STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495364	A. BUILDING _____ B. WING _____	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN NECK SENIOR CARE COMMUNITY	20 DELFAE DRIVE *REVISED* WARSAW, VA 22572

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification from 03/02/21 through 03/05/21. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification on 03/02/21 through 03/05/21. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Census: 72 Sample Size: 20 Supplemental Residents: 0 No complaints were investigated during the survey.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for	F 565		4/26/21

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

Electronically Signed | 03/26/2021

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

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F 565	Continued From page 1 providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews, and staff interviews, the facility failed to demonstrate their response to grievances voiced repeatedly by the Resident Council regarding call-light wait times. This deficient practice affected 11 residents who regularly participated in Resident Council meetings and five of 26 initial pool residents (Residents (R) 7, R54, R49, R15, and R20) reviewed for call-light concerns. This failure had the potential to cause accidents, skin breakdown, infection, and/or psycho-social distress related to long wait times. Findings include: After permission from the Resident Council	F 565	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. It is the policy of NNSC to ensure that resident/family group and responses are met according to 42 CFR 483 subpart B. All residents have the potential to be affected by this alleged deficient practice 2. Resident 7, 54, 49, 15 and 20 have had their call light concerns addressed.	

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F 565	Continued From page 2 President, a review of the "Resident Council Meeting Minutes" for the past five months (October 2020 through February 2021) was completed. The minutes indicated council members voiced concerns regarding call light response times on the following dates: a. 10/19/20 "Call light concerns." b. 11/20/20 "CNA's not helping residents in a timely manner when call lights are activated." c. 12/16/20 "Call lights not answered in timely manner." d. 01/13/21 "Call lights not answered in timely manner." e. 02/17/21 "CNA's not answering call lights in timely manner." On 03/02/21 at 3:37 PM, R54 stated, "There's not enough staff here." R54 stated he did not use his call light often, but usually waited a long time when he did. R54 stated he had not experienced any adverse outcome related to untimely call light response. On 03/03/21 at 11:12 AM, R49 stated, The facility did not have enough staff to help her without having to wait a long time. Additionally, R49 stated she sometimes had to wait for up to one hour for call light response; but had not had an accident because of this. On 03/03/21 at 2:36 PM, observation was made of R15 with her call light on and crying as she sat in her wheelchair. R15 stated she had to go to the bathroom. At 2:46 PM, the surveyor requested staff assistance at which time the staff assisted her with a Hoyer Lift. On 03/04/21 at 10:33 AM, interview with Resident	F 565	The Director of Nursing/Designee will reeducate clinical staff on call light response time. This education will include answering call lights in a timely manner and effectively communicating with residents to accurately understand their individual needs. An audit has been performed of all grievances from resident council meetings since (date of last annual survey 3/5/21) to ensure that grievances stated in resident council meetings were addressed, to include call light response times. Grievances not addressed will be discussed at the next resident council on 3/31/21. 3. Social services director will forward grievances related to call lights to the nursing department for resolution. The Administrator or designee will review grievance log routinely to ensure compliance 4. The SS Director/Designee will review the grievance log to identify resident grievances related to call lights and notify the nursing department for resolution. Director of Nursing/Designee will perform a call light response time audit 5 times weekly on each shift for 4 weeks and monthly thereafter until substantial compliance is achieved. Results of audits will be shared with the QAPI committee. Any patterns or trends will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. 4/26/21	

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F 565	Continued From page 3	F 565		

Council President (R7) revealed that after a Resident Council meeting, minutes were given to administration with no follow-up received back to the Resident Council. R7 stated the main concern of Resident Council was call light times. R7 added that he had personally waited 30 minutes for his call light to be answered.

On 03/04/21 at 12:38 PM, interview with the Director of Nursing (DON) revealed she felt resident concerns were responded to; however, she could not provide evidence of follow-up with resident council. The DON stated that "nursing huddles" took place weekly and resident concerns were addressed. The "huddle minutes" for six dates 10/29/20, 10/30/20, 12/02/20, 12/09/20, and 01/07/21 were provided and reviewed. Each of the "huddle minutes" documented that "Call light times are an issue and everyone's responsibility." The DON added that a new call system was installed in February 2021 and did not record call light times. She stated random audits were performed by nursing administration to monitor call light times. Audit documentation was not provided to confirm that audits were performed.

On 03/04/21 at 12:48 PM, the response to grievances policy was requested from the DON but was not provided prior to survey exit on 03/05/21 at 8:00 PM.

On 03/04/21 at 3:12 PM, the DON provided the "Nurse Meeting Agenda" for 02/23/21. Though call light response was not an item on the agenda, she stated that the call light times were addressed in this meeting. The DON was asked for clarification and stated that call lights were covered under "Charge Nurse, What are your

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F 565	Continued From page 4 responsibilities." There was no documentation that this was covered in the meeting. On 03/04/21 at 3:52 PM, interview with the Administrator about call light response times revealed he did not believe residents were waiting extended amounts of time for their call lights to be answered. "The Resident Council Meeting "Minutes" for five months (October 2020 through February 2021) were reviewed with the Administrator. The Administrator was informed of additional resident interviews that demonstrated ongoing concerns with call light wait times. The Administrator was unable to provide any additional follow-up to the repeated resident complaints. On 03/04/21 4:05 PM, interview with R20 revealed, "I must wait for my call light to be answered, depending on what nursing staff is working on that particular day."	F 565		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review it was determined the facility failed to provide activities of daily living (ADL) care for three of 20 sampled residents (Residents (R) 2, R44, and R63) who were unable to carry out ADL care without assistance. Specifically, the facility failed to provide/assist R2, R44, and R63 with facial grooming. This continued practice had	F 677	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation	4/26/21

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F 677	Continued From page 5 the potential to affect the residents' psychosocial well-being related to self-esteem and dignity. Findings include: Review of the facility's policy titled "Activities of Daily Living (ADLs), Supporting" revision date of March 2018 revealed, " ...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident and in accordance with the plan of care, including support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care ...If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just refuse or declining care." 1. Review R2's annual "Minimum Data Set (MDS)", found in the "MDS" tab in the electronic health record (EHR), with an Assessment Reference Date (ARD) of 04/06/20 revealed the resident was admitted on 05/15/18. R2's "Brief Interview for Mental Status (BIMS)" score was two out of 15 indicating R2 had severe cognitive impairment. R2 was documented as not having any behaviors, including the rejection of care. Review of the resident's functional status indicated the resident required extensive assistance of one staff member to maintain personal hygiene including combing hair, brushing teeth, and shaving. R2's active diagnoses included Alzheimer's disease, dementia, psychotic disorder, and anxiety. Review of R2's "Care Plan" found in the "Care Plan" tab in EHR, revealed that R2 "Required assistance with ADLs and mobility due to cognitive deficit, potential for further decline due	F 677	requirements. 1. It is the policy of NNSC to ensure that ADL care is provided for dependent residents. Dependent residents on staff for ADL'S are potentially at risk for this alleged deficient practice. Dependent residents will be identified and grooming provided according to their plan of care and as needed. 2. Residents #2, #44 and #63 have had facial hair trimmed and plans of care have been updated to address the residents' personal grooming needs and preferences, to include residents' rights to refuse care. A visual assessment/audit has been performed on residents to assess for facial hair. Residents identified to have facial hair have been offered the appropriate ADL care and those residents' plans of care have been updated to address personal grooming needs preferences and rights to and refusal of care. 3. The Director of Nursing/Designee will reeducate nursing assistants on performing ADL care on residents to include grooming, trimming of facial hair, residents' rights to refuse care, and updating plans of care to address individual residents' grooming preferences and noncompliance. 4. The Director of Nursing/Designee will perform a visual assessment/audit of 50% of dependent residents weekly for 4 week and monthly for 3 months or until substantial compliance is achieved to ensure that facial hair has been trimmed, and the residents' plans of care reflect their personal grooming preferences. The	

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F 677	Continued From page 6 to disease progression, dependent for bathing, requires extensive assistance with ...toileting, hygiene, dressing." The interventions included "Assist with ADLs (bathing, transfers, bed mobility, and grooming. Further review of R2's "Care Plan" revealed there was no evidence the resident refused assistance with ADLs or care by staff and there were no interventions in place to address refusal of care. Further review of R2's "Progress Notes" found in the "Progress Notes" tab in the EHR failed to indicate the resident had refused to be groomed and/or any interventions had been attempted to provide grooming to the resident. During the initial observations of the "Memory Care" unit on 03/02/21 at 11:51 AM, R2 was seated in her wheelchair in the dining room at a table asleep. She was observed to have several long gray hairs located on her chin. Observations conducted on 03/03/21, 03/04/21, and 03/05/21 revealed no evidence that R2 had been groomed. 2. Review of R44's quarterly "MDS", found in the "MDS" tab in the EHR, with an ARD of 02/16/21 revealed the resident was admitted to the facility on 08/26/20. R44's "BIMS" score was five out of 15 indicating the resident was severely cognitively impaired. R44 was documented as not having any behaviors, including the rejection of care. Review of the R44s' functional status indicated the resident required supervision of one staff member to maintain personal hygiene including combing hair, brushing teeth, and shaving. R44's active diagnoses included cerebral infarction (stroke), lack of coordination, and other	F 677	Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. 4/26/21	

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F 677	Continued From page 7 symptoms and signs involving cognitive functions and awareness. Review of R44's "Care Plan" found in the "Care Plan" tab in the EHR, revealed R44 had an "ADL self-care performance deficit related to cognitive deficit." The interventions included " ...check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse ...resident is able to: assist with bathing and showers. Allow sufficient time for dressing and undressing. Praise all efforts at self-care." Resident "Had a cerebral vascular accident [stroke] related to ETOH [alcohol] abuse." Interventions included " ...monitor and document [resident's] abilities for ADLs and assist as needed. Encourage (resident) to do what he is capable of doing for self." Further review of R44's "Care Plan" revealed there was no evidence the resident refused assistance with ADLs or care by staff and there were no interventions in place to address refusal of care. Further review of R44's "Progress Notes" found in the "Progress Notes" tab in the EHR failed to indicate the resident had refused to be groomed and/or any interventions had been attempted to provide grooming to the resident. During the initial observations of the "Memory Care" unit on 03/02/21 at 12:42 PM, R44 was seated at a table in the dining room. The resident had a thick growth of facial hair. R44 was asked if he was growing a beard; he laughed, rubbing the facial hair, and stated "No, I would like to shave." Observations conducted on 03/03/21, 03/04/21, and 03/05/21 revealed no evidence that R44 had been groomed.	F 677		

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F 677	Continued From page 8 3. Review of R63's quarterly "MDS" found in the "MDS" tab in the EHR, with an ARD of 02/25/21 revealed the resident was admitted to the facility on 01/16/19. R63's "BIMS" score was two out of 15 which indicated the resident was severely cognitively impaired. R63 was documented as not having any behaviors, including the rejection of care. Review of the R63's functional status indicated the resident required set-up care only and supervision to maintain personal hygiene including combing hair, brushing teeth, and shaving. R63's active diagnoses included progressive neurological conditions, dementia, cerebrovascular accident (stroke), anxiety, depression, and psychotic disorder (other than schizophrenia). Review of R63's "Care Plan", found in the "Care Plan" tab in the EHR, revealed R63 "Required assistance with ADLs and mobility related to dementia, impaired mobility, abilities fluctuate due to cognitive deficits. Requires supervision and/or set-up with meals, with occasional limited assistance, limited assistance with bed mobility, transfers, extensive assistance with dressing, hygiene, dependent for bathing, remains independent in walking and locomotion." The interventions included, "Assist with ADLs (bathing, bed mobility, transfers, dressing, grooming, toileting feeding, ambulation) if resident is unable to complete ...Report any decline in ability to participate/perform ADL care." Further review of R63's "Care Plan" revealed there was no evidence the resident refused assistance with ADLs or care by staff and there were no interventions in place to address refusal of care.	F 677		

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F 677	Continued From page 9	F 677		

Further review of R63's "Progress Notes" found in the "Progress Notes" tab in the EHR failed to indicate the resident had refused to be groomed and/or any interventions had been attempted to provide grooming to the resident.

During the initial observations of the "Memory Care" unit on 03/02/21 at 11:42 AM, R63 was sitting in the dining area at a table coloring, she was observed to have multiple long gray hairs on her chin.

Observations conducted on 03/03/21, 03/04/21, and 03/05/21 revealed no evidence that R63 had been groomed.

During an interview conducted with Certified Nurse Aide (CNA) 3 on 03/04/21 at 4:16 PM the CNA was asked when residents had facial hair removed. CNA3 stated, when we give baths and showers, we shave them if they let us. The CNA was asked what was done if the residents will not let you bathe or shower them. The CNA stated, we document that they refuse.

During an interview conducted with CNA 1 on 03/05/21 at 4:10 PM, the CNA was asked why R2, R44, and R63 had not been groomed. CNA 1 stated, she did not know about the other two residents [R2 and R63], but [R44] doesn't want to be shaved. CNA 1 stated, "I can go shave him now." When asked what she does when the resident refused care, CNA 1 stated "I just chart it as refused."

During an interview with the Assistant Director of Nursing (ADON) on 03/05/21 at 4:00 PM, she was asked where it was documented when a resident refused care and what other

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F 677	Continued From page 10 interventions were put into place to assist in making sure the residents received ADL care. The ADON stated, "I am sure it is documented somewhere, probably on paper. It's their right to refuse." On 03/05/21 at 4:30 PM, the Director of Nursing (DON) confirmed that R2, R44, and R63 had facial hair that had not been groomed. The DON was asked what her expectations were of the nursing staff to provide grooming for the residents. The DON stated, "I expect the staff to ensure there is no facial hair present, especially on female residents." The DON was asked what the staff were to do if a resident refused to be groomed. The DON stated, "The staff should document and make the nurse aware the resident refused care. The staff should also address it in the resident's care plan with appropriate interventions."	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		4/26/21

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F 692	Continued From page 11 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure one of four residents (Resident (R) 49) reviewed for nutrition received a therapeutic diet when there was a nutritional problem and the health care provider ordered a therapeutic diet. This failure placed R49 at risk of unplanned weight loss, nutritional deficiency, and choking or aspiration. Findings include: Review of R49's annual "Minimum Data Set (MDS)" assessment, found in the "MDS" tab in the electronic health record (EHR), with an Assessment Reference Date (ARD) of 02/12/21, revealed R49 did not receive a mechanically-altered diet. Review of R49's 03/02/21 "Care Plan," found in the "Care Plan" tab of the EHR revealed it addressed weight loss related to a progression of disease process and immobility. Interventions included assessment by the dietitian, supplements as ordered, weekly weight monitoring, lab tests as ordered, and food intake monitoring. Review of R49's "Physician's Orders," found in the "Orders" tab of the EHR, revealed an order for a "Regular diet, Mechanical Chopped texture" diet, which originated on 03/03/21.	F 692	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Resident 49's diet orders were verified and updated in the SNO system to ensure the resident is receiving the correct diet per MD order as well as plan of care. 2. The facility has determined that residents receiving a therapeutic diet have the potential to be affected. An audit of residents receiving therapeutic diet was performed 3/31/21 to ensure that SNO (Simplified Nutrition Online) matches the diet ordered in PCC (Point Click Care). 3. Therapeutic diet changes will be presented to the kitchen in written communication form from nursing staff. Therapeutic Diet changes will then be verified and changed in the SNO (Simplified Nutrition Online) system to match what has been put in PCC by the CDM (certified dietary manager). Diet conversion education was provided to CDM (certified dietary manager) by	

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	495364	A. BUILDING _____ B. WING _____	03/05/2021

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F 692	Continued From page 12 The facility's 03/05/21 lunch menu "Recipe Production Report" documented the following should have been served for a mechanical soft diet: -Beef meatloaf, ground -Roasted and seasoned red potatoes -Chopped broccoli florets in lemon sauce -Buttered dinner roll -Soft peanut butter cookie Beginning at 11:24 AM on 03/05/21, lunch service was observed in the kitchen. R49's meal tray card documented she was on a regular diet with chopped meats. She was served meatloaf, diced into cubes, cubed red potatoes, regular broccoli (not chopped in small pieces), a dinner roll, and a peanut butter cookie. On 03/05/21 at 1:00 PM, the Dietary Manager (DM) stated the diet orders input into the EHR system should automatically communicate with his menu software; however, he had noticed the communication was not occurring. The DM stated he would need to request the staff pass on a hard copy or email of any new diet orders to ensure they were corrected in the system. The DM stated he had not received any communication regarding R49's diet order on 03/03/21. The DM stated he would need to do an audit to ensure all diet orders are correct in his software. The DM stated R49's diet order reflected in his menu software was regular consistency with chopped meats. On 03/05/21 at 4:15 PM, the Director of Nursing (DON) stated she had not been alerted to the communication problem between the software programs, and she was under the impression	F 692	Regional Director on April 1, 2021. 4. CDM/designee will perform weekly audits of residents receiving therapeutic diets to ensure that diet orders in SNO match PCC for consistency and therapeutic accuracy. Audits will be completed weekly for 4 weeks and monthly for 3 months until substantial compliance has been achieved. The CDM/designee will identify any patterns or trends and report to the QAPI committee at least quarterly. 5. 4/26/21.	

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F 692	Continued From page 13 new diet orders were immediately communicated to the kitchen software. She stated the staff used to do a handwritten order change notification, and she would re-implement this process until the software systems were able to correctly communicate. Review of the facility's October 2019 "Therapeutic Diets" policy revealed, "Therapeutic diet is defined as a diet ordered by a physician or delegated registered or licensed dietician as part of the treatment for a disease or clinical condition . . . to provide food that a resident is able to eat (e.g. mechanically altered diet.). Mechanically altered diet means one in which the texture of the diet is altered . . . Diets are prepared in accordance with the guidelines in the approved diet manual and the individualized plan of care."	F 692		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident	F 726		4/26/21

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F 726	Continued From page 14 assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure that one of nine observed licensed or registered nurses (Licensed Practical Nurse (LPN) 1) received the specific competencies and skill sets necessary to use and clean the glucometer in a sanitary manner. This failure increased the potential to spread blood-borne pathogens among the three residents (Resident (R) 219, R47, and R15), out of seven residents with orders for finger-stick blood glucose testing, who tested with the same multi-use glucometer. Findings include: Review of the 01/5/21 "Facility Assessment Tool" revealed, "We accept residents with: . . . Diabetes . . . . All staff are licensed, certified, and trained as per job description requirements; new employees are oriented, and training is supplemented as needed to meet high standards of technical and other competencies. Staff member upon hire date, annually, and on a need basis, are trained on the following topics and	F 726	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. It is the policy of NNSC to ensure that care is provided by competent staff. All residents have the potential to be affected by this alleged deficient practice. 2. On 3/5/21 and on 3/6/2021, LPN #1 has received specific competencies and skill sets necessary to use and clean glucometers in a sanitary manner. Residents # 219 was not identified in the sample. Resident # 47 and 15 continue to receive finger stick blood glucose test with a clean and sanitized glucometer. 3. Licensed staff were re-educated on 3/2, 3/3, 3/5/21 on the proper use,	

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F 726	Continued From page 15 competencies through computer based learning, off site training, and one on one sessions: . . . Infection control. . . ." Observation revealed LPN1 did not follow correct procedures for infection control during use and cleaning of the glucometer. On 03/02/21 at 12:15 PM, LPN1 was observed performing a finger-stick blood glucose test for R219, who was under contact and droplet precautions. The LPN was gowned and gloved; she reached under her gown to retrieve the lancet from her pocket. She then reached back under her gown and removed the glucometer from her uniform pocket. LPN1 did not clean the glucometer after removing it from her pocket; she then used it to test R219's blood sugar. After testing, LPN1 placed the glucometer on the over-bed table, without first placing a clean barrier down or disinfecting the table. LPN1 wiped the resident's finger and applied a bandage. Without first sanitizing her hands, she picked up the glucometer and used an alcohol wipe to wipe off the glucometer. She then put the glucometer under her gown and into her uniform pocket and exited the room. Interview with LPN1 on 03/02/21 at 12:15 PM revealed she had worked at the facility for five months, and she had not received training on using or cleaning the facility's glucometer. However, LPN1 stated she had used the Assure Platinum Glucometer before in other positions. LPN1 stated she used an alcohol wipe to clean the glucometer after use; however, this was against facility procedure and manufacturer's instructions for disinfection of the device (Cross-reference F880: Infection Control). On 03/02/21 at 2:48 PM, the Infection	F 726	cleaning, disinfecting and storage of the Assure Platinum Glucometer utilizing the manufacturer's guidelines. The training included a demonstration of proper technique by the DON/Designee and return demonstrations by (Licensed staff) to ensure competency. After re-education and return demonstration, an observation audit was performed with LPN #1 on 3/5/21 and licensed staff to assure understanding of manufacturer's instructions on cleaning and disinfecting the assure platinum glucometer 4. The Director of Nursing/Designee will perform an observation audit on residents receiving finger stick blood glucose to assure that the glucometer is cleaned per manufacturer's guideline. Audits will be completed on each shift weekly for 4 weeks and monthly for 3 months until substantial compliance is achieved. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. 4/26/21	

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F 726	Continued From page 16 Preventionist (IP), who also served as the director of staff development, stated she had only been employed at the facility for 30 days and did not know if LPN1 had received training on glucometer use and cleaning. On 03/02/21 at 2:50 PM, the DON stated she was unsure whether LPN1 had been trained on the use and care of the glucometer. Education records for LPN1 regarding glucometer use and disinfection were requested; however, none were provided prior to survey exit on 03/05/21 at 8:00 PM. Review of LPN1's undated training "Transcript" revealed she received orientation training on 09/15/20. In addition, she received training on "Infection Prevention" on 10/31/20. However, review of the training offered in orientation and ongoing training revealed there was no content addressing the use and care of the glucometer.	F 726		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as	F 803		4/26/21

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F 803	Continued From page 17 input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure menus were followed for the 17 residents who received a pureed or mechanical soft diet out of a total census of 72. Specifically, these 17 residents did not receive a dinner roll as called for on the menu, and the five residents on a pureed diet did not receive foods that were on the menu. This failure had the potential to cause weight loss or nutritional deficiencies for these 17 residents on mechanical soft or pureed diets. Findings include: The facility's 03/05/21 lunch menu "Recipe Production Report" documented the following should have been served for a mechanical soft diet: -Beef meatloaf, ground -Roasted and seasoned red potatoes -Chopped broccoli florets in lemon sauce -Buttered dinner roll -Soft peanut butter cookie The facility's 03/05/21 lunch menu "Recipe	F 803	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. It is the policy of NNSC to ensure that resident menus meet their needs, and are prepared with the nutritional needs with the resident in mind. All residents have the potential to be affected by this alleged practice. All residents have the potential to be affected by the alleged deficient practice. A tray audit was performed on 3/5/2021 and is ongoing to ensure residents received the correct food items according to the dietary order and consistency. 2. An audit was performed by CDM on 3/5/2021 to ensure meal items were served to match what is on the menu and audits are ongoing.	

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F 803	Continued From page 18 Production Report" documented the following should have been served for a pureed diet: -Beef meatloaf, pureed -Mashed potatoes -Pureed buttered broccoli florets -Pureed buttered dinner roll -Pureed peanut butter cookie On 03/05/21 beginning at 11:24 AM, Cook1 was observed as she served the lunch meal in the kitchen. The 12 residents who received a mechanical soft diet received ground meatloaf, mashed potatoes, regular broccoli florets (not chopped in small pieces), and dessert. The five residents who received a pureed diet were served pureed, pre-packaged meat patties, mashed potatoes, pureed pre-packaged green beans, and dessert. The dinner roll, as called for on the menu, was not served for all residents on either mechanical soft or pureed diets. On 03/05/21 at 12:20 PM, the Dietary Manager (DM) stated there was no reason why the residents on mechanical soft diets should not have been served a dinner roll. He stated the cook should have prepared a pureed dinner roll for the five residents on pureed diets, but he did not know whether or not it had been prepared. On 03/05/21 at 12:30 PM, Cook1 stated she had not made any pureed bread for the meal, as the bread was no longer pre-prepared from the vendor as she was used to, and she had run out of time to prepare pureed bread. Cook1 stated she would serve bread with mechanical soft meals when the bread was soft enough, but the rolls served today were wheat and were well-browned, so she felt the rolls were too hard to be served for residents with mechanical soft	F 803	3. Culinary staff will be re-educated on how to read tray cards and how to follow menus as created. In-service sheets to be signed by culinary staff members given by CDM. If the food necessary is not available, the cook should notify the CDM immediately. 4. CDM/designee will perform weekly tray audits for 4 weeks to ensure residents receive the correct items as per the menu. Results of audits will be presented to QAPI committee. CDM/designee will identify any trends or patterns and report to QAPI committee quarterly. 5. 4/26/21.	

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F 803	Continued From page 19 diets. Cook1 added the previous food vendor supplied pre-packaged and formed pureed foods, and she thought the pre-packaged, pureed meat patties and green beans were left over from the previous vendor. She stated the new food vendor did not supply pre-packaged and formed pureed foods. Review of the facility's October 2019 "Menus" policy revealed, "The Registered Dietitian/Nutritionist (RDN) or other clinically qualified nutrition professional reviews and approves menus . . . Menus are served as written, unless changed in response to preference, unavailability of an item, or a special meal."	F 803		
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure food was prepared in a form designed to meet the individual needs of the 12 residents who received a mechanical soft diet. This failure had the potential to cause coughing, choking, aspiration, or nutritional deficiencies for these 12 residents on mechanical soft diets. Findings include: The facility's 03/05/21 lunch menu "Recipe	F 805	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. It is the policy of NNSC to ensure that resident menus met their needs, and are prepared with the nutritional needs of the	4/26/21

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F 805	Continued From page 20 Production Report" documented the following should have been served for a mechanical soft diet: -Beef meatloaf, ground -Roasted and seasoned red potatoes -Chopped broccoli florets in lemon sauce -Buttered dinner roll -Soft peanut butter cookie On 03/05/21 beginning at 11:24 AM, Cook1 was observed as she served the lunch meal in the kitchen. The 12 residents who received a mechanical soft diet received ground meatloaf, mashed potatoes, regular broccoli florets, and dessert. The broccoli served had one-to-three inch long pieces of long stems and large florets that were completely intact; the broccoli had not been chopped. On 03/05/21 at 12:20 PM, the Dietary Manager (DM) stated the broccoli the cook was serving was not appropriate for residents receiving a mechanical soft diet. The DM stated the broccoli florets should have been chopped into bite-size pieces for these 12 residents. On 03/05/21 at 12:30 PM, Cook1 stated she felt the broccoli was over-steamed today, so she felt like it was soft enough to be served to residents with mechanical soft diets, even though the menu called for chopped broccoli. On 03/05/21 at 12:35 PM, a test tray containing the regular broccoli florets that were also served to residents on mechanical soft diets was evaluated. The broccoli stems were tough and crisp. The broccoli florets were large and had to be cut into pieces when eating. The broccoli did not feel over-steamed or extremely soft.	F 805	resident in mind. All residents have the potential to be affected by this alleged practice. All residents on pureed or mechanical soft diets have the potential to be affected by the alleged deficient practice. A tray audit was performed on 3/5/2021 and is ongoing to ensure residents received the correct food items according to the dietary order and consistency. 2. An audit was performed by CDM on 3/5/2021 to ensure meal items were served to match what is on the menu and audits are ongoing. 3. Culinary staff will be re-educated on how to read tray cards and how to follow menus as created. In-service sheets to be signed by culinary staff members given by CDM. If the cook is unsure of the consistency or the food necessary is not available, the cook should notify the CDM immediately. 4. CDM/designee will perform weekly tray audits for 4 weeks to ensure residents receive the correct items as per the menu. Results of audits will be presented to QAPI committee. CDM/designee will identify any trends or patterns and report to QAPI committee quarterly. 5. 4/26/21.	

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F 805	Continued From page 21 Review of the facility's October 2019 "Therapeutic Diets" policy revealed, "Mechanically altered diet means one in which the texture of the diet is altered. When the texture is modified, the type of texture must be specific and part of the physicians' or delegated registered or licensed dietitian's order. . . . Diets are prepared in accordance with the guidelines in the approved diet manual and the individualized plan of care."	F 805		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure foods stored in the kitchen were labeled, dated, not expired, and sealed. These failures had the	F 812	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or	4/26/21

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F 812	Continued From page 22 potential to increase the prevalence and spread of foodborne illness and infection to all 72 facility residents. Findings include: On 03/02/21 at 9:38 AM, during the initial tour of the kitchen, the following were observed: In a stand-alone refrigerator near the handwashing sink, there was smoked ham in a zipper bag that was not sealed and cheese slices and lemon pudding in plastic containers with the lids resting on top, not sealed closed. On the countertop near the toaster, there were two tubs of peanut butter that were open but were not dated when opened and a bag of bread, halfway full and sealed with a tie, that was not dated when opened. In the stand-alone refrigerator near the dry storage area, there was one dessert wrapped in plastic wrap with no label or date on it. In the dry storage pantry, there was a tub of vanilla cream icing that had been opened on 01/05/21. Per the label, it could be stored at room temperature for only one week. There was an open bag of flour that was not sealed or dated when opened, resting on top of the flour storage container. There was a box of dried hash brown potatoes that was not sealed closed. Additionally, there were five bags of dried pasta that were partly used and tied in a knot to seal that did not have dates when opened. In the walk-in freezer, there were bags, tied in knots to seal, of sausage patties, French toast	F 812	that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. It is the policy of NNSC to ensure food is procured, stored, and prepared in a sanitary manner. Residents receiving meals from the kitchen have the potential to be affected by this alleged deficient practice. Certified Dietary Manager/Cook performed a walk-through and discarded out-of-date items, ensured all products were sealed and labeled correctly. 2. CDM (Certified Dietary Manager)/Cook will perform AM/PM walk-throughs to verify all items are sealed, labeled and dated per policy. Any items found out of compliance will be discarded. 3. Culinary staff will be educated on the proper labeling/dating/sealing as per policy. 4. CDM(Certified Dietary Manager)/Cook will perform AM/PM walk-throughs audits for 4 weeks and monthly x 3 months until substantial compliance is achieved. CDM will present audit findings and any trends/patterns to the QAPI committee on a quarterly basis. 5. 4/26/21.	

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F 812	Continued From page 23 sticks, and pastries that were not labeled or dated. During follow-up kitchen observations on 03/05/21 beginning at 11:24 AM, the following were observed: In the pantry, the five open bags of pasta, tied at the top, were again observed without dates of opening. There was a bag of gingerbread mix, folded at the top but not sealed, without a date when opened. The open, unsealed box of hash browns remained. There was also a tub of peanut butter that was opened, but not dated when opened. In the walk-in freezer, the plastic bags, tied at the top, with French toast sticks, pastries, and meat patties remained. There was also a plastic bag, tied at the top, of peas that had no label or date. On the counter near the toaster, the two tubs of peanut butter that were open and undated, and an undated bag of bread, closed with a tie at the top, remained. On 03/05/21 at 12:20 PM, the Dietary Manager (DM) stated the staff were supposed to date foods when they were opened and store foods in sealed containers. He stated when foods were stored in plastic bags, they should be labeled with the type of food and the date they were stored. Review of the facility's October 2019 "Food Storage: Cold" policy revealed, "The Dining Services Director/Cook(s) insures [sic] that all food items are stored properly in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination."	F 812		

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (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:	F 880		4/26/21

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F 880	Continued From page 25 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review, the facility staff failed to ensure a multi-use glucometer was cleaned between residents with an EPA registered disinfectant when performing fingerstick blood glucose testing on one of three residents (Resident (R) 219). This failure had the increased likelihood of transmission of blood borne pathogens between the three residents (R219, R47, and R15) undergoing fingerstick blood glucose [sugar] testing on Dogwood wing.	F 880	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. It is the policy of NNSC to ensure staff know all residents on transmission-based	

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F 880	Continued From page 26 In addition, the facility failed to ensure personnel protective equipment (PPE) was appropriately doffed after caring for a resident on contact and droplet precautions by one staff member in one of three units. This failure increased the potential for transmission of COVID-19 to a resident not on precautions. Findings include: 1. On 03/02/21 at 12:15 PM, observation of Resident (R) 219, who was under contact and droplet precautions, revealed Licensed Practical Nurse (LPN)1 in the resident's room preparing to perform a finger stick blood glucose check on the resident. The LPN was gowned and gloved; she reached under her gown to retrieve the lancet from her pocket. She then reached back under her gown and removed the glucometer from her uniform pocket. LPN1 did not clean the glucometer after removing it from her pocket; she then used it to test R219's blood sugar. After testing, LPN1 placed the glucometer on the over-bed table, without first placing a clean barrier down or disinfecting the table. LPN1 wiped the resident's finger and applied a bandage. Without first sanitizing her hands, she picked up the glucometer and used an alcohol wipe to wipe off the glucometer. She then put the glucometer under her gown and into her uniform pocket and exited the room. Interview with the LPN1 on 03/02/21 at 12:15 PM revealed she had worked at the facility for five months, and she had not received training on using or cleaning the facility's glucometer. However, LPN1 stated she had used the Assure Platinum Glucometer before in other positions.	F 880	precautions. All residents have the potential to be affected by this deficient practice. Resident #119 is no longer on Transmission-based precautions. Resident #59 was not identified on resident sample list provided. Reeducation of LPN #1 on disinfecting of glucometers has been addressed in the IJ removal plan. LPN #1 has been reeducated on the proper use of PPE in rooms of residents on transmission-based precautions 2. LPN #1 has been reeducated on the proper use of PPE in rooms of residents on transmission-based precautions on 3/6/2021. All LPNs and RNs have been reeducated in the proper use of PPE in rooms of residents on transmission-based precautions. The education included a demonstration of proper technique by the DON/Designee and return demonstrations by all LPNs and RNs to ensure competency. After reeducation and return demonstration, an observation audit was performed on all LPNs and RNs to assess compliance in proper use of PPE in resident rooms. All LPNs and RNs have been reeducated in the proper cleaning and disinfection of glucometers, as well as proper use of PPE in rooms of residents on transmission-based precautions. The education included a demonstration of proper technique by the DON/Designee and return demonstrations by all LPNs and RNs to ensure competency. After reeducation and return demonstration, an observation audit was performed on all LPNs and RNs to assess compliance in proper cleaning and disinfection of	

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F 880	Continued From page 27 LPN1 stated she typically used an alcohol wipe to clean the glucometer after use, and the glucometer was used for multiple residents. LPN1 stated that there were three medication carts, and each contained only one glucometer to serve all the residents in the area. LPN1 stated after the above observation, she put the glucometer back in the medication cart without additional cleaning or disinfection. On 03/02/21 at 2:48 PM, the Infection Preventionist (IP) stated she had only been employed at the facility for 30 days and did not know if LPN1 had received training on glucometer use and cleaning. She stated germicidal wipes (PDI Super Sani-Clothes) were to be used to disinfect the glucometer; one wipe for a clean glucometer and two wipes if blood was present on the glucometer. She stated the glucometer was then allowed to dry for one minute. Interview at 4:00 PM on 03/02/21 with the DON and the Chief Nursing Officer/VP of Clinical Operations revealed the expectation for glucometer cleaning was to clean the glucometer between each resident with a germicidal wipe following the appropriate contact time as directed on the wipe label. The DON stated LPN1 did not follow the correct facility protocol. Interview on 03/02/21 at 6:20 PM with LPN2 revealed the medication cart served the Dogwood wing where R219 resided, and there were two additional residents on the wing who required finger-stick blood glucose checks R47 and R15). Per LPN2, the medication cart for the wing contained one glucometer that was used for all three residents.	F 880	glucometers and proper use of PPE in resident rooms. 3. The Director of Nursing/Designee will reeducate RNs and LPNs on the proper use of PPE in resident rooms, including residents on transmission-based precautions upon hire and on an as-needed basis. The Director of Nursing/Designee will reeducate RNs and LPNs on properly cleaning and disinfecting glucometers upon hire and on as as-needed basis. The Director of Nursing/Designee will reeducate RNs and LPNs on the proper use of PPE in resident rooms, including residents on transmission-based precautions upon hire and on an as-needed basis. 4. The DON/Designee will perform an observation audit on 5 LPNs or RNs 2x weekly for 4 weeks to assess competency in usage of proper PPE in rooms of residents on transmission-based precautions. Reeducation will be provided to staff as needed. The Director of Nursing/Designee will perform an observation audit on 5 LPNs or RNs weekly for 6 weeks to assess competency in proper cleaning and disinfecting and storage of glucometers. The DON/Designee will perform an observation audit on 5 LPNs or RNs weekly for 6 weeks to assess competency in usage of proper PPE in rooms of residents on transmission-based precautions. Reeducation will be provided to staff as needed. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance	

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F 880	Continued From page 28 Per R47's "Medication Administration Record (MAR)," R47 received finger-stick glucose monitoring with the same multi-use glucometer from LPN1 at 11:00 AM on 03/02/21. R47 received finger-stick glucose monitoring with the same multi-use glucometer from LPN2 at 4:00 PM on 03/02/21. Per R15's "MAR," R15 received finger-stick glucose monitoring with the same multi-use glucometer at 6:00 AM on 03/02/21. On 03/02/21 at 7:45 PM, the Director of Nursing (DON) stated that the facility's glucometer did not store information from previous finger-sticks, as it was not calibrated to do so. She stated the "MAR" reflected the additional two residents received finger-stick blood glucose checks, and confirmed the glucometer dedicated to the medication cart was the only glucometer used for that wing [Dogwood] and confirmed that all three residents received finger-sticks from the same glucometer. Review of the manufacturer's instructions for the Assure Platinum Glucometer revealed it directed the staff to use an Environmental Protection Agency (EPA)-registered disinfectant detergent or germicide wipe. The instructions documented, "To use a wipe, remove from container and follow product label instructions to disinfect the meter. Take extreme care not to get liquid in the test strip and key code ports of the meter. Many wipes act as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used; use one wipe to clean and a second wipe to disinfect." Review of the instructions on the "PDI Super Sani-Cloth" container label revealed, "To disinfect nonfood contact surfaces only: Unfold a clean wipe and thoroughly wet surface. Allow treated	F 880	Improvement Committee at least quarterly. 5. 4/26/21	

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F 880	Continued From page 29 surface to remain wet for two (2) minutes. Let air dry. For heavily soiled surfaces, use a wipe to pre-clean prior to disinfecting." The PDI Super Sani-Cloth contained isopropyl alcohol, quaternary ammonium, and ammonium chloride. Review of the facility's March 2014 "Schedule for Cleaning, Disinfection, and/or Disposal of Equipment" policy revealed "10% bleach wipes" were to be used on the outside of the meter. The policy did not address specific procedures for use and cleaning of the glucometer. The facility's 01/21/2020 "Isolation Precautions" policy documented, "When possible, dedicate the use of non-critical resident-care equipment to single resident to avoid sharing between residents (i.e., use of disposable thermometer, single use BP [blood pressure] cuff and stethoscope, etc.). If use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another resident using bleach wipes." The facility's immediate jeopardy removal plan indicated: "All licensed nursing staff will be trained on proper handling and cleaning of glucometers per facility protocols and also per the manufacturer's guidelines. Competencies were completed on 03/02/21 and 03/03/21 with nursing staff to ensure understanding and compliance. This was started 03/02/21 immediately upon notification of the concern by the surveyors and each licensed nurse who uses the glucometer will be in-serviced and have return demonstration prior to their next scheduled assignment of glucometer administration. Additionally, the glucometer was cleaned and sanitized at approximately 11:15 am	F 880		

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F 880	Continued From page 30 on 03/03/21. The facility's procedure on cleaning glucometers was revised on 03/02/21 to ensure shared glucometers are cleaned as outlined below and also utilizing the manufacturer's guidelines. System Change: The process for handling glucometers has been changed. See below. Process for Cleaning Glucometer 1. Licensed staff will clean glucometer before and after each resident/patient use. 2. Glucometers will be cleaned and disinfected utilizing the purple top wipes (germicidal disposable wipes-Sani-wipes). 3. Use l wipe if no visible blood is noted. (allow 2-minute dwell time). 4. If blood is noted, use 2 wipes. One wipe to clean and another wipe to disinfect. 5. Wipes will be applied in a manner of the manufacturer's instruction including "wet time" and "drying" time (2 minutes) 6. Glucometers must be transported in a clean manner, ensuring that the glucometer does not come in contact with any potentially contaminated surface. (Glucometers must be placed in a Ziploc bag). 7. Gather all required supplies before entering room. 8. Wash your hands with soap and water or apply an ABHR. [Alcohol-Based Hand Rub] 9. Clean glucometer with germicide disposable wipes and place in a Ziplock bag prior to entering room. 10. Perform hand hygiene prior to wearing your PPE [Personal Protective Equipment]. Wear PPE if applicable.	F 880		

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F 880	Continued From page 31 12. Prior to starting procedure to obtain blood, place a surgical drape down prior to taking the glucometer out of the bag. 13. Place glucometer on the barrier and prepare for procedure. 14. Perform the procedure. 15. After the procedure is complete, remove gloves, dispose Ziplock bag in trash, (wash hands with soap and water or use hand sanitizer) 16. Clean the glucometer with a Sani-wipe (1 wipe to clean and 2 wipes if visibly soiled with blood) and place the cleaned glucometer on a field drape. 17. Wash hands or perform hand hygiene. 18. Take glucometer back to the med cart, disinfect again with Sani-wipes, allow 2 minutes dwell time prior to placing in the med cart. Education: 8 out of 9 licensed staff and 100% of nursing management staff were in-serviced on 03/02/21 and 03/03/21 on disinfecting glucometers per facility protocol and based on the procedure outlined above. Per diem staff will be in-serviced prior to the start of their next scheduled shift. Monitoring: Director of Nursing or designee with conduct routine audits of residents that require fingerstick to ensure compliance with the cleaning and disinfecting protocol for glucometers. Audits will be completed daily for a week and weekly thereafter until such time substantial compliance is achieved. Results of audits will be reviewed by the QA [Quality Assurance] team monthly times 3 months. If variances are observed, the nurse will be immediately re-educated." Validation of the immediate jeopardy removal plan included:	F 880		

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F 880	Continued From page 32 Policy Review: Review of the facility's policy and process titled, "Schedule for Cleaning, Disinfection, and/or Disposal of Equipment" and "Process for Cleaning Glucometer," revision date 03/02/21, revealed the policy had been revised to reflect the protocol described in the facility's IJ Removal Plan (above). Training: Review of the 03/02/21 through 03/05/21 "Education Attendance Records" indicated one-to-one training on the "Glucometer Cleaning Procedure" was completed. The procedure included in the training reflected the procedure documented in the facility's IJ Removal Plan. Additionally, competency audits were conducted for all staff who received training. As of 03/05/21 at 8:30 AM, 20 licensed clinical staff had completed the "Glucometer Cleaning Procedure" education and competency testing. The records revealed the DON, ADON, IP, and Unit Manager had received training and competency testing. In addition, seven of seven LPNs who were on the schedule from 03/02/21 to 03/05/21 received training and competency testing (100%), and four of four Registered Nurses (RNs) on the schedule received training and competency testing. In total, 12 of 21 facility LPNs have received training and competency testing, and four of eight facility RNs received training and competency testing. Per the Administrator on 03/04/21 at 10:30 AM, the additional staff who had not yet received training would be trained prior to starting their next scheduled shift, as they were PRN (as needed) workers.	F 880		

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F 880	Continued From page 33 Observations: Surveyors conducted observations of the nursing staff performing the handling and cleaning of a glucometer for the following nurses: On 03/04/21 at 4:15 PM, RN3 was observed performing a finger stick blood sugar test and handling and the handling/cleaning the glucometer. The facility's revised protocol was followed. On 03/04/21 at 4:16 PM, LPN3 was observed performing a finger stick blood sugar test and the handling/cleaning the glucometer. The facility' revised protocol was followed. On 03/05/21 at 11:04 AM, LPN1 was observed performing a finger stick blood sugar test and handling/cleaning the glucometer. The facility's revised protocol was followed. On 03/05/21 at 11:21 AM, RN2 was observed performing a finger stick blood sugar test and handling/cleaning the glucometer. The facility's revised protocol was followed. On 03/05/2021 at 11:40 AM, LPN4 was observed performing a finger stick blood sugar test and handling/cleaning the glucometer. The facility's revised protocol was followed. 2. On 03/02/21 at 12:40 PM, R119's room was observed with signage at the entrance indicating the resident was on transmission-based precautions (TBP), and Personal Protective Equipment (PPE) including gown and gloves, was to be used when caring for the resident. There	F 880		

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	495364	A. BUILDING _____ B. WING _____	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN NECK SENIOR CARE COMMUNITY	20 DELFAE DRIVE *REVISED* WARSAW, VA 22572

(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
F 880	Continued From page 34 was a cart containing the appropriate PPE in front of R119's room. On 03/02/21 at 12:41 PM, R59's room was observed without any signage indicating TBP were required, and there was no PPE cart in front of R59's room. On 03/02/21 at 12:43 PM, LPN1 was observed as she donned a gown from a paper bag in the hallway that was not labeled with a room number or date, just her name. She entered R119's room and assisted the resident with a breathing treatment apparatus. LPN1 exited the room, removed her gloves, and sanitized her hands with alcohol-based hand sanitizer. While still wearing her gown, LPN1 began to input data in the computer on top of the medication cart in the hallway. She then pushed the medication cart down to the opposite end of the hall. While in the same gown, LPN1 entered R59's room and washed her hands. She exited the room, and still while wearing the same gown, began working on the computer on the medication cart in the hallway. At 12:52 PM, LPN1 re-entered R59's room to administer oral medications to the resident, still wearing the gown. At 12:55 PM, LPN1 exited the room and doffed her gown and put it back in the paper bag hanging in the hall. She wrote the date on the bag but did not label the bag with a room number or resident name. On 03/02/21 at 12:55 PM, LPN1 stated she thought R119 and R59 were both on contact and isolation precautions; however, when it was pointed out that R59's room did not contain signage indicating TBP were in place or a PPE cart at the door, LPN1 stated, "I'm not sure. It looks like she may have been taken off. I don't	F 880		

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	495364	A. BUILDING _____ B. WING _____	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN NECK SENIOR CARE COMMUNITY	20 DELFAE DRIVE *REVISED* WARSAW, VA 22572

(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
F 880	Continued From page 35	F 880		

usually work on this hall." When asked how gowns were supposed to be donned, doffed, and stored, LPN1 stated she did not know. She stated she usually used one gown for her shift, which she wore into each room on TBP, and discarded her gown at the end of her shift.

On 03/02/21 at 2:48 PM, Certified Nurse Aide (CNA) 2 stated staff were to use one gown per resident. She stated each paper bag should be labeled with the staff name and the room number, including bed number if there are two residents in a room. She stated the date should also be included on the bag, and usually changed daily. CNA2 also explained that R119 was on TBP, but R59 was not. She stated the residents on TBP had signage on the door, and a PPE cart at the entrance, to indicate such.

On 03/05/21 at 4:00 PM, the DON and IP were interviewed concurrently. The IP stated LPN1 had received training on correct PPE use for residents on TBP. The DON stated she expected staff to use dedicated gowns for each resident on TBP, and to change their gown between every interaction, to minimize the chance of spreading infection. She stated a gown used for a resident on TBP should not be also used for a resident who was not on TBP, as this could introduce infection to the resident.

Review of LPN1's undated training "Transcript" documented she received training on "COVID-19 Awareness" on 09/16/20, the "CDC/CMS COVID nursing home front line training" on 10/27/20, "Infection Prevention" on 10/31/20, and "Infection Prevention for COVID-19" on 11/16/20.

Review of the facility's 01/31/20 policy titled,

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	495364	A. BUILDING _____ B. WING _____	03/05/2021

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F 880	Continued From page 36 "Isolation Precautions" revealed, "Removal of PPE: Gloves, gown, mask, eye protection or face shield will be removed before leaving the room. Do not wear when exiting the resident's room."	F 880		