloves...cleanse injection site...insert needle quickly...inject insulin slowly...remove needle...remove gloves..."

At approximately 3:30 PM, the administrator, DON, and ICP (infection control preventionist) were made aware of the above observations and information in an end of day meeting with the survey team.

On 9/02/21 at approximately 10:30 AM, the DON stated that staff should wash their hands while singing the birthday song and gloves were expected to be worn for insulin administration.

No further information and/or documetnation was presented prior to the exit conference on 09/02/21 at 12:15 PM.

2. Resident #50 was admitted to the facility on 7/17/21 with diagnoses that included pulmonary embolism, COVID-19, diabetes, bipolar disorder, chronic kidney disease, atrial fibrillation, hypertension, anemia and dysphagia. The minimum data set (MDS) dated 7/26/21 assessed Resident #50 as cognitively intact, frequently incontinent of bowel/bladder and requiring extensive assistance of two people for toileting and hygiene.

On 9/1/21 at 10:25 a.m., certified nurses' aides (CNA #1 and CNA #2) were observed from the

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hallway providing incontinence care and a brief change for Resident #50. The door to the resident's room was open and there was no privacy curtain pulled around the resident's bed. CNA #1 and CNA #2 were observed wiping and cleaning the resident's buttocks and peri-area following fecal/urinary incontinence.

On 9/1/21 at 10:28 a.m., CNA #1 came out of Resident #50's room into the hallway wearing the gloves used during incontinence care. CNA #1 then returned to the resident's room, removed her gloves and went to the sink. CNA #1 held her hands under the water for no more than two to three seconds and without scrubbing or applying soap, dried her hands with a paper towel. CNA #1 then exited the room and went down the hall to the supply room. After acquiring a new pack of briefs, CNA #1 returned to the resident's room, applied gloves and assisted the resident with the brief change.

On 9/1/21 at 10:35 a.m., CNA #2 came out of Resident #50's room without removing her gloves and went to the clean linen cart positioned in the hall. CNA #2 removed her gloves in the hallway, placed the soiled gloves in her right hand, and searched through the clean linen with the left hand. CNA #2 then walked down the hall past several resident rooms to another linen cart, retrieved a clean gown and then returned to the resident's room. After completion of care, CNA #1 and CNA #2 removed gloves, washed hands and disposed of dirty linens. CNA #1 reported to licensed practical nurse (LPN) #2 that Resident #50 had diarrhea/loose stool.

Resident #50's clinical record documented the resident was on droplet precautions due to

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COVID-19.

On 9/1/21 at 10:40 a.m., CNA #1 was interviewed about not removing gloves and improper hand hygiene during/after incontinence care. CNA #1 stated she should have removed gloves and washed hands prior to leaving the room. CNA #1 stated it had been a "bad" morning and there "was a lot going on back here." CNA #1 stated she was aware that hands were supposed to be washed following personal care.

On 9/1/21 at 10:43 a.m., CNA #2 was interviewed about coming in the hall and accessing the linen cart with soiled gloves/hands. CNA #2 stated she was supposed to take gloves off before leaving the room and should have washed her hands after incontinence care.

This finding was reviewed with the administrator and director of nursing (DON) during a meeting on 9/1/21 at 3:00 p.m.

On 9/2/21 at 10:30 a.m., the DON was interviewed about the hand hygiene observed during Resident #50's incontinence care. The DON stated it was standard nursing practice to avoid wearing soiled gloves in the hallway and to wash hands after incontinence or any personal care. The DON stated aides were expected to sanitize or wash hands prior to care, put on gloves, provide care, dispose of gloves and wash hands prior to leaving the room. The DON stated all staff had been educated in proper hand washing technique that included scrubbing hands for the time it takes to sing the "birthday song."

The facility's policy titled Hand Washing Technique (effective 2/2017) documented, "All

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personnel will wash hands before beginning the treatment/care of a resident and upon completion of such tasks, to prevent the spread of nosocomial infections. Wash hands after removal of gloves or other personal protective barrier equipment." This procedure included in steps for hand washing, "...Wet your hands and wrists, keep fingers pointing downward, allowing for water to run from the least contaminated to the most contaminated areas...Apply soap to hands. Using friction, wash all parts of hands, between fingers, knuckles and wrists for 10 to 15 seconds...Rinse thoroughly...Dry your hands thoroughly with paper towels...your five moments for hand hygiene...before touching a patient...before clean/aseptic procedure...after body fluid exposure risk...after touching patient...after touching patient surroundings..."

The Lippincott Manual of Nursing Practice 11th edition documents on page 843, "Hand hygiene is the single most recommended measure to reduce the risks of transmitting microorganisms...Hand hygiene should be performed between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles; before donning and after removing gloves is vital for infection control...To perform hand hygiene, clean hands with soap and water, applying friction for 15 seconds upon all surfaces of the hands, or applying alcohol-based waterless hand sanitizer covering all surfaces of both hands until completely dry..." Page 847 of this reference documents concerning glove use, "...Gloves are worn to provide a protective barrier and prevent gross contamination of the hands...if used properly, they reduce the transmission of microorganisms...Perform hand hygiene before

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F 880	Continued From page 29 putting on gloves...Change gloves after contact with infective material, such as feces and wound drainage...Remove gloves before leaving the patient's environment and perform appropriate hand hygiene immediately with soap and water or alcohol-based waterless antiseptic agent...As a general practice, examination gloves are not to be worn outside a patient's room..." (1) (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.	F 880		
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide a privacy curtain for one of twenty residents in the survey sample, Resident #53. Resident #53's room had no suspended room curtain installed for privacy. The findings include: Resident #53 was admitted to the facility on 7/31/18 with diagnoses that included Huntington's disease, COVID-19, myopia, anxiety, mood	F 914	To remain in compliance with all federal and state regulations, the center has taken or will take the action set forth in the following plan of correction. 1)Privacy curtain installed in room of resident #53. 2)All residents in a semi-private room are at risk of being affected by this practice. 3)Reeducate maintenance regarding the	9/24/21

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F 914	Continued From page 30 disorder, insomnia, cognitive communication deficit, major depressive disorder, gastroesophageal reflux disease, peptic ulcer disease, osteoarthritis and hypertension. The minimum data set (MDS) dated 7/27/21 assessed Resident #53 with severely impaired cognitive skills and as totally dependent upon staff for dressing and transfers. On 8/31/21 at 3:20 p.m., Resident #53 was observed in her room in a specialized Broda wheelchair with protective floor mats surrounding the chair. The resident's roommate (Resident #28) was in bed at the time of the observation. There was no privacy curtain installed in the room. On 9/1/21 at 10:45 a.m., the certified nurses' aide (CNA #1) caring for Resident #53 was interviewed about the lack of a privacy curtain. CNA #1 stated Resident #53 and her roommate (Resident #28) required assistance with bathing, dressing and incontinence care. CNA #1 stated Resident #53 had a roommate since yesterday and she had provided care for both residents. CNA #1 stated there was no curtain in their room to pull for privacy when providing personal care. On 9/1/21 at 10:50 a.m., the licensed practical nurse (LPN #2) caring for Resident #53 was interviewed about the privacy curtain. LPN #2 stated the room was once private but now had two residents. LPN #2 stated she was not sure if a curtain could be mounted in Resident #53's room. On 9/1/21 at 1:54 p.m., the director of nursing (DON) was interviewed about the privacy curtain. The DON stated Resident #53's room should	F 914	need for a privacy curtain in a semi-private room. 4)Installation of privacy curtains in semi-private rooms will be monitored during care keeper rounds and reviewed in weekly QAPI for 3 months. 5)Date of completion September 25, 2021.	

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F 914	Continued From page 31 have a curtain mounted for privacy as two residents now resided in the room. This finding was reviewed with the administrator and DON during a meeting on 9/1/21 at 3:00 p.m.	F 914		