STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _____ B. WING _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT LYNCHBURG	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 11/29/2021 through 12/1/2021. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/30/21 through 12/01/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey; VA00053179 had three allegations, all unsubstantiated, with three related defieniencies. VA00051975 had four allegations, all unsubstantiated, no deficient practice. The Life Safety Code survey/report will follow. The census in this 120 bed facility was 75 at the time of the survey. The survey sample consisted of twenty current residents and three closed record reviews.	F 000		
F 570 SS=F	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide security of all resident personal funds deposited with the	F 570	Choice Healthcare at Lynchburg (_Facility_) is filing this plan of correction for the purpose of regulatory compliance.	1/4/22

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

Electronically Signed | 12/14/2021

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F 570	Continued From page 1 facility. The facility did not have a surety bond in an amount to cover resident fund balances. The facility's surety bond was for $55,000 and resident funds equaled $146,285. The findings include: On 11/30/21 at 4:24 p.m., the business office manager (other staff #8) was interviewed about resident fund accounts as part of the triggered personal fund survey task. The business office manager presented a balance sheet dated 11/30/21 listing the current balance of all resident deposited funds as $146,285.99. The surety bond was requested as part of the review. The business office manager presented a copy of the facility's surety bond (effective date 7/1/19) with the amount of coverage listed as $55,000. On 11/30/21 at 4:30 p.m., the business office manager was interviewed about the surety bond amount not covering resident funds. The business office manager stated she did not realize the surety bond amount was less than the residents' fund balance. 12/1/21 at 8:23 a.m., the administrator was interviewed about the surety bond. The administrator stated he was not aware the surety bond did not cover resident fund amounts. This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 12/1/21 at 11:30 a.m.	F 570	The Facility is submitting this plan of correction to comply with the applicable law. The submission of this plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies. See Plan of Correction for F570 See Plan of Correction for F607 See Plan of Correction for F609 See Plan of Correction for F610 See Plan of Correction for F641 See Plan of Correction for F657 See Plan of Correction for F684 See Plan of Correction for F686 See Plan of Correction for F690 See Plan of Correction for F695 See Plan of Correction for F761 See Plan of Correction for F880 See Plan of Correction for F886 1. The facility did not have a surety bond in an amount to cover resident fund balance. 2. All residents with a trust fund account could have the potential to be affected by deficient practice. 3. The Business Office Manager will be in-serviced on the policy and procedure for Surety Bond Requirements by 12/08/2021. 4. Business Office Manager will audit monthly the Surety Bond amount will cover the trust fund balance. Findings will be reported to the Nursing Home Administrator (NHA) immediately when	

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F 570	Continued From page 2	F 570	policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow abuse prevention policies for reporting and thoroughly investigating an allegation of abuse for one of 23 residents in the survey sample, Resident #67. Allegations by Resident	F 607	1. Resident # 67 is no longer a resident. No adverse effect noted in the medical record. 2. All residents have the potential to be affected by this deficient practice.	1/4/22

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F 607	Continued From page 3 #67 of inappropriate sexual comments from another resident that made the resident "uncomfortable" were not reported or thoroughly investigated as required by the facility's abuse prevention policies. The findings include: Resident #67 was admitted to the facility on 4/26/21 and was discharged to the hospital on 11/17//21. Diagnoses for Resident #67 included viral hepatitis C, cirrhosis of liver, liver failure, affective mood disorder, renal failure, coronary artery disease, hypertension and hypothyroidism. The minimum data set (MDS) dated 11/2/21 assessed Resident #67 as cognitively intact. The facility's complaint/grievance logs were reviewed. The social services director documented a complaint/grievance form dated 6/17/21 stating, "Resident [#67] reports that another resident is making inappropriate sexual comments toward her." The investigation section of the grievance form was blank. Findings on the report were documented by the social services director on 6/21/21 and stated, "SSD [social services director] talked with other resident who denied making these comments. this writer advised that resident stay away from [Resident #67's] room and off her hallway as she feels uncomfortable. Resident agreed." (Sic) The social services director signed the form and listed the grievance as "Resolved." The form listed no communication or review of the incident by the administrator, director of nursing or nursing staff caring for either resident. Resident #67's grievance form dated 6/17/21 included no documentation identifying the	F 607	3. All staff will be in-serviced on sexual assault and reporting. 4. All incidents, accidents, and allegations of abuse will be immediately reported and thoroughly investigated to the appropriate agencies per guidelines. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee consisting of DON, Medical Director, NHA, MDS, Safety Officer, Social Services Director, Infection Control Officer monthly to review the need for continued intervention or amendment of plan.	

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F 607	Continued From page 4	F 607		

resident accused of making the comments, what alleged comments were made, where the incident occurred or frequency of the alleged comments. There was no documented interview with the resident about the comments or any details describing the situation or events surrounding the residents' interactions. There was no documented interview of the accused resident and no interviews with staff or other residents about any issues with the accused resident.

Resident #67's closed record including a plan of care (revised 6/7/21) made no mention of the resident feeling "uncomfortable" or of any incidents with other residents.

On 11/30/21 at 3:30 p.m., the director of social services (other staff #1) was interviewed about Resident #67's allegation of sexual comments. The social services director stated it was reported to her from other staff and Resident #67 that another resident made inappropriate sexual comments to Resident #67 that made the resident uncomfortable. The social services director identified the resident accused of making the inappropriate comments as Resident #43. The social services director stated she talked with Resident #43 about the allegations after the report and he denied making the comments. When asked if she documented her interview with Resident #43, the social services director stated, "It was not a formal complaint." The social services director stated she called "local social services" about the incident but did not make an official report to adult protective services. When asked about what Resident #43 was accused of saying and where the incident took place, the social services director stated she did not remember exactly. The social services director

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F 607	Continued From page 5	F 607		

stated, "It was her [Resident #67's] word against his [Resident #43's]...I spoke with [Resident #43] and asked him to kind of stay away from her. It was a conversation." The social services director stated she reported the incident to "administration."

On 12/1/21 at 9:00 a.m., the administrator was interviewed about reporting and investigating Resident #67's allegation of sexual comments by Resident #43. The administrator stated the incident "was not an actual assault" and Resident #43 "said some things." The administrator stated Resident #67 took care of the incident herself. The administrator stated, "She [Resident #67] told him off [Resident #43] and it didn't happen again." The administrator stated the reason for not reporting or investigating the incident was because the resident took care of it herself.

The director of nursing at the time of the incident was not interviewed, as she no longer worked at the facility.

Resident #67's allegations of sexual comments from Resident #43 were not thoroughly investigated. The social services director failed to document identification of the accused resident, the alleged comments made or where the incident occurred. There were no documented interviews with Resident #67 other than on the original grievance form. There was no interview with the accused resident (#43) other than the social services director documenting the resident denied the allegation. There was no documented communication of the incident to administration including the director of nursing. There were no social worker notes about the incident in Resident #67's clinical record.

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The facility's policy titled Abuse, Neglect and Exploitation (revised 10/22/20) documented, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property...'Verbal Abuse' means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability..." This policy documented regarding investigation/reporting of allegations, "...procedures for investigation include...Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations...Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and...Providing complete and thorough documentation of the investigation... The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation..." This policy's steps for reporting/response included, "...Reporting of all alleged violations to the Administrator, state agency, adult protective services...within specified time frames...Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury...Assuring that reporters are free from retaliation or reprisal...Taking all necessary actions as a result if [of] the investigation which may include...Analyzing the occurrence(s) to

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F 607	Continued From page 7 determine...what changes are needed to prevent further occurrences...Defining how care provision will be changed and/or improved to protect residents receiving services...The Administrator will follow up with government agencies...to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies..." This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 12/1/21 at 11:30 a.m.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		1/4/22

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F 609	Continued From page 8 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to report to the state agency and adult protective services, an allegation of inappropriate sexual comments toward one of 23 residents in the survey sample. Allegations by Resident #67 of inappropriate sexual comments from another resident that made the resident "uncomfortable" were not reported to the state agency or local adult protective services. The findings include: Resident #67 was admitted to the facility on 4/26/21 and was discharged to the hospital on 11/17//21. Diagnoses for Resident #67 included viral hepatitis C, alcoholic cirrhosis of liver, liver failure, affective mood disorder, renal failure, coronary artery disease, hypertension and hypothyroidism. The minimum data set (MDS) dated 11/2/21 assessed Resident #67 as cognitively intact. While investigating complaint allegations regarding Resident #67, the facility's complaint/grievance logs were reviewed. The social services director documented a complaint/grievance form dated 6/17/21 stating, "Resident [#67] reports that another resident is making inappropriate sexual comments toward her." The investigation section of the grievance	F 609	1. In-service Administrator/Director of Nursing on Reporting abuse to State Agencies and Other Entities/ Individuals policy and Abuse Investigation policy. 2. All residents with incidents, accidents, and allegations of abuse have the potential to be affected by deficient practice. 3. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of Health Reporting of Incidences and facility policy on Abuse Prohibition. 4. All incidents, accidents, and allegations of abuse will be immediately reported and thoroughly investigated to report to the appropriate agencies per guidelines. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy	

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F 609	Continued From page 9 form was blank. Findings on the report were documented by the social services director on 6/21/21 and stated, "SSD [social services director] talked with other resident who denied making these comments. this writer advised that resident stay away from [Resident #67's] room and off her hallway as she feels uncomfortable. Resident agreed." (Sic) The social services director signed the form and listed the grievance as "Resolved." The form listed no communication or review of the incident by the administrator, director of nursing or nursing staff caring for either resident. Resident #67's grievance form dated 6/17/21 included no documentation identifying the resident accused of making the comments, what alleged comments were made, where the incident occurred or frequency of the alleged comments. There was no documented interview with the resident about the comments or any details describing the situation or events surrounding the residents' interactions. There was no documented interview of the accused resident and no interviews with staff or other residents about any issues with the accused resident. Resident #67's closed record including a plan of care (revised 6/7/21) made no mention of the resident feeling "uncomfortable" or of any incidents with other residents. On 11/30/21 at 3:30 p.m., the director of social services (other staff #1) was interviewed about Resident #67's allegation of sexual comments. The social services director stated it was reported to her from other staff and Resident #67 that another resident made inappropriate sexual comments to Resident #67 that made the	F 609	The Administrator will be responsible for overseeing all abuse/neglect allegation investigations and ascertaining that the facility policy for Abuse Prevention, Investigation and Reporting is followed including reporting requirements. The Administrator will contact the Corporate Director of Clinical Services within eight hours of being informed of an abuse allegation to review the allegations of abuse, review the investigation process, the reporting requirements, and the overall compliance with the facility policy for abuse reporting and investigation as well as the Elder Justice Act.	

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F 609	Continued From page 10	F 609		

resident uncomfortable. The social services director identified the resident accused of making the inappropriate comments as Resident #43. The social services director stated she talked with Resident #43 about the allegations after the report and he denied making the comments. When asked if she documented her interview with Resident #43, the social services director stated, "It was not a formal complaint." The social services director stated she called "local social services" about the incident but did not make an official report to adult protective services. When asked about what Resident #43 was accused of saying and where the incident took place, the social services director stated she did not remember exactly. The social services director stated, "It was her [Resident #67's] word against his [Resident #43's]...I spoke with [Resident #43] and asked him to kind of stay away from her. It was a conversation." The social services director stated she reported the incident to "administration."

On 12/1/21 at 9:00 a.m., the administrator was interviewed about reporting and investigating Resident #67's allegation of sexual comments by Resident #43. The administrator stated the incident "was not an actual assault" and Resident #43 "said some things." The administrator stated Resident #67 took care of the incident herself. The administrator stated, "She [Resident #67] told him off [Resident #43] and it didn't happen again." The administrator stated the reason for not reporting or investigating the incident was because the resident took care of it herself.

The director of nursing at the time of the incident was not interviewed, as she no longer worked at the facility.

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F 609	Continued From page 11 Resident #67's allegations of sexual comments from Resident #43 were not thoroughly investigated and were not reported to the state agency or adult protective services. This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 12/1/21 at 11:30 a.m.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to thoroughly investigate allegations of potential verbal abuse for one of 23 residents in the survey sample. Allegations by Resident #67 of inappropriate sexual comments from another	F 610	1. In-service Administrator/Director of Nursing on Reporting abuse to State Agencies and Other Entities/ Individuals policy and Abuse Investigation policy. 2. All residents with incidents, accidents,	1/4/22

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F 610	Continued From page 12 resident that made the resident "uncomfortable" were not thoroughly investigated. The findings include: Resident #67 was admitted to the facility on 4/26/21 and was discharged to the hospital on 11/17//21. Diagnoses for Resident #67 included viral hepatitis C, alcoholic cirrhosis of liver, liver failure, affective mood disorder, renal failure, coronary artery disease, hypertension and hypothyroidism. The minimum data set (MDS) dated 11/2/21 assessed Resident #67 as cognitively intact. While investigating complaint allegations regarding Resident #67, the facility's complaint/grievance logs were reviewed. The social services director documented a complaint/grievance form dated 6/17/21 stating, "Resident [#67] reports that another resident is making inappropriate sexual comments toward her." The investigation section of the grievance form was blank. Findings on the report were documented by the social services director on 6/21/21 and stated, "SSD [social services director] talked with other resident who denied making these comments. this writer advised that resident stay away from [Resident #67's] room and off her hallway as she feels uncomfortable. Resident agreed." (Sic) The social services director signed the form and listed the grievance as "Resolved." The form listed no communication or review of the incident by the administrator, director of nursing or nursing staff caring for either resident. Resident #67's grievance form dated 6/17/21 included no documentation identifying the	F 610	and allegations of abuse have the potential to be affected by deficient practice. 3. Corporate Clinical Consultant in-serviced Administrator/ Director of Nursing on Virginia Department of Health Reporting of Incidences and facility policy on Abuse Prohibition. 4. All incidents, accidents, and allegations of abuse will be immediately reported and thoroughly investigated per guidelines. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy The Administrator will be responsible for overseeing all abuse/neglect allegation investigations and ascertaining that the facility policy for Abuse Prevention, Investigation and Reporting is followed including reporting requirements. The Administrator will contact the Corporate Director of Clinical Services within eight hours of being informed of an abuse allegation to review the allegations of abuse, review the investigation process, the reporting requirements, and the overall compliance with the facility policy for abuse reporting and investigation as well as the Elder Justice Act.	

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resident accused of making the comments, what alleged comments were made, where the incident occurred or frequency of the alleged comments. There was no documented interview with the resident about the comments or any details describing the situation or events surrounding the residents' interactions. There was no documented interview of the accused resident and no interviews with staff or other residents about any issues with the accused resident.

Resident #67's closed record including a plan of care (revised 6/7/21) made no mention of the resident feeling "uncomfortable" or of any incidents with other residents.

On 11/30/21 at 3:30 p.m., the director of social services (other staff #1) was interviewed about Resident #67's allegation of sexual comments. The social services director stated it was reported to her from other staff and Resident #67 that another resident made inappropriate sexual comments to Resident #67 that made the resident uncomfortable. The social services director identified the resident accused of making the inappropriate comments as Resident #43. The social services director stated she talked with Resident #43 about the allegations after the report and he denied making the comments. When asked if she documented her interview with Resident #43, the social services director stated, "It was not a formal complaint." The social services director stated she called "local social services" about the incident but did not make an official report to adult protective services. When asked about what Resident #43 was accused of saying and where the incident took place, the social services director stated she did not remember exactly. The social services director

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stated, "It was her [Resident #67's] word against his [Resident #43's]...I spoke with [Resident #43] and asked him to kind of stay away from her. It was a conversation." The social services director stated she reported the incident to "administration."

On 12/1/21 at 9:00 a.m., the administrator was interviewed about reporting and investigating Resident #67's allegation of sexual comments by Resident #43. The administrator stated the incident "was not an actual assault" and Resident #43 "said some things." The administrator stated Resident #67 took care of the incident herself. The administrator stated, "She [Resident #67] told him off [Resident #43] and it didn't happen again." The administrator stated the reason for not reporting or investigating the incident was because the resident took care of it herself.

The director of nursing at the time of the incident was not interviewed, as she no longer worked at the facility.

Resident #67's allegations of sexual comments from Resident #43 were not thoroughly investigated. The social services director failed to document identification of the accused resident, the alleged comments made or where the incident occurred. There were no documented interviews with Resident #67 other than on the original grievance form. There was no interview with the accused resident (#43) other than the social services director documenting the resident denied the allegation. There was no documented communication of the incident to administration including the director of nursing. There were no social worker notes about the incident in Resident #67's clinical record.

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F 610	Continued From page 15 This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 12/1/21 at 11:30 a.m.	F 610		
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 observation, resident interview, and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) for one of 23 residents in the survey sample. Resident #49's 5-day and significant change MDS both documented an inaccurate assessment of bladder function. The findings include: Resident #49 originally admitted to the facility on 06/25/2018 and readmitted on 10/25/2021 with diagnoses that included hypertension, chronic kidney disease, vitamin d deficiency, depression, hypokalemia, after care for amputation, and urine retention. The most recent MDS dated 11/9/2021 was a significant change and assessed Resident #49 as cognitively intact for daily decision making with a score of 15 out of 15. Under Section H - Bowels and Bladder, Resident #49 was assessed as having an indwelling catheter. A comparative review of the 5-day MDS dated 11/1/21 was completed. Under Section H - Bowels and Bladder, Resident #49 was assessed as having an indwelling catheter.	F 641	1. Resident # 49□s MDS was revised appropriately to reflect indwelling catheter removal and bladder incontinence before Survey exit. 2. All residents newly admitted or readmitted from the hospital could have the potential to be affected by deficient practice. 3. An assessment and audit of all current residents with indwelling catheters has been conducted to assure that their most recent MDS reflects their appropriate urinary elimination status. Inservicing by the Clinical Consultant Nurse to the MDS Coordinator on correct coding of indwelling catheters on the MDS and appropriate care planning of urinary elimination status has been completed. 4. All newly admitted/readmitted residents will be assessed for the presence of an indwelling catheter and have their orders and Admission-Readmission Screening reviewed at the next Clinical Meeting	1/4/22

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F 641	Continued From page 16 On 11/29/2021 during the initial tour, Resident #49 was observed sleeping in his bed, no catheter bag or catheter related devices were observed. On 11/29/2021, Resident #49 was again observed in his room eating, no catheter bag or catheter related devices were observed. On 11/30/2021 at 8:30 a.m., Resident #49 was observed eating breakfast in his room, no catheter bag or catheter related devices were observed. Resident was #49 was interviewed regarding the quality of care and life since his admission at the facility. Resident #49 stated things were good and the staff took good care of him. Resident #49 stated he had been in and out of the hospital because of his leg amputation. Resident #49 was asked about his assistance for activities of daily living (ADL) care including bladder and bowels. Resident #49 stated he required toileting assistance. Resident #49 was asked if he had a catheter. Resident #49 stated, "I did, but it was removed about a month ago." On 11/30/2021 Resident #49's clinical record was reviewed. The Admission/Readmission Screening dated 10/25/2021 assessed Resident #49's bladder continence as always incontinent. Resident #49 was not assessed as having a catheter on the 10/25/2021 Admission/Readmission Screening. A review of the care plans documented the following: "The resident has an indwelling Catheter r/t (related to) urethra trauma/urinary retention.... Date Initiated 3/25/2021..." A review of the orders documented the foley catheter orders were discontinued on 10/17/2021. On 12/01/2021 at 8:00 a.m., the MDS coordinator (RN #4) was interviewed regarding Resident	F 641	following the admission/readmission for the presence/absence of orders r/t an indwelling catheter. All residents with indwelling catheters will be discussed at the weekly Risk meeting and an audit maintained by the MDS Coordinator to assure that the presence of said catheter remains in place and/or that the MDS reflects the correct urinary elimination status. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	

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F 641	Continued From page 17 #49's MDS accuracy. RN #4 reviewed Resident #49's clinical record including the hospital discharge summary and the facility's admission/readmission screening dated 10/25/2021. RN #4 stated, "[Resident #49] had the foley catheter for so long I just thought he was readmitted with it. It's not showing on the hospital discharge summary nor the readmission screening so I made a mistake. It should not have been assessed on either the 5-day or the significant change MDS and I will submit a modification for both of those MDS for correction." On 12/02/2021 at 11:20 a.m., the above findings were discussed with the administrator, director of nursing (DON) and corporate consultant. No additional information was received by the survey team prior to the exit on 12/02/2021 at 1:15 p.m.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		1/4/22

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F 657	Continued From page 18 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and clinical record review, the facility staff failed to review and revise a comprehensive care plan for 2 of 23 residents in the survey sample, Resident #49 and Resident #47. Resident #49's care plans were not reviewed and revised for discontinuation of a foley catheter. Resident #47's care plans were not reviewed and revised for code status change. The findings include: 1. Resident #49 originally admitted to the facility on 06/25/2018 and readmitted on 10/25/2021 with diagnoses that included hypertension, chronic kidney disease, vitamin d deficiency, depression, hypokalemia, after care for amputation, and urine retention. The most recent MDS dated 11/9/2021 was a significant change and assessed Resident #49 as cognitively intact for daily decision making with a score of 15 out of 15. Under Section H - Bowels and Bladder, Resident #49 was assessed as having an indwelling catheter. A comparative review of the 5-day MDS dated 11/1/21 was	F 657	1. Resident # 49□s Care Plan was revised appropriately to reflect indwelling catheter removal and bladder incontinence before Survey exit. Resident□s 47□s Care Plan was revised appropriately to reflect current Code Status before Survey exit. 2. All residents newly admitted, or readmitted from the hospital, and changed to hospice could have the potential to be affected by deficient practice. 3. An assessment and audit of all current residents with indwelling catheters has been conducted to assure that their most recent MDS reflects their appropriate urinary elimination status. Inservicing by the Clinical Consultant Nurse to the MDS Coordinator on correct coding of indwelling catheters on the MDS and appropriate care planning of urinary elimination status has been completed.	

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F 657	Continued From page 19 completed. Under Section H - Bowels and Bladder, Resident #49 was assessed as having an indwelling catheter. On 11/29/2021 during the initial tour, Resident #49 was observed sleeping in his bed, no catheter bag or catheter related devices were observed. On 11/29/2021, Resident #49 was again observed in his room eating, no catheter bag or catheter related devices were observed. On 11/30/2021 at 8:30 a.m., Resident #49 was observed eating breakfast in his room, no catheter bag or catheter related devices were observed. Resident was #49 was interviewed regarding the quality of care and life since his admission at the facility. Resident #49 stated things were good and the staff took good care of him. Resident #49 stated he had been in and out of the hospital because of his leg amputation. Resident #49 was asked about his assistance for activities of daily living (ADL) care including bladder and bowels. Resident #49 stated he required toileting assistance. Resident #49 was asked if he had a catheter. Resident #49 stated, "I did, but it was removed about a month ago." On 11/30/2021 Resident #49's clinical record was reviewed. The Admission/Readmission Screening dated 10/25/2021 assessed Resident #49's bladder continence as always incontinent. Resident #49 was not assessed as having a catheter on the 10/25/2021 Admission/Readmission Screening. A review of the care plans documented the following: "The resident has an indwelling Catheter r/t (related to) urethra trauma/urinary retention.... Date Initiated 3/25/2021..." A review of the physician orders documented the foley catheter orders were	F 657	All residents Code Status has been completed and accuracy verified that the Code Status is addressed in the Care Plan. Inservicing to the SS by the MDS Coordinator on timeliness and appropriate Code Status was completed. 4. All newly admitted/readmitted residents will be assessed for the presence of an indwelling catheter and have their orders and Admission-Readmission Screening reviewed at the next Clinical Meeting following the admission/readmission for the presence/absence of orders r/t an indwelling catheter. All residents with indwelling catheters will be discussed at the weekly Risk meeting and an audit maintained by the MDS Coordinator to assure that the presence of said catheter remains in place and/or that the MDS reflects the correct urinary elimination status. Any resident newly admitted to Hospice will have their Code Status verified at the time of the Hospice admission and appropriately reviewed and revised in the care plan. MD orders will be reviewed daily for Code Status changes by Social Worker and any changes will be made in the care plan. An audit will be conducted by the SW weekly to assure the changes in Code Status are reflected appropriately in the Care Plan Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy.	

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F 657	Continued From page 20 discontinued on 10/17/2021. On 12/01/2021 at 8:00 a.m., the MDS coordinator (RN #4) was interviewed regarding Resident #49's care plans. . RN #4 reviewed Resident #49's clinical record including the hospital discharge summary and the facility's admission/readmission screening dated 10/25/2021. RN #4 stated, "[Resident #49] had the foley catheter for so long I just thought he was readmitted with it. It's not showing on the hospital discharge summary nor the readmission screening so I made a mistake, it should have been removed from his care plans..." On 12/02/2021 at 11:20 a.m., the above findings were discussed with the administrator, director of nursing (DON) and corporate consultant. No additional information was received by the survey team prior to the exit on 12/02/2021 at 1:15 p.m. 2. Resident #47 originally admitted to the facility on 03/24/2009 and readmitted on 10/22/2021 with diagnoses that included hypertension, peripheral vascular disease, septicemia, urinary tract infection, type 2 diabetes, cerebrovascular accident (CVA/Stroke), depression, and hyperlipidemia. The most recent MDS dated 10/29/2021 was a quarterly assessment and assessed Resident #47 as moderately impaired for daily decision making with a score of 9 out of 15. On 11/29/2021, Resident #47's clinical record was reviewed. Observed on the resident manager contact screen was the following: "Code Status: DNR..." Observed on the physician orders was	F 657	The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	

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the following: "DNR. Revision Date: 11/29/2021" and "Admit to hospice services with [Hospice Provider]....Patient is a DNR... Revision Date: 11/29/2021..."

Observed on Resident #47's care plans was the following: "...Advanced Directives: Full Code..."

On 12/01/2021 at 8:00 a.m., the MDS coordinator (RN #4) was interviewed regarding Resident #47's hospice admission and code status. RN #4 stated Resident #47 was admitted to hospice on 11/29/2021 and the facility social worker was responsible for updating the code status care plan. RN #4 was asked if the social worker was aware of the hospice admission and code status change. RN #4 stated, "yes."

On 12/01/2021 at 8:25 a.m., the facility's social worker (OS #1) was interviewed regarding Resident #47's code status change and care plan revision. OS #1 stated, "I was aware that hospice was going to have a conversation with the family about the code status change from full code to DNR. This was a brand new hospice admission and took place on Saturday." OS #1 reviewed the orders and stated, [Facility Medical Director] gave the order to change the code status from full code to DNR. But this order was changed at 5:43 p.m. and it was not communicated to me but I was aware there was a conversation taking place with hospice. The care plan should have been updated to reflect the change."

On 12/01/2021 at 11:20 a.m., the above findings were discussed with the administrator, director of nursing (DON), and corporate consultant. The corporate consultant stated, "it is a team effort and the care plans should have been revised."

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F 657	Continued From page 22 A review of the facility's policy titled "Care Plan Revisions Upon Status Change (Date Implemented: 11/1/2020)" documented the following: "1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. "2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse or any member of the interdisciplinary team will notify the MDS Coordinator, the physician, and the resident representative, if applicable.... d. The care plan will be updated with the new or modified interventions.... f. Care plans will be modified as needed by MDS Coordinator or other designated staff member..." No additional information was received by the survey team prior to exit on 12/01/2021 at 1:15 p.m.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that 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, resident interview, staff	F 684	1. Resident # 72 the Nystatin powder was	1/4/22

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F 684	Continued From page 23 interview and clinical record review, the facility staff failed to obtain a physician's order prior to use of a topical medication for one of 23 residents in the survey sample. Resident #72 had topical Nystatin powder applied to her skin without a physician's order for its use. The findings include: Resident #72 was admitted to the facility on 8/15/17 with a readmission on 11/5/21. Diagnoses for Resident #72 included hypoxia, respiratory failure, morbid obesity, diabetes, urinary tract infection, obstructive sleep apnea, anxiety, urinary retention, depression and anemia. The minimum data set (MDS) dated 11/12/21 assessed Resident #72 as cognitively intact. On 11/30/21 at 9:30 a.m., Resident #72 was observed in bed. A bottle of Nystatin powder was observed on the resident's over-bed table. Resident #72 was interviewed at this time about the Nystatin powder. Resident #72 stated the aides or nurses sprinkled the powder on "hot spots" on her skin as needed. Resident #72 stated she did not apply the powder herself but the nurses applied it to skin areas that were burning or red. Resident #72 stated staff members had been applying the powder when needed for about two months. Resident #72's clinical record documented no current physician's order for Nystatin powder. The record documented the resident was assessed with moisture associated skin damage under her left breast on 10/11/21. A physician's order dated 10/11/21 was documented for Nystatin powder to be applied to the affected area	F 684	removed and discarded. No adverse effect noted. 2. All residents with discontinued Nystatin powder physician orders could have the potential to be affected by deficient practice. 3. An audit of all residents with recent discontinue orders for Nystatin powder will be inspected for continued use. 4. Director of Nursing/ or designee will audit weekly times 2 months then monthly for 1 month for recent discontinued Nystatin powder orders and the discontinued use of the powder. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	

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and covered with an ABD pad twice per day until resolved. The record documented the order for Nystatin powder was discontinued on 10/31/21. Resident #72's treatment administration records documented the Nystatin powder was applied as ordered from 10/11/21 through 10/31/21. The resident's November 2021 treatment administration record documented no use of Nystatin powder.

On 11/30/21 at 10:43 a.m., the licensed practical nurse (LPN #4) was interviewed about the use of the Nystatin powder located in the resident's room. LPN #4 reviewed the resident's clinical record and stated she did not see a current order for use of Nystatin powder. LPN #4 stated there should be a physician's order prior to use of the Nystatin powder.

On 11/30/21 at 3:00 p.m., the unit manager (LPN #3) was interviewed about Resident #72's report of staff applying Nystatin powder as needed to "hot spots" on her skin. LPN #3 stated there should be a physician's order for use of the Nystatin and the powder was supposed to be stored in the treatment cart.

Resident #72's plan of care (revised 10/16/21) documented the resident was at risk of skin breakdown due to obesity, immobility and incontinence. Interventions to maintain skin integrity included applying moisturizer to skin/back daily, assisting to turn/reposition on rounds, a bariatric air mattress and notification to physician of any changes in skin status. The care plan listed the use of Nystatin powder as ordered for moisture associated skin damage under the left breast until resolved.

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F 684	Continued From page 25 The Nursing 2017 Drug Handbook on page 1056 describes Nystatin powder as a topical medication used to treat fungal infections of the skin. (1) This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 11/30/21 at 2:30 p.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure one of 23 residents in the survey sample, Resident #30, was provided care and treatment to promote healing and prevent infection of a pressure ulcer.	F 686	1. Resident # 30 has been under the services of the wound care medical doctor. RN#2 was educated on the procedures for changing wound dressings. No adverse effect noted. 2. All residents with pressure ulcer	1/4/22

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F 686	Continued From page 26 Findings include: Resident #30 was admitted to the facility on 07/06/19, with the most recent readmission on 01/05/21. Diagnoses for Resident #30 included, but were not limited to: anemia, CHF (congestive heart failure), high blood pressure, history of multiple strokes with hemiparesis/hemiplegia, cardiac arrhythmias, schizophrenia, and a stage 4 pressure ulcer. The most current MDS (minimum data set) was a quarterly assessment dated 10/08/21. This MDS assessed the resident with a cognitive score of 9, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance for all ADL's (activities of daily living). The resident was assessed as having a current stage 4 pressure ulcer. On 11/29/21 at 1:30 PM, a dressing change was observed on Resident #30. The dressing change was conducted by RN (Registered Nurse) #2. RN #2 entered the room of Resident #30 with supplies in hand. RN #2 went to the resident's bedside, pulled the privacy curtain and put the supplies on the resident's bedside table. RN #2 did not clean the bedside table prior to placing supplies down and did not provide a clean field for the dressing supplies. RN #2 cleaned her scissors with an alcohol prep, and donned gloves. RN #2 did not wash her hands after entering the resident's room or prior to donning gloves. RN #2 then turned the resident to her left side and unfastened the brief, opened the back side of the brief and laid it open onto the pad under the resident. The resident's bottom was exposed, and a dressing was observed on the coccyx. RN	F 686	dressing changes could have the potential to be affected by deficient practice. 3. Re-education was provided to the wound care nurse RN#2 regarding the proper wound changing procedures before Survey exit. The Director of Nursing will have oversight of the skin management program. 4. Director of Nursing/ or designee will audit the Pressure Ulcer changing procedure of 2 residents weekly times 1 month then monthly for 2 months. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	

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#2 removed the dressing and laid the open dressing on the opened brief. RN #2 then took a syringe of normal saline from the supplies located on the bedside table and squirted it in and around the wound/wound bed and laid the empty syringe on the opened brief. RN #2 did not dispose of the soiled dressing, did not remove her gloves, or wash her hands after removing the soiled dressing. RN #2, then took off her gloves, laid them on top of the resident's brief, along with the soiled dressing and empty saline syringe. RN #2 then donned new gloves. RN #2 did not wash her hands prior to putting on the new gloves.

RN #2 then took a gauze pad and wiped around the resident's wound, laid the soiled gauze down on the opened brief, took another pre-filled saline syringe from the bedside table and squirted it in and around the wound, laid that empty syringe on the bed, took another gauze and wiped all around the wound, and laid that on the bed. RN #2 then took a sterile Q-tip and inserted it into the wound and used another saline syringe to irrigate the wound. RN #2 put the used supplies on the bed with the other used supplies and soiled dressing. RN #2 did not remove her gloves or wash her hand during this process.

RN #2 then took off the left glove (the right hand remained gloved) and laid it on the bed, along with the other used supplies. RN #2 took her left hand and got a skin prep pack with her left hand and opened it with her left (ungloved hand) and her right (gloved) hand, and applied skin prep around the wound with the right gloved hand. RN #2 then started to pick up the old dressing and used supplies, but stopped and donned a new glove for the left hand. RN #2 then picked up the wound medication, along with a tongue

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depressor, and mixed the medication with a small amount of gel product (hydrogel). RN #2 took the tongue depressor and put the medication mixture into the wound. RN #2 laid the medication cup with tongue depressor onto the bed/brief with the other used supplies and soiled dressing. RN #2 did not wash her hands during this portion of the dressing change and did not change gloves. RN #2 then gathered the soiled dressing and used supplies and discarded the trash into the receptacle and proceeded to cover the resident up with the same gloves on. RN #2 stated that she needed to call the nurse's station for a new dressing to cover the resident's wound. RN #2 then removed her gloves, pushed the call bell and proceeded to the sink to wash her hands. RN #2 started washing her hands with soap and water (approximately 5-10 seconds), turned off the faucet with her bare hand, and proceeded to dry her hands.

The new dressing arrived, RN #2 donned new gloves, dated the dressing and applied the new dressing to Resident #30. RN #2 then washed her hands and exited the room.

At approximately 2:00 PM, RN #2 was interviewed. RN #2 was made aware of the observations. RN #2 stated that she was a little nervous and that she should have washed her hands before the glove change. RN #2 was asked about the facility's policy regarding wound care and dressing changes. RN #2 stated that she wasn't sure what the policy said. RN #2 was asked if she could provide a copy of the policy; RN #2 stated that she wasn't sure where to get it.

On 11/29/21 at approximately 3:30 PM, a policy was requested on wound care/dressing changes

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from the administrator. On 11/30/21 at 11:20 AM, the facility's policy was again requested on wound care/dressing changes from the Director of Nusrsing (DON).

The policy titled, "Wound Care", documented, "...care of wounds to promote healing...assemble equipment and supplies as needed...dressing material, as indicated...gauze, tape, scissors...disposable gloves..Steps in the Procedure...disposable cloth (paper towel is adequate) to establish a clean field on the resident's overbed table. Place all items to be used...on the clean field. Arrange...so they can be easily reached...wash and dry your hands thoroughly...position resident, place disposable cloth next to resident (under the wound) to serve as a barrier to protect bed linen and other body sites...put on exam gloves...remove dressing...pull glove over dressing and discard into appropriate receptacle...wash and dry hands thoroughly...put on gloves...use no touch technique...apply treatments...dress wound...apply dressing. Be certain all clean items are on a clean field...remove the disposable cloth next to resident and discard...remove disposable gloves and discard...wash and dry hands thoroughly...reposition bed covers...make resident comfortable...use clean field saturated with alcohol to wipe overbed table...wipe reusable supplies with alcohol...outside of containers...scissors...wash and dry hands thoroughly...if resident desires return the door and curtains to open position..."

The resident's CCP (comprehensive care plan) was reviewed and documented, "...history of MRSA in sacral wound...Stage 4 pressure ulcer...administer medications as

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F 686	Continued From page 30 ordered...observed for signs and symptoms of infection...cleanse sacral wound...open wounds should be covered..." On 12/01/21 at 11:25 AM, the DON, administrator and corporate consultant were informed of the above information and observations. The corporate consultant stated that the nurse was educated. No further information and/or documentation was provided prior to the exit conference on 12/01/21 at 1:30 PM.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		1/4/22

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F 690	Continued From page 31 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide appropriate catheter care for two of 23 residents in the survey sample. Resident #72 had a urinary catheter in use with the tubing unsecured to prevent pulling/tugging at the insertion site. Resident #50's catheter bag was observed in the floor under the resident's bed. The findings include: 1. Resident #72 was admitted to the facility on 8/15/17 with a re-admission on 11/5/21. Diagnoses for Resident #72 included hypoxia, respiratory failure, morbid obesity, diabetes, urinary tract infection, obstructive sleep apnea, anxiety, urinary retention, depression and anemia. The minimum data set (MDS) dated 11/12/21 assessed Resident #72 as cognitively intact. On 11/30/21 at 9:12 a.m., Resident #72 was observed in bed with a Foley urinary catheter in use. Resident #72 was interviewed at this time	F 690	1. Resident # 72 catheter tubing was secured before survey exit. Resident #50 catheter bag was removed from the floor and placed in the privacy bag before survey exit. No adverse effect noted. 2. All residents with foley catheters will be audited to ensure the foley is secured and not on the floor. 3. Nursing staff will be in-serviced on the foley catheter care policy. The current staff and agency staff will be in-serviced on the foley catheter care policy. All new hires and starting agency will be in-serviced on foley catheter care policy. 4. Director of Nursing/ or designee will audit the residents with a foley catheter. To ensure the foleys are secure and not on the floor. This audit will take place twice weekly for 2 months, then monthly for 2 months. Findings will be reported to the QAPI committee.	

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about catheter care provided by the facility. When asked about an anchor or a device to secure the catheter tubing, Resident #72 stated the catheter tubing was not anchored or attached in any manner. Resident #72 pulled back the bed covers and the catheter tubing was observed positioned over top of the left leg. The tubing was not anchored or attached in any manner to prevent pulling or movement. Resident #72 stated concerning the catheter, "It feels like I'm about to crown down there sometimes."

On 11/30/21 at 9:30 a.m., the licensed practical nurse (LPN #4) caring for Resident #72 was interviewed about the catheter tubing. LPN #4 stated catheter tubing was supposed to be anchored to prevent movement.

On 11/30/21 at 10:47 a.m., accompanied by LPN #4 and with the resident's permission, Resident #72's catheter tubing was observed. The tubing was positioned over the left upper leg and was not attached and/or anchored to prevent pulling/tugging. Resident #72 stated at this time that the catheter "tugged" and was uncomfortable at times especially when she was turned in bed.

On 11/30/21 at 3:00 p.m., the unit manager (LPN #3) was interviewed about Resident #72's unsecured catheter tubing. LPN #3 stated that checking for the tubing anchor was part of the daily care for Foley catheters. LPN #3 stated catheter tubing was expected to be anchored or secured with a device to minimize pulling.

The resident's plan of care (revised 11/8/21) listed the resident had an indwelling Foley catheter due to urinary retention. Interventions listed to prevent complications from catheter use

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included to monitor/document for pain/discomfort due to catheter.

The facility's policy titled Catheter Care, Urinary (revised Sept. 2014) documented, "The purpose of this procedure is to prevent catheter-associated urinary tract infections...Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh)...Secure catheter utilizing a leg band..."

This finding was reviewed with the administrator, director of nursing and regional director of clinical services on 11/30/21 at 2:30 p.m.

2. Resident # 50 was admitted to the facility 1/8/21 with diagnoses to include, but not limited to: cardiovascular disease, hidradenitis suppurativa (an inflammatory process requiring the use of a catheter), COPD, diabetes, and depression.

The most recent MDS (minimum data set) was a quarterly assessment dated 11/18/21 and had the resident coded as cognitively intact with a total summary score of 15 out of 15.

On 11/29/21 at 12:56 P.M. Resident # 50 was observed in bed with the catheter bag and partial tubing laying on the floor under the bed. Resident # 50 stated "It's always on the floor, it keeps falling." CNA (certified nursing assistant) # 1 was outside the resident's door, and was asked for assistance. CNA # 1 entered the room, and was advised of the catheter bag on the floor. CNA # 1 stated "Yes, we've had a time with this. The clip that attached the bag to the bedrail broke off. I tried fixing it but it won't stay, it keeps falling." At

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F 690	Continued From page 34 that time, LPN (licensed practical nurse) # 1 entered the room, and repeated CNA # 1's remarks. She stated they would work on it to devise a way to keep the bag off the floor. On 11/29/21 at 1:30 the DON (director of nursing) was asked for a policy on catheter care. The policy "Catheter Care, Urinary" documented under "Infection Control 2.b. Be sure the catheter tubing and drainage bag are kept off the floor." The administrator, DON, and corporate nurse consultant were advised of the above findings during a meeting with facility staff 11/30/21 beginning at 2:26 p.m. No further information was provided prior to the exit conference.	F 690		
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 observation, resident interview, staff interview and facility document review, the facility staff failed to ensure oxygen equipment was maintained in sanitary manner for one of 23 residents, Resident #44.	F 695	1. Resident # 44 oxygen tubing and humidifier bottle was changed. No adverse effect noted. 2. All residents using oxygen concentrators could has the potential to	1/4/22

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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 695	Continued From page 35 Findings include: Resident #44 was admitted to the facility on 10/19/21. Diagnoses included, but were not limited to: acute kidney failure, COPD (chronic obstructive pulmonary disease), heart failure, diabetes, HIV, history of pulmonary embolis, major depressive disorder and SIRS (systemic inflammatory response). The most current MDS (minimum data set) was an admission assessment dated 10/26/21. This MDS assessed the resident as a 9 cognitively, indicating the resident had moderate impairment in daily decision making skills. On 11/29/21 at 12:23 PM, Resident #44's oxygen concentrator was observed in his room. The oxygen tubing was dated 11/22/21. The humidifier canister had approximately 1/8th of water remaining in the humidifier, and the humidifier canister was not dated. On 12/01/21 at approximately 7:45 AM, Resident #44 was interviewed. Resident #44 was sitting in his wheelchair in the hall near the nurse's station. Resident #44 was asked about his oxygen, and stated that he uses his oxygen mainly at night and later in the day. Resident #44 stated that as the day goes on and he becomes more tired that is when he tends to use the oxygen more. At approximately 7:50 AM, Resident #44's oxygen concentrator was observed again in his room. The oxygen tubing dated 11/22/21 and the humidifier was almost empty and there was no date on it. At 7:55 AM, LPN (Licensed Practical Nurse) #2	F 695	be affected by deficient practice. 3. All residents with oxygen concentrators will be audited to ensure the tubing and humidifier bottles have been changed per policy. The current staff and agency staff will be in-serviced on the Oxygen Concentrator Usage policy. All new hires and starting agency will be in-serviced on Oxygen Concentrator Usage policy. 4. Director of Nursing/ or designee will audit 5 oxygen concentrator residents weekly for 1 month then monthly for 2 months for tubing and humidifier bottles in date per policy. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	

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F 695	Continued From page 36	F 695		

was interviewed about Resident #44's oxygen tubing and humidification. LPN #2 stated that the tubing is to be changed weekly and that she thought it was done on Sunday nights, and the humidifier should be dated and changed out accordingly (when empty).

On 12/01/21 at 10:00 AM, a policy was requested on oxygen care and administration. The policy titled, "Oxygen Administration" documented, "...Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: ...change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated...Change humidifier bottle when empty, every 72 hours, or as recommended by manufacturer...Use only sterile water for humidification...keep delivery devices covered in a plastic bag when not in use..."

Resident #44's physician's orders were reviewed and documented, "...Change O2 humidifier bottle weekly and as needed...every Mon...Change Oxygen set up and bag weekly and as needed...Monday...place in labeled O2 bag..."

Resident #44's comprehensive care plan was reviewed and documented, "...COPD related to smoking...monitor for breathing difficulties...oxygen settings O2 via nasal cannula per MD order...resistive to care, refuses to wear oxygen at times..."

On 12/01/21 at 11:00 AM, the DON (director of nursing), the administrator and corporate nurse consultant were made aware that the resident's oxygen tubing had not been changed for over a

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F 695	Continued From page 37 week, that the humidifier was nearly empty and was not labeled to indicate when it was changed last. The DON stated that those items should be dated. No further information was presented prior to the exit conference on 12/01/21 at 1:30 PM.	F 695		
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 observation, resident interview, staff	F 761	1. Resident # 28 and Resident #72	1/4/22

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F 761	Continued From page 38 interview, clinical record review, and facility document review, the facility staff failed to properly store medications for two of 23 residents in the survey sample, Resident # 28 and #72. Findings include: 1. On 11/30/21 at 7:45 a.m., a medication pass and pour observation was conducted on the Riverside unit with LPN (licensed practical nurse) # 1. LPN # 1 was observed administering medications to Resident # 28. Upon entering the resident's room, a medication bag containing prescription nasal spray was on the overbed table. LPN # 1 asked the resident to hand her the bag. LPN # 1 was asked why the bag was there, and she stated "I don't know, it could have been left there on night shift." LPN # 1 returned the nasal spay to the medication cart. On 11/30/21 at approximately 10:00 a.m. Resident # 28, who was assessed as cognitively intact, was asked about the nasal spray. She stated "It's been there on that table since yesterday morning, I guess they just forgot." The administrator, DON, and corporate nurse consultant were advised of the above findings during a meeting with facility staff 11/30/21 beginning at 2:26 p.m. No further information was provided prior to the exit conference. 2. Resident #72 was admitted to the facility on 8/15/17 with a readmission on 11/5/21. Diagnoses for Resident #72 included hypoxia, respiratory failure, morbid obesity, diabetes, urinary tract infection, obstructive sleep apnea,	F 761	medication that was left in the resident room was removed. No adverse effect noted. 2. All residents could has the potential to be affected by deficient practice. 3. All residents rooms will be audited to ensure medications have not left in the room. The current nursing staff and agency nursing staff will be in-serviced on the proper medication distribution. All new hires and starting agency will be in-serviced on proper medication distribution. 4. Director of Nursing/ or designee will audit 10 residents rooms weekly for 1 month then monthly for 2 months to ensure the medications are secure and not in the resident rooms. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued	

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F 761	Continued From page 39 anxiety, urinary retention, depression and anemia. The minimum data set (MDS) dated 11/12/21 assessed Resident #72 as cognitively intact. On 11/30/21 at 9:30 a.m., Resident #72 was observed in bed. A bottle of Nystatin powder was observed on the resident's over-bed table. Resident #72 was interviewed at this time about the Nystatin powder. Resident #72 stated the aides or nurses sprinkled the powder on "hot spots" on her skin as needed. Resident #72 stated she did not apply the powder herself but the nurses applied it to skin areas that were burning or red. Resident #72 stated staff members had been applying the powder when needed for about two months. On 11/30/21 at 3:00 p.m., the unit manager (LPN #3) was interviewed about Resident #72's report of staff applying Nystatin powder as needed to "hot spots" on her skin. LPN #3 stated the Nystatin powder was supposed to be stored in the treatment cart. On 11/30/21 at approximately 10:15 a.m. the DON (director of nursing) was asked for the policy for medication storage. The policy "Medication Storage" documented "1. General Guidelines: All medications and biologicals will be stored in locked compartments... During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication cart/storage area..."	F 761	intervention or amendment of plan.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		1/4/22

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F 880	Continued From page 40 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 41 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure infection control practices were maintained during a dressing change for one of 23 residents (Resident #30), and during a medication pass and pour observation on one of two nursing units. Findings include: 1. Resident #30 was admitted to the facility on 07/06/19, with the most recent readmission on	F 880	1. RN#2 was educated in proper handwashing technic while providing wound care. LPN#1 was in-serviced in the handwashing policy. 2. All residents have the potential to be affected by deficient practice. 3. Nursing staff and nursing agency staff will be in-serviced in the Hand Hygiene policy by 12/16/2021.	

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F 880	Continued From page 42 01/05/21. Diagnoses for Resident #30 included, but were not limited to: anemia, CHF (congestive heart failure), high blood pressure, history of multiple strokes with hemiparesis/hemiplegia, cardiac arrhythmias, schizophrenia, and a stage 4 pressure ulcer. The most current MDS (minimum data set) was a quarterly assessment dated 10/08/21. This MDS assessed the resident with a cognitive score of 9, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance for all ADL's (activities of daily living), no ambulation, and a current stage 4 pressure ulcer for the look back period. On 11/29/21 at 1:30 PM, a dressing change was observed on Resident #30. The dressing change was conducted by RN (Registered Nurse) #2. RN #2 entered the room of Resident #30 with supplies in hand. RN #2 went to the resident's bedside, pulled the privacy curtain and put the supplies on the resident's bedside table and donned gloves. RN #2 did not wash her hands after entering the resident's room or prior to donning gloves for the dressing change. RN #2 then turned the resident to her left side, removed the brief exposing the resident's bottom with a dressing intact on the resident's coccyx. RN #2 removed the dressing and took a syringe of normal saline and squirted in and around the wound/wound bed. RN #2 did not dispose of the soiled dressing, and did not remove the gloves after the dressing was removed and did not wash her hands. RN #2 took off her gloves, and then donned new gloves. RN #2 did not wash her hands prior to putting on the new gloves. RN #2 then took a gauze pad and wiped around the	F 880	All new hires and new agency nursing staff will be trained in proper hand washing techniques. LPN#1 and RN#2 will be tracked and trended for compliance. 4. Director of nursing or designee will audit 5 Nursing staff members complete hand washing/sanitizing procedures weekly for one month and then 5 monthly for two months. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy The Administrator will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	

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resident's wound, took another pre-filled saline syringe and squirted it in and around the wound, took another gauze and wiped around the wound again. RN #2 did not remove her gloves or wash her hand during this process.

RN #2 then took off the left glove (right hand remained gloved), and opened a skin prep pack and applied skin prep around the wound with the gloved hand. RN #2 then donned a new left glove, mixed the medication with a small amount of gel product and put the medication mixture into the wound. RN #2 then gathered the soiled dressing and used supplies, discarded in the trash, and proceeded to cover the resident up with the same gloves on. RN #2 did not wash her hands or use any hand sanitizer during this portion of the dressing change and did not change gloves.

RN #2 then removed her gloves and proceeded to the sink to wash her hands. RN #2 started washing her hands with soap and water (approximately 5-10 seconds), turned off the faucet with a bare hand, and dried her hands.

RN #2 then donned new gloves and applied the new dressing to the resident's coccyx, removed the gloves and then washed her hands and exited the room.

At approximately 2:00 PM, RN #2 was interviewed. RN #2 was made aware of the observations. RN #2 stated that she was a little nervous and that she should have washed her hands before the glove change and should not have turned the water off with a bare hand. RN #2 stated she should have washed her hands for at least 20 seconds.

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F 880	Continued From page 44	F 880		

On 11/29/21 at approximately 3:30 PM, a policy was requested on handwashing. On 11/30/21 at 11:20 AM, the facility's policy titled, "Hand Hygiene" was presented and documented, "...Staff will perform hand hygiene when indicated...soap and water...hand sanitizer...using proper technique...under the conditions listed...soap and water...visibly soiled...before and after eating...after using restroom...between resident contact...after handling contaminated objects...before applying and after removing personal protective equipment...including gloves...when in doubt....soap and water...rub vigorously for at least 15 seconds...the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning and immediately after removing gloves.."

On 12/01/21 at 11:25 AM, the DON (director of nursing), administrator and corporate consultant were informed of the above information.

No further information and/or documentation was provided prior to the exit conference on 12/01/21 at 1:30 PM.

2. On 11/30/21 at 7:45 a.m., a medication pass and pour observation was conducted on the Riverside unit with LPN (licensed practical nurse) # 1. After administering medications, LPN # 1 proceeded to wash her hands with soap and water. After washing her hands, she turned off the water faucet with her bare hands, retrieved a paper towel from the dispenser, and dried her hands. LPN # 1 was asked about the technique observed, and she stated "Oh, yeah...I should have turned off the water with a paper towel..."

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F 880	Continued From page 45 The DON (director of nursing) was asked for a policy on hand hygiene 11/30/21 at approximately 8:45 a.m. The policy "Hand Hygiene" documented "5. Hand hygiene when using soap and water: a wet hands with water...b. apply to hands the amount of soap...c. rub hands together vigorously for 15 seconds...d. rinse with water...e. dry thoroughly with a single-use towel...f. use towel to turn off faucet." The administrator, DON, and corporate nurse consultant were advised of the above findings during a meeting with facility staff 11/30/21 beginning at 2:26 p.m. No further information was provided prior to the exit conference.	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms	F 886		1/4/22

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consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state

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F 886	Continued From page 47 and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure routine COVID-19 testing for unvaccinated staff was conducted based on level of community transmission rates, for two of four weeks in the month of November. Findings include: A review of the facility's infection control program was reviewed from 11/29/21 through 12/01/21. There were no current COVID-19 positive cases for residents or staff. On 11/30/21 the administrator presented the routine COVID-19 testing requirements for staff based on the facility's level of community transmission. The facility had a binder with the level of community transmission rates listed. For the month of November 2021 the following rates were recorded. 11/02/21 - 11.88 % (HIGH - twice weekly testing required) 11/09/21 - 9.55 % (SUBSTANTIAL - twice weekly testing required) 11/15/21 - 7.53 % (MODERATE - once weekly testing required) 11/22/21 - 9.84 % (SUBSTANTIAL - twice weekly testing required) On 12/1/21 at 8:50 AM, the facility's routine testing records for unvaccinated staff was	F 886	1. COVID-19 testing will be conducted per CMS guideline. No resident was affected due to testing requirement is for unvaccinated employees. 2. All residents had the potential to be affected by deficient practice. All unvaccinated employees will test to according to CMS QSO-20-38 NH. 3. Administrator, Director of Nursing were in-serviced by the Clinical Nurse Consultant in monitoring CMS COVID-19 Nursing Home Data webpage for testing frequency updates. 4. Administrator, Director of Nursing or designee will monitor the COVID-19 Nursing Home Data webpage for testing frequency updates weekly. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy The Administrator will be responsible for overseeing all audit of findings and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _____ B. WING _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 886	Continued From page 48 reviewed. Routine testing of unvaccinated staff was conducted once a week for the week of 11/09/21 and 11/22/21. The DON (director of nursing) was asked for the testing records for the weeks that required twice a week testing. The DON stated that unvaccinated staff had only been tested once and if they were tested twice during that week, she did not have evidence of that. The facility's policy/COVID-19 action plan was reviewed and documented the following: "...Unvaccinated facility staff located in counties with a substantial to high community transmission should be tested twice weekly...Routine Testing of Staff...routine testing of unvaccinated staff should be based on the extent of the virus in the community...the facility will utilize their community transmission level as the trigger for staff testing frequency...the facility will test unvaccinated staff per the routine testing intervals as follows: Low - not recommended...Moderate - once a week...Substantial - twice a week...High - twice a week..." On 12/01/21 at 11:30 AM, the DON, administrator and corporate consultant were made aware of the above concerns with the lack of routine testing per the requirements. No further information and/or documetnation was presented prior to the exit conference on 12/01/21 at 1:30 PM.	F 886	subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan.	