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	495368	A. BUILDING ______ B. WING ______	04/22/2021

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/20/2021 through 04/22/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced {Medicare/Medicaid} standard survey was conducted 04/20/2021 through 04/22/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 60 certified bed facility was 32 at the time of the survey. The survey sample consisted of 22 current Resident reviews and 2 closed record reviews.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		5/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/06/2021

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 578	Continued From page 1 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, staff interviews and facility document review the facility staff failed to ensure that 5 of 24 residents in the survey sample were allowed to participate in and/or formulate an advance directive upon admission, Residents #180, #181, #230, #231 and #26. The findings included: 1. Resident #180 was admitted to the facility on	F 578	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 faclity is in compliance with participation requirements.	

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F 578

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4/14/2021 with diagnoses to include but not limited to Right Femur Fracture, Hypertension and Spina Bifida. Due to Resident #180 being a new admission the Minimum Data Set was not scheduled to be started until 4/20/21 therefore a current Brief Interview for Mental Status was not available. However, based on nursing notes and an initial interview with Resident #180 she was determined to be alert and oriented.

During a review of Resident #180's electronic medical record I was unable to locate an Advance Directive or documentation to show the facility discussed or helped to formulate an Advance Directive for the resident.

Resident #180's Physician Orders were reviewed and are documented in part, as follows:

Full Code
Notes:
Instructions:
Order Date: 4/14/2021.

On 4/22/21 at 11:10 A.M. a phone interview was conducted with the Administrator and the Director of Nursing regarding Resident #180's Advance Directives being formulated upon admission. The Administrator was asked if the facility discussed or helped formulate Advance Directives for Resident #180 and completed the Initial Assessment for Advance Directives form and if so where was it located in Resident #180's medical record. The Administrator stated, "No, the Advance Directive Form is not in there, (the medical record)." The Administrator stated, "We do discuss it with them whether it be the Doctor, Nurse Practitioner or admissions and it is documented by someone. We have a solid

F 578

1. The Advance Directive assessment form was completed for resident numbers 180, 181, 230, 231 and 26 by 4/30/21.

2. The Social Worker/Designee will complete the Advance Directive assessment form within 7 days of admission and with comprehensive assessments

3. The Social Worker was educated on use of advance directive form per policy and will complete a form for every new admission with in 7 days of admission

4. The Administrator/Designee will conduct a weekly review of clinical record for all new admits for 6 weeks to ensure completion of the advance directive assessment form. Any issue noted will be corrected immediately and trends will be reported to our Quality Assurance Committee at least quarterly.

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F 578	Continued From page 3	F 578		

process that it was discussed and what the outcome was. Everything we have we have sent to you."

The facility policy titled "Advance Directives" last reviewed 1/10/12 was reviewed and is documented in part, as follows:

Policy: Advance Directives will be discussed with resident and/or family member upon admission or as soon as clinically appropriate so the resident's wishes, with respect to life prolonging treatments, can be documented in the medical record.

Procedure and Advance Directives will be:

1. The admissions staff/social worker will attempt to obtain Advance Directives information from the resident, family and/or hospital staff during the admission process and document the information on the Initial Assessment for Advance Directives form. If advance directive information is provided, then this information will be placed in the resident's medical record.

On 2/22/21 at 5:45 P.M. a pre-exit debriefing was conducted with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.

2. Resident #181 was admitted to the facility on 4/16/2021 with diagnoses to include but not limited to Stage 3 Chronic Kidney Disease, Acute Kidney Failure and Hypertension. Due to Resident #181 being a new admission the Minimum Data Set was not scheduled to be started until 4/22/21 therefore a current Brief Interview for Mental Status was not available.

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However, based on nursing notes and an initial interview with Resident #180 she was determined to be alert and oriented.

During a review of Resident#181's electronic medical record I was unable to locate an Advance Directive or documentation to show the facility discussed or helped to formulate an Advance Directive for the resident.

Resident #181's Physician Orders were reviewed and are documented in part, as follows:

Do Not Resuscitate
Notes:
Instructions:
Order Date: 4/16/2021.

On 4/22/21 at 11:10 A.M. a phone interview was conducted with the Administrator and the Director of Nursing regarding Resident #181's Advance Directives being formulated upon admission. The Administrator was asked if the facility discussed or helped formulate Advance Directives for Resident #181 and completed the Initial Assessment for Advance Directives form and if so where was it located in Resident #181's medical record. The Administrator stated, "No, the Advance Directive Form is not in there, (the medical record)." The Administrator stated, "We do discuss it with them whether it be the Doctor, Nurse Practitioner or admissions and it is documented by someone. We have a solid process that it was discussed and what the outcome was. Everything we have we have sent to you."

The facility policy titled "Advance Directives" last reviewed 1/10/12 was reviewed and is

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documented in part, as follows:

Policy: Advance Directives will be discussed with resident and/or family member upon admission or as soon as clinically appropriate so the resident's wishes, with respect to life prolonging treatments, can be documented in the medical record.

Procedure and Advance Directives will be:

1. The admissions staff/social worker will attempt to obtain Advance Directives information from the resident, family and/or hospital staff during the admission process and document the information on the Initial Assessment for Advance Directives form. If advance directive information is provided, then this information will be placed in the resident's medical record.

On 2/22/21 at 5:45 P.M. a pre-exit debriefing was conducted with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.

3. Resident #230 was admitted to the facility on 4/12/21 with diagnoses that included but were not limited to sepsis, acute and chronic respiratory failure with hypoxia, chronic heart failure, morbid obesity, and high blood pressure. Resident #230 did not have a completed MDS (Minimum Data Set) assessment at this time. Resident #230 was documented as being alert and cognitively intact.

Review of Resident #230's admission orders revealed a "DNR (Do Not Resuscitate)" order. This order was initiated on 4/12/21.

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Review of Resident #230's DDNR (Durable Do Not Resuscitate Order) form signed by the resident and dated 4/9/21 documented in part, the following: "The patient is capable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment."

On 4/20/21 at 2:06 p.m., an interview was conducted with Resident #230. She could not recall anything about an advanced directive.

There was no evidence in Resident #230's clinical record showing that advanced directives were discussed with Resident #230 and whether she had already executed an advanced directive or given the opportunity to formulate one.

On 4/22/21 at 9:16 a.m., an interview was conducted with OSM (Other Staff Member) #2, the facility social worker. When asked if she had a role in discussing advanced directives with residents, OSM #2 stated that upon admission the only thing she will do is inquire if the resident already has an advanced directive and if so she will request that a family member bring it in. OSM #2 stated that if the resident is not cognitively intact, she will mail a form to the RP (Responsible Party) requesting that the advanced directive be brought into the facility if one has already been developed. OSM #2 stated that she didn't actually go over how to formulate an advanced directive with residents. OSM #2 stated she wasn't sure the staff member responsible for assisting with formulating an advanced directive.

On 4/22/21 at 9:27 a.m., an interview was conducted with ASM #1, the facility Administrator.

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ASM #1 stated that the resident's provider (physician) will usually go over advanced directives with each resident, such as what their wishes are for treatment etc. ASM #1 stated that not all the time will the provider document this discussion.

Review of Resident #230's provider notes dated 4/12/21 and 4/15/21, failed to evidence that Resident #230 was given the opportunity to formulate an advanced directive.

On 4/22/21 at 5:47 p.m., the Administrator and the DON (Director of Nursing) were made aware of the above concerns.

4. Resident #231 was admitted to the facility on 4/12/21 with diagnoses that included but were not limited to atrial fibrillation, cerebral palsy, high blood pressure, stroke, and altered mental status. Resident #231 did not have a completed MDS (Minimum Data Set) assessment at this time.

On 4/20/21 through 4/21/21 this writer had several interactions with Resident #231. Resident #231 had periods of confusion during these interactions.

Review of Resident #231's POS (physician order summary) revealed the following order: "Full Code." This order was initiated on 4/12/21.

There was no evidence in Resident #231's clinical record showing that advanced directives were discussed with Resident #231 or her representative and whether she had already executed an advanced directive or given the opportunity to formulate one.

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On 4/22/21 at 9:16 a.m., an interview was conducted with OSM (Other Staff Member) #2, the facility social worker. When asked if she had a role in discussing advanced directives with residents, OSM #2 stated that upon admission the only thing she will do is inquire if the resident already has an advanced directive and if so she will request that a family member brings it in. OSM #2 stated that if the resident is not cognitively intact, she will mail a form to the RP (Responsible Party) requesting that the advanced directive be brought into the facility if one has already been developed. OSM #2 stated that she didn't actually go over how to formulate an advanced directive with residents. OSM #2 stated she wasn't sure the staff member responsible for assisting with formulating an advanced directive.

On 4/22/21 at 9:27 a.m., an interview was conducted with ASM #1, the facility Administrator. ASM #1 stated that the resident's provider (physician) will usually go over advanced directives with each resident, such as what their wishes are for treatment etc. ASM #1 stated that not all the time will the provider document this discussion.

Review of Resident #231's provider notes dated 4/15/21, failed to evidence that Resident #231 was given the opportunity to formulate an advanced directive.

On 4/22/21 at 5:47 p.m., the Administrator and the DON (Director of Nursing) were made aware of the above concerns.

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5. The facility staff failed to ensure Resident #26 was given the opportunity to formulate an Advance Directive.
Resident #26 was admitted to the facility on 04/01/21. Diagnosis for Resident #26 included but not limited to Acute Kidney Failure.

Review of Resident #26's Physician Order Sheet (POS) for April 2021 revealed the following order: Full Code starting on 04/02/21.

The review of Resident #26's clinical record did not show evidence of an Advance Directive.

On 04/22/21 at approximately 8:45 a.m., a phone interview was conducted with the Social Worker (SW) who said
if a resident is their own representative, they are asked if they have an Advance Directive and if so, to provide a copy for their clinical record. If the resident is not their own representative or not able to make their own decision, then their representative is asked to provide a copy of their Advance Directive.

The Social Worker said there is an Advance Care Planning document which is part of the admission packet. The surveyor and the SW reviewed Resident #26's clinical record together but was not able to locate the an Advance Care Planning document, an Advance Directive or documentation that an Advance Directive was discussed with Resident #26 or her representative. When asked if Resident #26 was given the Advance Care Planning document or asked if they wanted information related to an Advance Directive, she replied, "Not with me, I

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F 578	Continued From page 10 did not bring it up." The Administrator, Director of Nursing, Assistant Director of Nursing and Cooperate Nurse were informed during the debriefing on 04/22/21 at approximately 5:40 p.m. The facility did not present any further information about the findings. The facility provided the following document: Advance Care Planning Assessment that read in part: Residents and/or responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at times in condition, and periodically for routine updating of care plans.	F 578		

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F 578	Continued From page 11 .	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580		5/28/21

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F 580	Continued From page 12 update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review the facility's staff failed to inform the resident representative of an acute condition and the necessity start a new treatment for 1 of 24 residents (Resident 24), in the survey sample. The findings included: Resident #24 was originally admitted to the facility 4/1/21 and had never been discharged from the facility. The current diagnoses included; cognitive impairment and right wrist pain. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/6/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #24's cognitive abilities for daily decision making were moderately impaired. In section"G" (Physical functioning) the resident was coded as requiring total care of one person	F 580	1. Resdident #24 confirmed that she wishes for her daughter to be made aware of any changes. The daughter of Resident #24 was updated on chest xray results and changes to the resident's plan of care on 4/26/21. The resident's medical record was updated to list her daughter as first contact for any changes. 2. The Social Worker/designee will review all residents who are listed as their own responsible party and review with the resident if they have another person they wish to be notified of any changes. If any changes of notifications are identified, then the information will be updated in the resident's medical record. The Director of Nursing/designee will review all current resident records from the past 30 days to ensure resident representatives were made aware, when applicable, of any changes in condition. If there are any changes that were not communicated to the resident representative, then the	

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with bathing, extensive assistance of one with walking in room, dressing and toileting, limited assistance of one with transfers, locomotion, personal hygiene and supervision of one with eating.

On 4/20/21 at approximately 1:40 p.m., Resident #24 stated her side was hurting and there had been concern with the right wrist. The resident further stated x-rays had been completed approximately one week ago and she had just been told an antibiotic would be started later today for the the left side pain was pneumonia.

Review of the physician/Nurse Practitioner's (NP) progress notes revealed the following; on 4/12/21 the resident's chief complaint was right wrist pain and follow-up of secretions. The narrative read " Also complained of right wrist pain on movement or palpation; no trauma but is using hands more that she is in physical therapy. Has slight swelling at the base of the thumb, is able to use her hand to eat, etc. Has not tried anything to make it better but is taking routine Tylenol every morning. Tenderness on palpation to the base of thumb and fat pad. The plan x-ray of the right wrist. The 4/19/21, the physician/Nurse Practitioner's (NP) progress notes revealed the following; chief complaint; bilateral lower extremity edema, congestion and pain with breathing". "Resident states she has left upper chest pain and palpation and called it pleurisy. Afebrile but an occasional cough. The plan chest x-ray to rule out pneumonia. Lasix for seven days.

On 4/20/21 at approximately 3:40 p.m., an interview was conducted with Registered Nurse #1 who stated x-ray results could be found in the paper record for a resident.

F 580

resident's representative will be updated on the resident's condition.

3. The Administrator/designee will in-service the social worker and the admission team on identifying a resident respresentative with a resident. The in-service included a review of discussing with residents who are their own responsible party if they wish to have a resident representative listed for notification of changes. The social worker/designee will review with all new admissions if they wish to designate a resident representative for notification of changes. The Director of Nursing/designee will in-service LPNs and RNs on notification to a resident's representatives when there is a change in condition.

4. The Administrator/Designee will audit 20% of new admissions who are listed as their own responsible party weekly for six weeks to ensure it has been discussed with them if they wish to have someone listed as their resident representative for notification of changes. The Director of Nursing/designee will audit 20% of resident charts weekly for six weeks to ensure the resident representative was made aware of any changes in condition, when applicable. The Administrator/designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement Committee at least quarterly.

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Further review of the clinical record revealed on 4/20/21, the NP ordered Avelox (an antibiotic) 400 milligrams by mouth once daily for 14 days for pneumonia and Lasix (a fluid pill) 40 milligrams, one by mouth daily for six days on 4/21/21 for bilateral lower extremity edema.

On 4/21/21 at approximately 10:45 a.m., Resident #24's paper record was reviewed but the x-ray results were observed in the paper record; therefore an interview was conducted with the Director of Nursing (DON). The DON viewed the resident's "hard chart" (paper record) but was unable to locate the x-ray results. After viewing two other books, the x-ray results were located in the physician/NP's notebook. The X-ray result dated 4/13/21, was of the right wrist. The result read under impression degenerative arthritis and soft tissue swelling.. The report was signed by the NP 4/13/21. The second x-ray report for Resident #24 was dated 4/19/2, it was a chest x-ray which revealed rales of the left lung. The impression read mild scattered interstitial pneumonia, no tuberculosis is seem. This report had not been signed by a practitioner. The DON stated after x-rays are reviewed by the physician/NP they are to filed in the "hard chart" by the night shift (11 p.m. - 7 a.m.) nurse.

On 4/22/21 at approximately 9:00 a.m. an interview was conducted with the resident's Power of Attorney/daughter. The daughter stated Resident #24 shared with her on 4/20/21 the NP ordered an antibiotic on her because she had pneumonia and that explained why her side was hurting. The daughter stated no one representing the facility called to inform her of new medications or of a change in her mother's status. The

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F 580	Continued From page 15 daughter further stated that was her major concern with the facility; communication wasn't effective and she couldn't visit her mother to see for herself. Review of the clinical record on 4/22/21 didn't reveal documentation the daughter had been notified of the changes in care related to the x-ray report and observations by the NP. On 4/22/21 at approximately 5:20 p.m., the above information was shared with the Administrator, DON, ADON and the Vice president of Nursing. The DON stated Resident #24's daughter should have been notified of the x-ray results and addition of new medications.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and clinical record review the facility staff failed to ensure for 1 of 24 residents in the survey sample, Resident #13, that the residents status was accurately reflected in the Resident Assessment. The findings included: Resident #13 was originally admitted to the facility on 09/11/2018. Resident #13 was discharged to another nursing home on 11/29/2020 and readmitted to the facility on 12/16/2020. Diagnosis included but were not limited to Parkinson's Disease and Dementia with Lewy	F 641	1. The MDS for Resident #13 with ARD on 12/23/2020 was modified on 4/23/2021 to accurately reflect the limitations in range of motion, which were present on readmit. The MDS staff were re-educated on the importance of accurately coding limitations in range of motion. 2. The Managed Care Coordinator/designee will review all MDSs completed in the past 30 days to ensure limitations in range of motion were accurately coded on the MDS. Any variances identified will be corrected in	5/28/21

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Bodies. Resident #13's Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 03/08/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 00 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #13 as requiring extensive assistance of 1 for eating and extensive assistance of 2 for bed mobility and toilet use and total dependence of 1 for dressing and personal hygiene and total dependence of 2 for transfer and bathing.

On 04/21/2021 at 5:30 p.m., an interview was conducted with the Director of Nursing. When asked if Resident #13 had contractures prior to contracting COVID and transferring to another nursing home, Director of Nursing stated, "No, he was rigid due to his Parkinson's but not contracted. He was readmitted with contractures." When asked if he had been seen by therapy, DON stated, "Yes." Requested Physical Therapy notes.

On 04/22/2021 at 1:30 P.M., an interview was conducted with Occupational Therapist. When asked if Resident #13 had contractures to his extremities prior to his transfer to another nursing home, Occupational Therapist stated, "(Resident Name) left the facility with full range of motion and came back from the COVID Unit with severe contractures." COVID Unit was at another facility.

On 04/22/2021 received copies of Occupational and Physical Therapy notes. Review of therapy notes revealed the following: Admission Date: 12/16/2020 Therapeutic Activities Note: PTA (Physical Therapy Assistant) performed PROM (Passive Range of Motion)/stretching to LE's

F 641

accordance with the RAI manual.

3. The Director of Nursing/designee will in-service all RNs and LPNs on Observing a Resident for Limitations in Range of Motion. The in-service will include, but is not limited to, a review of checking all residents for any limitations in range of motion during the admission assessment and with the MDS. The admitting nurse is responsible for ensuring limitations in range of motion are noted on the admission assessment.

4. The Director of Nursing/Designee will audit 20% of MDS completed weekly for six weeks to ensure the any observed limitations in range of motion are accurately coded on the MDS. The Director of Nursing/Designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement Committee at least quarterly.

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(Lower Extremities) in supine into extension, pt (Patient) very resistive and unable to maintain extension in (B) (Bilateral) LE's. Pt. c/o (Complain of) pain with movement; yelling at therapist and throwing hands in the air. Pt demo (B) LE flexion contracture.; OT (Occupational) Daily Document 12/17/2020 OT Self Care/ADL's (Activities of Daily Living) Note: Pt. positioned in bed to prevent further LE contractures per OT goal."; PT (Physical Therapy) Daily Document 12/17/2020 PT Therapeutic Activities Note: BLE (Bilateral Lower Extremities) flexion contracture w (With)/ limited PROM.; OT Daily Document 12/18/2020 OT Therapeutic Activities Note: Pt. positioned in geri chair to prevent further LE contractures per OT goal.; PT Daily Document 12/18/2020 PT Therapeutic Activities Note: Attempt LE PROM, pt. contracted and resistant to motion............require 2 staff to ensure pt. safety 2/2 hip flexion contractures.

On 04/22/2021 requested copies of Minimum Data Sets that were completed after readmission on 12/16/2020. Minimum Data Sets were received. Review of Minimum Data Sets revealed the following:

Minimum Data Set A2300. Assessment Reference Date Observation end date: 12-23-2020 G0400. Functional Limitation in Range of Motion Coding: 0. No impairment 1. Impairment on one side 2. Impairment on both sides A. Upper extremity (shoulder, elbow,wrist,hand) coded with 0 indicating no impairment. B. Lower extremity (hip, knee, ankle, foot) coded with 0 indicating no impairment.

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Minimum Data Set A2300. Assessment Reference Date Observation end date: 03-08-2021 G0400. Functional Limitation in Range of Motion Coding: 0. No impairment 1. Impairment on one side 2. Impairment on both sides A. Upper extremity (shoulder, elbow, wrist, hand) coded with 0 indicating no impairment. B. Lower extremity (hip, knee, ankle, foot) coded with 2 indicating impairment on both sides.

An interview was conducted with MDS Coordinator on 04/22/2021 at 1:45 p.m. When asked how do you obtain information to complete an Minimum Data Set, MDS Coordinator stated, "I look at records for look back period of time, meet the resident and talk to them." It was discussed that PT and OT documented in their notes during the period of 12/16/2020 through 12/23/2020 that Resident #13 had lower extremity contractures. Requested that MDS Coordinator review Admission Minimum Data Set with Assessment Reference Date of 12/23/2020. It was discussed that the Admission Minimum Data Set with the Assessment Reference Date of 12/23/2020 does not reflect the resident's contractures in his lower legs. MDS Coordinator stated, "I interviewed (Resident Name.)" When asked did you check Resident #13 for contractures, MDS Coordinator stated, "I don't remember."

On 04/22/2021 at 4:00 p.m., an interview was conducted with Assistant Director of Nursing (ADON). When asked if the Admission Minimum Data Set with the Assessment Reference Date of 12/23/2020 was an accurate assessment, indicating that Resident #13 had no impairment in range of motion, ADON stated, "No, should do a correction MDS to ensure it gets captured."

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F 641	Continued From page 19 The Administrator, Director of Nursing, Assistant Director of Nursing and Corporate Nurse were made aware of the finding at the pre-exit meeting on 04/22/2021 at approximately 6:45 p.m. No further information was provided.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed to provide physician ordered wound treatment to 1 of 24 residents in the survey sample, Resident #13. The findings included: Resident #13 was originally admitted to the facility on 09/11/2018. Resident #13 was discharged to another nursing home on 11/29/2020 and readmitted to the facility on 12/16/2020. Diagnosis included but were not limited to Parkinson's Disease and Dementia with Lewy Bodies. Resident #13's Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date of 03/08/2021 was coded with a BIMS (Brief Interview for Mental Status) score of	F 684	1. The wound treatment to resident #13 was completed as ordered by the physician on 4/21/2021 with no negative effects noted to the resident. 2. The Director of Nursing /designee will inspect all residents with a wound dressing to ensure they were completed as ordered. If variances are identified, they will be corrected to ensure wound care has been provided as ordered. 3. The Director of Nursing/designee will in-service RNs and LPNs who are responsible for the wound care Wound Care Completion and Documentation. The in-service included a review of ensuring wound care is provided as	5/28/21

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00 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #13 as requiring extensive assistance of 1 for eating and extensive assistance of 2 for bed mobility and toilet use and total dependence of 1 for dressing and personal hygiene and total dependence of 2 for transfer and bathing.

On 04/21/2021 at 2:35 p.m., in at Resident #13's bedside to observe Assistant Director of Nursing (ADON) perform wound care. ADON performed hand hygiene and applied gloves. Observed the ADON remove a dressing that was covering wounds on the residents sacrum and right buttocks. Observed 4/18 was written on the dressing. When asked how often should the treatments to the residents sacrum and right buttocks be done, ADON stated, "Suppose to be done daily."

Copy of Treatment Administration Record for April 2021 was requested on 04/21/2021.

Copy of Wound Care Policy and Procedure was requested on 04/21/2021.

Copy of Treatment Administration Record for April 2021 was received on 04/22/2021.

Copy of Dressing Change (Clean) Policy was received on 04/22/2021.

On 04/22/2021 at approximately 9:00 a.m., review of Resident #13's April 2021 Treatment Administration Record revealed the following: Wound Care One Time Daily Starting 03/22/2021 Order Date: 3/22/2021 Notes: Sacral Wound - apply puracol ultra powder and a small amount of anasept gel then place a Large Allevyn foam

F 684

ordered and of signing off ordered wound care after it has been completed. The assigned nurse is responsible for ensuring wound care is completed on their residents during their shift and that the order should not be signed off until the wound care has been completed. If for any reason wound care is not able to be completed as ordered, the on-coming nurse will be notified for follow up.

4. The Director of Nursing/Designee will inspect 20% of resident□s with wound dressings weekly for six weeks to ensure the dressing has been changed as ordered. The Director of Nursing/Designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement Committee at least quarterly.

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dressing once daily and prn (As Needed) soiling. Observed ADON's initials in the spaces dated for the 19th and 20th; Wound Care One Time Daily Starting 04/13/2021 Order Date: 4/13/2021 Instructions: Right buttocks: Cleanse wound, pat dry, apply puracol ultra powder and a small amount of anasept gel and cover with the large foam dressing once daily and prn soiling. Observed ADON's initials in the spaces dated for the 19th and 20th.

On 04/22/2021 at 4:20 p.m., an interview was conducted with the ADON. When asked what do your initials on the treatment administration record on the 19th and 20th indicate, ADON stated, "Indicates it should have been done." The ADON stated, "I did the treatment on the 19th even though the dressing was dated 4/18. I saw my initials on the dressing and 4/18 but I did the treatment on the 19th." When asked were the treatments done on the 20th, ADON stated, "I did not do the treatment on the 20th because the Wound Doctor was suppose to come in but because of the survey she did not come in." When asked should the treatments to the sacrum and right buttocks be done everyday, ADON stated, "Yes ma'am."

The Administrator, Director of Nursing, Assistant Director of Nursing and Corporate Nurse were made aware of the finding at the pre-exit meeting on 04/22/2021 at approximately 6:45 p.m. No further information was provided.

Policy: Dressing Change (Clean)

Dressing changes will be performed according to the physician's order. The order should include site, cleaning solution, medication (if applicable),

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F 684	Continued From page 22 gauze, and frequency of change.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined that facility staff failed to to provide oxygen at the correct prescribed rate for one of 24 residents in the survey sample; Resident #230. The findings included: Resident #230 was admitted to the facility on 4/12/21 with diagnoses that included but were not limited to sepsis, acute and chronic respiratory failure with hypoxia, chronic heart failure, morbid obesity, and high blood pressure. Resident #230 did not have a completed MDS (Minimum Data Set) assessment at this time. Resident #230 was documented as being alert and cognitively intact. Review of Resident #230's current physician orders documented the following order: "Oxygen 2 L (liters)/min (minute) per nasal cannula." On 4/20/21 through 4/21/21 observations of Resident #230 were conducted. The following	F 695	1. The liter flow of oxygen for Resident #230 was adjusted to the ordered liters per minute on 4/22/2021. The resident was assessed and without negative outcome related to the oxygen. 2. The liter flow of oxygen for residents currently receiving oxygen have been inspected to ensure the oxygen was set at the ordered liters per minute. The nursing staff will be responsible for ensuring the oxygen equipment is set at the ordered liters per minute. 3. RNs and LPNs were re-educated on Oxygen Settings by the Director of Nursing/Designee. The in-service included a review on the facility policy on oxygen as well as the importance of checking the liter flow on the oxygen concentrator/tank to ensure it is set at the ordered liters per minute. The Charge nurse/designee will run the Nursing Room	5/28/21

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was observed:

On 4/20/21 at 2:06 p.m., Resident #230's oxygen was set to 2.5 liters. Resident #230 was laying in the bed at this time, not within reach of the oxygen concentrator.

On 4/20/21 at 2:21 p.m., Resident #230's oxygen was set to 2.5 liters. Resident #230 was laying in the bed at this time, not within reach of the oxygen concentrator.

On 4/21/21 at 11:26 a.m., Resident #230's oxygen was set to 2.5 liters. Resident #230 was laying in the bed at this time, not within reach of the oxygen concentrator.

On 4/22/21 at 1:22 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3, the nurse assigned to Resident #230. When asked if she could verify the liters of oxygen Resident #230's flow meter was set at, LPN #3 entered Resident #230's room and stated, "It's between the 2 and the 3 so it looks like 2.5." When asked if Resident #230 was supposed to be on 2.5 liters of oxygen, LPN #3 stated that she would have to check Resident #230's chart and orders. At 1:25 p.m., LPN #3 stated that Resident #230 should have been receiving 2 liters of oxygen, not 2.5.

Review of Resident #230's baseline care plan dated 4/13/21, documented Resident #230 as needing "Transfer assistance when transferring to and from different surfaces: Gait belt attended by at least 1 staff member." This information shows that Resident #230 was unable to get out of bed on her own to change the oxygen dial.

F 695

list daily and compare the ordered Oxygen flow amount with liter flow setting on the concentrator to ensure resident is receiving the prescribed liters per minute.

4. The Director of Nursing/Designee will inspect 20% of current residents weekly for six weeks to ensure the oxygen concentrator/tank is set at the ordered liters per minute. The Director of Nursing/Designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement Committee at least quarterly.

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F 695	Continued From page 24 On 4/22/21 at 5:47 p.m., the Administrator and the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Oxygen Administration and Safety Guidelines" documented in part the following: "Resident are administered oxygen therapy as prescribed by physician ..." No further information was presented prior to exit.	F 695		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, and clinical record review, the facility's staff failed to investigate underlying causes of the resident's anxiety and depression, address, review and revise the resident's behavioral health care plan and create an environment conducive for a resident with known mental health disorders who voiced a suicide attempt while hospitalized for 1 of 24 residents (Resident #130), in the survey sample. The findings included:	F 740	1. Resident # 130 discharged to home as planned on 4/24/21. The wired call bell was returned to residents room on 4/23/21 after it was determined resident was not at risk for further self-harm. 2. Facility staff has interviewed all current residents with known mental health disorders to ensure understanding of underlying causes for anxiety or depression. DON/designee in collaboration with the Interdisciplinary	5/28/21

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Continued From page 25

Resident #130 was originally admitted to the facility 4/8/21 and readmitted had not been discharged from the facility. The current diagnoses included; a bipolar disorder, an anxiety disorder and chronic pain syndrome.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/14/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #130's cognitive abilities for daily decision making were intact.

In section "D0200" (Mood) of the MDS assessment the resident was coded as having hopelessness, little energy, feeling bad about herself and trouble concentrating 12-14 days out of 14 days; restless/fidgeting and thoughts of being better off dead 7-11 days out of 14 days. The resident's total severity score was 18 out of 27. In section "E" (Behaviors) the assessment was coded for behaviors not directed towards others which significantly interfered with care.

In section "G" (Physical functioning) of the MDS assessment the resident was coded as requiring total care of one person with bathing, limited assistance of one person with transfers, walking, locomotion, dressing, toileting, and personal hygiene and supervision of one person with bed mobility and eating. On 4/20/21 at approximately 2:15 p.m. an interview was conducted with Resident #130. The resident asked if I could get a wall nurse call light for the room. The resident stated "I used it too much therefore they removed it and gave me this tap bell which no one answers". Resident #130 further stated "they all

F 740

Care plan Team have reviewed and updated the behavioral health care plan of these residents to ensure individualized interventions are care planned. The room of any resident who has voiced suicidal attempt have been evaluated for potential hazards and adapted to meet the needs of the individual.

3. The facility will interview newly admitted residents with known mental health disorders to ensure understanding of underlying causes for anxiety or depression. If any history of suicide attempt is determined, the resident□s room will be evaluated to ensure a safe and conducive environment. A specific step will be added in the MDS process to enhance communication between the MDS staff and floor staff to ensure individualized interventions are care planned.

4. DON/Designee will conduct an interview with 20% of the current residents with known mental health disorders to ensure underlying causes for anxiety or depression have been identified and the care plan reflects individualized interventions are care planned appropriately. The Administrator/designee will evaluate the resident□s room to ensure a conducive environment. The DON/designee will review the audit results for any patterns or trends and report any findings to our Quality Assurance Performance Improvement Committee.

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F 740	Continued From page 26 hate me and doesn't want to help me" and they haven't been providing my Seroquel as it was prescribed. "I am supposed to receive eight tablets each day". Further interview with the resident revealed she had called 911 on several occasions because staff didn't respond to her calls for assistance using the tap bell. The resident expressed " I just want people to come when I call". Review of Resident #130's care plan revealed the following; 4/20/21- problem; resident is receiving an antipsychotic drugs on a regular basis for a diagnosis of Bipolar disorder. The goal read; the resident will not cause harm or injury to self or others over the next 90 days. The interventions included; medication as ordered. Record behaviors on the tracking form. Remind the resident that behaviors are not appropriate. Remove the resident from situations, allow time for her to calm down. 4/20/21- problem; the resident is receiving an antidepressant drug on a regular basis. The goal read; symptoms of depression will be controlled with minimal side effects over the next 90 days. The interventions included; Conduct one to one visits to discuss current status and adjustment to lifestyle. Monitor for side effects of medication (dry mouth, anxiety, agitation, headache and falls). Plan with the resident and physician for a trial period of dose reduction. Observe for changes in mood/ behavior, crying, sleep patterns, fatigue, appetite, ability to concentrate and participation in activities. 4/20/21- problem; Resident is receiving an antianxiety drug on an as needed basis. The goal	F 740		

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F 740	Continued From page 27	F 740		

read; symptoms of anxiety will be controlled with minimal side effects over the next 90 days.
The interventions included; engage the resident in group/individual activities that reduce periods of anxiety. Resident to abstain from alcohol. Provide a quiet atmosphere with one-on-one support during periods of increased anxiety. Allow resident to talk about events and causes if known.

On 4/20/21 at approximately 2:35 p.m., an interview was conducted with Certified Nursing Assistant CNA) #1. CNA #1 stated she had been told that Resident #130 attempted to commit suicide therefore a wall call bell was not in the room and to keep the tap bell on the bedside table. CNA #1 further stated the resident has poor balance, doesn't call very often, likes to do things a specific way and often complains that some staff "have an attitude" with her. CNA #1 stated she had not been instructed to monitor the resident any more frequently than other residents, or report specific behaviors and ensure all interactions are quiet and positive.

A Nurse Practitioner's progress note date 4/8/21 stated "the resident was see by psychiatry in the hospital and the medications had been adjusted. The progress note further stated the resident was in bed complaining of not having a phone, not being able to see her husband, not being able to have visitors and stated that she tried to kill herself a few days ago at the hospital by putting a plastic bag over her nose and mouth. The information was given to the Administrator and they will provide a bell in the room and take away the call light. The resident denied wanting to kill herself currently but is very upset and not answering questions, only complaining". The

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plan was for a psychological consult, continue current medications and treatments, discontinue as needed Seroquel, consider Risperdal if needs an antipsychotic.

A progress note dated 4/11/21 at 8:11 a.m., read the Administrator received a call form the facility that the resident was making statements about wanting to die and specific comments about harming herself. Monitoring of the resident was increased and the Community Services Board (CSB) was called. The CSB instructed if the facility's staff felt the resident was a danger to herself or others to send the resident to the emergency room for evaluation. Instructions were given to the facility to transport Resident #130 to the emergency room.

A Nurse Practitioner's progress note dated 4/12/21 stated the resident was suicidal and sent out to the emergency room last night and came back. The resident denies wanting to kill herself.

On 4/13/21, Resident #130 was seen by the psychiatric Nurse Practitioner post an emergency room visit, for anxiety and suicidal ideation. At the hospital the resident was seen by the Psychiatrist but had no medication changes because the resident was stable. The resident was monitored for a few hours and returned back to the facility. The progress further stated the resident stated "she felt good this morning" because she got some rest at the hospital. The resident reported to the psychiatric Nurse Practitioner that she received Seroquel 25 milligram (mg) seven to eight times each day as needed. The psychiatric Nurse Practitioner ordered scheduled Seroquel 25 milligram three times each day.

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The psychiatric Nurse Practitioner's recommendation included; monitor for changes in mood, mental status, behaviors, pain, appetite/weight, sleep, safety/safety awareness, AIMS assessment per nursing protocol. Continuous non-pharmacological interventions to include; maintain a quiet and stress-free environment, gentle redirection and reassurance, reinforcement of self efficacy. Identify, address and eliminate underlying causes of distress and or behavioral disregulation.

On 4/13/21 the resident's psychoactive medications are as follows; Seroquel 25 mg three times each day, Buspirone 30 mg twice a day, Clonazepam 1 mg at bedtime, Carbamazepine 400 mg daily, and Nefazodone 50 mg daily.

On 4/22/21 at approximately 11:00 a.m., observation of Resident #130's room revealed the following; no wall call bell but a tap bell which was not answered when tapped. A string hanging from the over the bed light attached to the bed rail. Mini blind strings at the window, a Food Lion plastic bag on the chest of drawers beneath the television, a large plastic bag in a hamper to hold soiled linen, a trash can beside the bed with a plastic bag and a trash can in the bathroom with a plastic bag. On the resident's meal tray was all disposable products including plastic utensils which could be broken and used as sharp instruments. The resident was also noted to be in a room at the distal corridor from the nurse's station and absent of high traffic.

The above items were potential items to use for suicide but during the resident's thirteen days of having them in her presence didn't attempt to

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F 740	Continued From page 30 utilize them to harm herself. On 4/22/21 at approximately 3:00 p.m., an interview was conducted with CNA #4. CNA #4 stated they were not instructed to do more frequent monitoring of the resident or attempts to engage her in activities, report warning signs such as negative statements, mood swings, etc. CNA #4 could only recall removal of the wall call light and use of disposable products on the meal tray related to the resident's suicidal ideation. On 4/22/21 at approximately 5:20 p.m., the above information was shared with the Administrator, DON, ADON and the Vice president of Nursing. The DON stated Resident # 130's psychological services are being addressed but we can do more to produce a therapeutic environment.	F 740		
F 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility's staff failed to ensure a resident displaying mental health concerns received the care and services to	F 742	1. On 04/25/2021 Resident #16 discharged from facility to an ALF. Instructions given on discharge to follow up with psychiatry	5/28/21

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F 742	Continued From page 31 address identified concerns (staying in a totally dark room most of the time, social isolation, no interest and withdrawal) for 1 of 24 residents (Resident #16), in the survey sample. The findings included: Resident #16 was originally admitted to the facility 3/15/21 and had never been discharged from the facility. The current diagnoses included; severe anxiety, depression and dementia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/22/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #16's cognitive abilities for daily decision making were intact. In section "D0200" (Mood) the resident was coded as having little to no interest, depressed, little energy and trouble concentrating 12-14 days out of 14 days; sleeping too much 7-11 days out of 14 days, and feeling bad about himself 2-6 days out of 14 days. The resident's total severity score was 15 out of 27. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing and supervision of one person with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene and independent after set-up with eating. Review of the person-centered Care Plan revealed the following; 3/26/21- problems; Resident has little interest or pleasure in doing things; social interaction. The	F 742	2. DON/designee will review the past 60 days of provider visit notes to ensure any necessary behavioral health referrals/consults (i.e. Psychiatrist Consults) have been scheduled or completed. If there are identified issues, corrective action will be implemented 3. The facility nursing staff will initial the bottom of the provider visit notes to indicate they have read them and initiated appropriate follow-up with any new orders. 4. DON/Designee will review 10 Provider visit notes for 8 weeks of a random sample of residents, to ensure that all behavioral health follow-ups have been completed timely. The DON/designee will review the audit results for any patterns or trends and report any findings to our Quality Assurance Performance Improvement Committee.	

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goal read Resident will show interest and willingness to socialize with others over the next 90 days. The interventions included; Resident to eat all meals in the dining room as tolerated. Encourage family visitors to eat with the resident. Assist resident to activities and social events. Assist the resident to establish compatible relations with others.

3/26/21- problem; Resident has no involvement in activities. The goal; Resident will participate in group and/or individual activities 2-3 times per week as tolerated over the next 90 days. The interventions included; Involve resident in appropriate social groups at meals. Provide a copy of activity schedule and allow resident to choose activities. Provide room visits 2-3 times per week to establish friendship and trust.

3/26/21- problem; Resident has trouble falling or staying asleep or sleeping too much. The goal; Resident will verbalize adequate sleep/rest over the next 90 days. The interventions included; allow the resident extra time in the morning before starting care/activities.

3/26/21- problem; Resident has trouble staying asleep. The goal; A sleep/wake cycle that is acceptable to the resident will be achieved. Delayed bedtime until resident is drowsy and ready to sleep. Engage in active daytime recreation/exercise program; minimize daytime sleeping events. Provide an environment conducive to sleep (minimize noise and light, verify with resident if the temperature is comfortable). Reduce eliminate intake of caffeine.

3/26/21- problem; Resident states feeling down, depressed or hopeless. The goal; Periods of

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sadness will be reduced over the next 90 days. The interventions included; Assess and record behaviors. Assess changes in mental status. Discuss with physician and team a trial period of antidepressant medication therapy.

The above care plan goals and interventions were no person-centered to reflect Resident #16.

Review of the Nurse Practitioner's progress notes revealed on 3/16/21 a psychological consult was recommended. The resident was admitted to the facility receiving Clonazepam 2 milligram by mouth at bed time, Fluoxetine 40 milligrams by mouth each morning and Olanzapine 7.5 milligrams at bed time. As of 4/22/21 the psychological consult had not transpired.

On 4/20/21 at approximately 1:05 p.m., during the initial tour Resident #16 was observed in his room with the door closed completely, in bed with the bed linens over the entire body, the window blinds completely closed, and the lights off. The resident stated "my stomach is bothering me".

On 4/21/21 at approximately 11:00 a.m., Resident #16 was again observed in his room with the door closed completely, in bed with the bed linens over the entire body, the window blinds completely closed, and the lights off. He answered the knock at the door and was easily engaged in conversation. The resident stated he spent most of his days in bed at home and felt it was more related to depression than a physical illness. The resident stated he didn't know if he could defeat the depression and there was no desire to harm himself or others.

On 4/21/21 at approximately 3:00 p.m., certified

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F 742	Continued From page 34 nursing assistant #4 was interviewed. CNA #4 stated Resident #16's mood hadn't changed; she stated the resident never initiates a conversation and has never enjoyed doing anything except lying in bed in the dark with the door closed. CNA #4 further stated the resident is never rude, complies with care most of the time, eats well and states he just wants to be alone. On 4/21/21 at approximately 3:20 p.m., CNA #1 was interviewed. CNA #1 stated Resident #1 requires little assistance with care, prefers to stay in his room in the dark, blinds and door closed, no television, peer interactions, reading, puzzles or other activity. CNA #1 stated the resident will sit up for meals for approximately 1 hour total with encouragement but as soon as the hour has passed he closes the door, turns off the light, closes the blinds and climbs back in bed. On 4/21/21 at approximately 3:30 p.m., an interview was conducted with the Speech Therapist who treats Resident #16. The Speech Therapist stated Resident #16 is usually in a dark room with the door closed, blinds drawn and in bed when she goes to him for treatment but he enjoys eating therefore he usually complies with her sessions but based on the rehabilitation meetings the resident isn't as motivated with physical and occupational therapy and the therapist feels he's capable of doing more than he does during their sessions. The Speech Therapist stated the lack of motivation is conveyed to the interdisciplinary team during meetings. On 4/21/21 at approximately 1:00 p.m., an interview was conducted with the spouse of Resident #16. The spouse stated for the past 9	F 742		

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years the resident hadn't wanted to do anything and she had exhausted her abilities to care for the resident; therefore alternative placement was being strongly considered. The spouse stated she believed the resident's mother suffered from depression. The spouse further stated the resident often complained of pain if he didn't want to do something and it was difficult getting the resident to see doctors or do anything therefore; the pain doctor had prescribed the psychoactive medications the resident was taking at home. The spouse stated prior to the resident's admission to the hospital the resident had become very weak and suffered complications from drinking water while lying in bed instead of sitting up to drink.

On 4/22/21 at approximately 4:50 p.m., an interview was conducted with the Nurse Practitioner regarding Resident #16's social isolation, withdrawal, lack of interest, preference of darkness and lack of motivation. The Nurse Practitioner stated coordination of the psychological services didn't go as planned for the practice she is employed by had planned to bring a psychological Nurse Practitioner on board but it didn't happen and the day the other psychological Nurse Practitioner was in the facility there wasn't enough time for Resident #16 to be evaluated and treated but she would make more attempts to obtain services for the resident. The Nurse Practitioner stated he does need the services and she prefers not to prescribe or change psychoactive medications.

On 4/22/21 at approximately 5:20 p.m., the above information was shared with the Administrator, DON, ADON and the Vice president of Nursing. The DON stated Resident # 16 psychological services would be coordinated and a practitioner

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F 742	Continued From page 36 would see him soon.	F 742		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and facility documentation review the facility staff failed to remove expired medication from 1 of 2 medication carts (Cart A). The findings included:	F 761	1. A new Advair Diskus inhaler was delivered by the pharmacy on 4/21/2021 and the expired inhaler was removed from the medication cart. 2. The medication carts have been inspected to ensure any expired	5/28/21

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F 761	Continued From page 37 On 04/21/2021 at 11:30 a.m., during inspection of Medication Cart A observed Advair Diskus box and on the outside of the box the date 11/3/20 was written. Requested to see Advair Diskus box. When asked what does the date 11/3/20 indicate, Licensed Practical Nurse (LPN) #1 stated, "That was when it was opened." Review of the label on the box revealed the following: Advair Diskus AER 250/50 60 AEPB 10/27/20 1 PUFF BY MOUTH TWICE A DAY - RINSE MOUTH AFTER EACH USE "DISCARD WHEN COUNTER READS 0 OR 30 DAYS AFTER FOIL POUCH IS OPENED, WHICHEVER COMES FIRST." Requested that LPN #1 remove the Advair Diskus from the box. Observed that the Advair Diskus was not in a foil pouch and 11/3/20 was written on the diskus. Requested that LPN #1 review the label on the Advair Diskus box. When asked when should the Advair Diskus have been discarded, LPN #1 stated, "30 days after opening." When asked was it discarded, LPN #1 stated, "No." On 04/22/2021 at approximately 8:30 a.m., a copy of the Medication Administration Policy and Procedure was requested. On 04/22/2021 at approximately 10:00 a.m., a copy of "Medication Administration Guidelines" was received. The Administrator, Director of Nursing, Assistant Director of Nursing and Corporate Nurse were made aware of the finding at the pre-exit meeting on 04/22/2021 at approximately 6:55 p.m. No further information was provided. Titled: Medication Administration Guidelines	F 761	medications have been removed from the medication carts. 3. The Director of Nursing/designee will in-service RNs and LPNs on Expired Meds. The in-service will include a review on ensuring the nurses are checking medications for expiration dates and/or use by dates. A quick check reference form has been created and is readily available for staff to ensure they are discarding medications that expire within a designated time frame after opening. 4. The Director of Nursing/designee will inspect the medication carts weekly for six weeks to ensure there are no expired medications on the medication. The Director of Nursing will report findings to the Quality Assurance and Assessment committee at least quarterly.	

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F 761	Continued From page 38 Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medication Administration: .... If the medication is discontinued, outdated, or unusable, remove the medication for proper disposal.	F 761		
F 779 SS=D	X-Ray Diagnostic Report in Record Sign/Dated CFR(s): 483.50(b)(2)(iv) §483.50(b)(2)(iv) File in the resident's clinical record signed and dated reports of radiologic and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review the facility's staff failed to file in the resident's clinical record signed and dated x-ray reports dated 4/13/21 and 4/19/21 for 1 of 24 residents (Resident 24), in the survey sample. The findings included: Resident #24 was originally admitted to the facility 4/1/21 and had never been discharged from the facility. The current diagnoses included; cognitive impairment and right wrist pain. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/6/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated	F 779	1. The x-ray results from 4/13/2021 and 4/19/2021 for resident #24 was filed into the resident□s medical record on 4/21/2021. 2. The medical records for all residents who had any x-rays in the past 30 days will be reviewed to ensure the results have been filed in the resident□s medical record. If any variances are identified, then the resident□s medical record will be updated to include x-ray results 3. RNs and LPNs will be re-educated on Filing X-Ray Results by the Director of Nursing/Designee. The in-service included education on the process of filing x-ray results to be scanned into the resident□s medical record. The process	5/28/21

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F 779	Continued From page 39 Resident #24's cognitive abilities for daily decision making were moderately impaired. In section"G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of one with walking in room, dressing and toileting, limited assistance of one with transfers, locomotion, personal hygiene and supervision of one with eating. On 4/20/21 at approximately 1:40 p.m., Resident #24 stated her side was hurting and there had been concern with the right wrist. The resident further stated x-rays had been completed approximately one week ago and she had just been told an antibiotic would be started later today for the the left side pain was pneumonia. Review of the physician/Nurse Practitioner's (NP) progress notes revealed the following; on 4/12/21 the resident's chief complaint was right wrist pain and follow-up of secretions. The narrative read " Also complained of right wrist pain on movement or palpation; no trauma but is using hands more that she is in physical therapy. Has slight swelling at the base of the thumb, is able to use her hand to eat, etc. Has not tried anything to make it better but is taking routine Tylenol every morning. Tenderness on palpation to the base of thumb and fat pad. The plan x-ray of the right wrist. The 4/19/21, the physician/Nurse Practitioner's (NP) progress notes revealed the following; chief complaint; bilateral lower extremity edema, congestion and pain with breathing". "Resident states she has left upper chest pain and palpation and called it pleurisy. Afebrile but an occasional cough. The plan chest x-ray to rule out pneumonia. Lasix for seven days.	F 779	for scanning documents into the resident records has been updated to ensure timely placement in the resident□s medical record. 4. The Director of Nursing/Designee will audit 20% of new x-ray results weekly for six weeks to ensure the results are in the resident□s medical record. The Director of Nursing/Designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement Committee at least quarterly	

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F 779	Continued From page 40 On 4/20/21 at approximately 3:40 p.m., an interview was conducted with Registered Nurse #1 who stated x-ray results could be found in the paper record for a resident. On 4/21/21 at approximately 10:45 a.m., Resident #24's paper record was reviewed but the x-ray results were observed in the paper record; therefore an interview was conducted with the Director of Nursing (DON). The DON viewed the resident's "hard chart" (paper record) but was unable to locate the x-ray results. After viewing two other books, the x-ray results were located in the physician/NP's notebook. The X-ray result dated 4/13/21, was of the right wrist. The result read under impression degenerative arthritis and soft tissue swelling.. The report was signed by the NP 4/13/21. The second x-ray report for Resident #24 was dated 4/19/2, it was a chest x-ray which revealed rales of the left lung. The impression read mild scattered interstitial pneumonia, no tuberculosis is seem. This report had not been signed by a practitioner. The DON stated after x-rays are reviewed by the physician/NP they are to filed in the "hard chart" by the night shift (11 p.m. - 7 a.m.) nurse. On 4/22/21 at approximately 5:20 p.m., the above information was shared with the Administrator, DON, ADON and the Vice president of Nursing. The DON stated she had no additional information.	F 779		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining	F 791		5/28/21

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routine and 24-hour emergency dental care.

§483.55(b) Nursing Facilities.
The facility-

§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:
(i) Routine dental services (to the extent covered under the State plan); and
(ii) Emergency dental services;

§483.55(b)(2) Must, if necessary or if requested, assist the resident-
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services locations;

§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;

§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred

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medical expense under the State plan.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview and facility policy. The facility staff failed to assist one resident Resident #5 in the survey sample of 24 residents with making arrangements for dental services.

The findings included:

Resident #5 was admitted to the facility on 02/05/15 with diagnoses which included cerebrovascular disease, Ataxia, hypertension, acute peptic ulcer, type II diabetes, mental disorder due to known physiological condition, anxiety disorder, vascular dementia with behavioral disturbance, insomnia, and abnormal weight loss. The facility staff failed to provide Resident #5 with dental services.

A Quarterly Minimum Data Set dated 2/2/21 assessed this resident in the area of Cognitive Impairment (Brief Interview of Mental Status) BIMS as a (0). In the area of Activities of Daily Living this resident was assessed in the area of eating as a (1-1) requiring set up help only. In the area of Pain Management this resident was assessed as receiving PRN (as needed pain medication. In the area of Oral/Dental this area was not coded.

A Care Plan dated 4/22/21 indicated: Has no natural teeth or tooth fragments - Resident complains of mouth or facial pain. Discomfort or difficulty with chewing.

A 4/22/21 Nutritional Plan indicated: Dental pain, discomfort difficulty chewing- swallow disorder-

F 791

1. The daughter for resident #5 was offered dental services on 4/23/2021 but declined as long as the tooth pain did not interfere with resident eating. The POST form was discussed with daughter and record updated to indicate advance directives. There were no negative outcomes to the resident.

2. All residents will be assessed for any dental pain and follow up for any dental services that are needed.

3. RNs and LPNs will be re-educated on Dental Services by the Director of Nursing/Designee. The in-service included but is not limited to a review of ensuring dental services have been offered when indicated and assisting with arranging dental appointments.

4. The Director of Nursing/Designee will review the clinical notes weekly for six weeks to review any residents with dental concerns to ensure dental services have been offered when indicated. The Director of Nursing/Designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement Committee at least quarterly

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difficulty or pain swallowing.

Diet Order: indicated: Mechanical soft, LCS, NAS, fortified foods if on Fluid Restriction.

A review of Nursing Notes dated 4/4/21 indicated: "9: PM -Tramadol given for mouth pain. Complaining of remaining teeth hurting."

Nursing Notes dated 4/2/21 indicated: " 3:46 A.M. Resident- up so far through this shift complain of teeth, mouth hurting pain, and unable to sleep. Clearly stating wants to go to the dentist. Resident does have many discolored teeth and fragments present in her mouth. Pain medication given. MD made aware. Will have the oncoming shift make daughter aware as well."

Speech Therapy Note dated 12/23/20 at 4:58 P.M. indicated: Resident #5's diet was changed on 12/23/20 from a regular diet to a puree/mech due to a choking incident with regular meats during the afternoon meal. Heimlich maneuver and finger sweeps required to clear oral cavity.

During an interview on 4/22/21 at 9:25 A.M. with the social worker, she was asked had a dental appointment been made for Resident #5. The social worker stated, she does not make the appointments "nursing" makes the appointments. The social worker stated, she would get with the Director of Nursing (DON) and get back with me and let me know if a dental appointment has been made for Resident #5. Note- the social worker did not inform me during the survey of an appointment or the status of Resident #'S dental care.

During an interview on 4/22/21 at 6:36 P.M. with

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F 791	Continued From page 44 the DON she stated Resident #5's daughter did not want her to go out on any appointments. When asked if staff had contacted the daughter regarding Resident #5's complaint of wanting to see a dentist due to mouth and teeth pain, the DON stated, the daughter did not want her to go out. When asked for documentation that the daughter had signed or requested Resident #5 not have dental services, none was presented during the survey. A review of the facility's Dental Service Policy indicated: "The facility will assist residents, as necessary, in making appointments and arranging transportation to and from the dentist offices if services are not provided in the facility. Arrangements for dental care shall be made promptly within 3 days if a residents loses or damages his/her dentures. If a referral does not occur within 3 days the facility must provide documentation of what was done to ensure the resident could still eat and drink adequately while awaiting dent services and the extenuating circumstances that led to the delay." The facility staff failed to assist one resident in obtaining routine dental services.	F 791		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		5/28/21

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except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-

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F 842	Continued From page 46 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed to document that one of 24 residents; Resident #231 received a bed bath on 4/16/21 and 4/17/21. The findings included: Resident #231 was admitted to the facility on 4/12/21 with diagnoses that included but were not limited to atrial fibrillation, cerebral palsy, high blood pressure, stroke, and altered mental status. Resident #37 did not have a completed MDS (Minimum Data Set) assessment at this time. On 4/20/21 through 4/21/21 this writer had several interactions with Resident #231. Resident #231 had periods of confusion during these interactions.	F 842	1. The medical record for Resident #231 was updated to reflect a complete bed bath was given on 4/16/21 and 4/17/21. 2. The bathing records for all residents were reviewed for the past week to ensure the records accurately reflected when a resident received a shower or complete bed bath. Any variances identified were updated to accurately reflect the care given. 3. The Charge Nurse/ designee will review the daily ADL documentation at the end of each shift to ensure the records accurately reflect any bathing activity resident has received. The CNAs will be reeducated on the importance of timely, accurate and complete documentation	

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On 4/20/21 at 1:17 a.m., an interview was conducted with Resident #231. When asked if she received showers, Resident #231 stated, "Don't know. I am not sure when I am supposed to get showers." When asked if she received bed baths, Resident #231 stated that sometimes staff provided bed baths.

Review of Resident #231's ADL (Activity of Daily Living) care plan documented the following for bathing: "Assist (Name of Resident #231) with bathing as needed."

Review of Resident #231's ADL (Activities of Daily Living) flow chart for bathing failed to evidence that Resident #231 received a bed bath on 4/16/21 and 4/17/21. There were concerns related to receiving showers.

On 4/22/21 at 3:14 p.m., an interview was conducted with CNA #2, the nursing aide assigned to Resident #231 on 4/16/21 and 4/17/21. CNA #2 stated that residents received bed baths everyday unless it was a scheduled shower day. When asked if showers/baths should be documented in the clinical record, CNA #2 stated that they should. When asked if Resident #231 was provided a bed bath or shower on 4/16/21 and 4/17/21, CNA #2 stated that she could not recall, that a bed bath was probably given and she probably forgot to document. CNA #2 also stated that sometimes when she charted late, the system would kick her out and she was unable to chart.

On 4/22/21 at 5:47 p.m., the Administrator and the DON (Director of Nursing) were made aware of the above concerns.

regarding bathing activities.

4. The ADON/designee will review the resident bathing records weekly for six weeks to ensure documentation is complete and accurate. The Director of Nursing/Designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement Committee at least quarterly

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F 842	Continued From page 48 Facility policy titled, "Medical Records," documented in part, the following: "A complete, timely, and accurate resident record is created and maintained for each resident ...Every entry in the medical record must be legible, complete, and is authenticated and dated by the person responsible for ordering, providing or evaluating the service in a prompt manner." No further information was presented prior to exit.	F 842		
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	F 880		5/28/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 49 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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	495368	A. BUILDING ______ B. WING ______	04/22/2021

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F 880	Continued From page 50 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review the facility staff failed to maintain infection control practices for 2 residents in the survey sample, (Resident #8 and #231. The findings included: 1. Staff failed to clean over bed table after removing metal tray. 1. Resident #8 was admitted to the facility on 09/03/2021. Diagnosis included but were not limited to, Anxiety Disorder and Hypertension. Resident #8's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 02/25/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 01 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #8 as requiring limited assistance of 1 for eating and personal hygiene, limited assistance of 2 for dressing, extensive assistance of 1 for toilet use, extensive assistance of 2 for bed mobility and transfer and total dependence of 1 for bathing. On 04/21/2021 at 10:07 a.m., standing at treatment cart in hallway and observed Assistant Director of Nursing (ADON) obtain treatment supplies and place them on a barrier lined metal tray. ADON walked from treatment cart down to Isolation Storage Bins sitting in hallway outside of Room 1 and sat the metal tray down on the Isolation Storage Bin. The ADON then picked the metal tray up and took it into Room 2 and placed the metal tray down on Resident #8's over bed table. ADON performed hand hygiene, applied	F 880	1. The overbed table for resident #8 was cleaned on 4/21/2021 with no negative outcomes noted to the resident. There were no negative outcomes related to the staff members not applying appropriate PPE in the warm room. The involved staff members were re-educated on infection control procedures and appropriate PPE to be worn in a warm room. 2. The responsible staff members will be observed for following infection control precautions for three rooms focusing on ensuring appropriate PPE is worn into the room and any contaminated surfaces are cleaned. 3. The Director of Nursing/Designee will re-educate staff on Following Infection Control Precautions. The in-services include but is not limited t a review of what PPE should be worn in warm rooms and ensuring any possible contaminated surfaces are cleaned. 4. The Administrator/Designee will perform staff observations on three staff members weekly for six weeks to ensure infection control is being performed appropriately. The Administrator/Designee will identify any patterns or trends and report results to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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F 880	Continued From page 51 gloves, removed the residents old dressing. ADON removed her gloves and performed hand hygiene. ADON applied clean gloves and cleaned wound on right heel with Normal Saline and patted area dry with dry dressing. ADON removed gloves and performed hand hygiene. ADON applied clean gloves and applied iodine soaked gauze to wound bed and covered with dry dressing, wrapped kling gauze around dressing, dated tape and applied tape to kling gauze. ADON removed gloves and performed hand hygiene. ADON picked up discarded trash and metal tray and walked out to cart. ADON disposed of trash and cleaned metal tray with germicidal wipes. ADON performed hand hygiene. When the ADON was asked if she had completed the procedure, ADON stated, "Yes." On 04/21/2021 at approximately 11:30 a.m., an interview was conducted with the ADON. Discussed observations while preparing to do wound care, placing metal tray on Isolation Bin in hallway and then placing the metal tray on the residents over bed table. The ADON stated, "I should have cleaned the bedside table after removing the tray." When asked what can occur when placing the metal tray on the Isolation Bins in the hallway and then placing on the resident over bed table, ADON stated, "Infections and germs can occur." The Administrator, Director of Nursing, Assistant Director of Nursing and Corporate Nurse were made aware of the finding at the pre-exit meeting on 04/22/2021 at approximately 6:45 p.m. No further information was provided.	F 880		

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2. Resident #230 was admitted to the facility on 4/12/21 with diagnoses that included but were not limited to sepsis, acute and chronic respiratory failure with hypoxia, chronic heart failure, morbid obesity, and high blood pressure. Resident #230 did not have a completed MDS (Minimum Data Set) assessment at this time. Resident #230 was documented as being alert and cognitively intact.

Review of Resident #230's hospital discharge report dated 4/12/21, revealed that her last COVID test was conducted on 4/7/21 and was negative.

Review of Resident #230's clinical record revealed that Resident #230 was placed on the warm "Observation" unit upon admission into the nursing facility.

On 4/20/21 at 2:50 p.m., an observation was made of Resident #230. Resident #230 had a sign outside her door with the following documentation: "Let's protect each other WARM PPE required when with me ..." A picture of an N95 mask, face shield, gloves and gown were also displayed on the sign. A medical mask is acceptable for staff not currently fitted with an N95."

On 4/21/21 at 11:25 a.m., an observation was made of OSM (Other Staff Member) #1, the housekeeper. OSM #1 was observed walking into Resident #230's room wearing a surgical mask, hair net, shield and gloves. OSM #1 did not have a gown on. OSM #1 swept around Resident #230's bed, approximately one foot away from the resident.

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On 4/21/21 at 11:30 a.m., an interview was conducted with OSM #1. When asked what she is supposed to wear when going into a quarantine room, OSM #1 stated that if she was touching the resident's belongings she would have worn a gown. OSM #1 stated that when she comes back to do the bathrooms, she will be wearing gown.

On 4/21/21 at 1:22 p.m. LPN (Licensed Practical Nurse) #3 was asked to verify Resident #230's oxygen settings. LPN #3 entered Resident #230's room wearing a face shield and N95 mask only. LPN #3 failed to don a gown and a pair of gloves prior to entering the room. LPN #3 was less than three feet away from Resident #230's bed when checking the oxygen concentrator.

On 4/21/21 at 1:25 p.m., an interview was conducted with LPN #3. When asked if Resident #230 was on quarantine, LPN #3 stated, "I am not sure when her admission date was, I would have to check." LPN #3 stated that Resident #230 was on warm room precautions when she first arrived to the facility. When asked what warm room precautions meant, LPN #3 stated that a gown, shield, face mask and gloves were required to be worn while working with the resident. LPN #3 then stated that Resident #230's admission date was 4/12/21. When asked if that meant Resident #230 was still on observation for signs and symptoms related to COVID, LPN #3 stated that she wouldn't know, that this writer would have to ask the unit manager. When asked how she would know what protective gear to wear for each resident while working with them; LPN #3 stated that signs were usually posted in front of each door who was considered "Warm" and on observation. This writer pointed out the sign on Resident #230's door. When asked what should

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be worn when entering Resident #230's room, LPN #3 stated that she didn't think of it, that she didn't go into the room to provide care or even touch the resident, so she didn't think to put on a gown and gloves. LPN #3 stated, "If I was going to be close to her, I'd consider it."

On 4/21/21 at 2:16 p.m., an interview was conducted with ASM (Administrative Staff Member) #5, the DON (Director of Nursing). When asked what PPE was required prior to entering a room of a resident on observation or on "Warm Precautions," ASM #5 stated that staff should be putting on a gown, gloves, shield and face mask. When asked if this was still true if the staff did not touch the resident while in the room, ASM #5 stated, "If they are not touching her, they don't have to wear the gown and gloves." When asked how COVID was spread, ASM #5 confirmed it was by droplet transmission. When asked at what point do staff need to don a gown and a pair of gloves (How many feet from the resident), ASM #5 stated, "Oh I thought you meant if they were just popping their head in the room. Staff should be wearing a gown and gloves when entering the room."

On 4/22/21 at 9:49 a.m., an interview was conducted with ASM #2, the ADON (Assistant Director of Nursing) who is the ICP (Infection Control Preventionist) When asked how it is determined if a resident needs to be on precautions for observation upon admission, ASM #2 stated that if a resident is not vaccinated against the COVID-19 virus, or have only received one vaccination; they have to be on quarantine for 14 days. ASM #2 stated that if a resident does receive the second vaccination but two weeks have not gone by since last

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F 880	Continued From page 55 vaccination and prior to admission, they are also placed on quarantine. ASM #2 confirmed that Resident #230 was still on quarantine. When asked what PPE was required prior to entering Resident #230's room, ASM #2 stated a gown, gloves, N95 mask and face shield. When asked if a gown and gloves were required even if the caregiver does not touch anything, ASM #2 stated that since COVID-19 was airborne, you would want to also wear a gown and gloves while in close proximity to the resident. ASM #2 also stated that once in the resident's room, the caregiver doesn't know what the resident may ask them to do, get for them etc. ASM #2 stated that it was recommended to wear all required PPE before entering a resident's room on quarantine. On 4/22/21 at 5:47 p.m., the Administrator and the DON (Director of Nursing) were made aware of the above concerns.	F 880		