STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING _____ B. WING _____	C 03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 Emergency Preparedness survey was conducted 3/06/23 through 3/08/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/06/23 through 03/08/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint (Finding-compliant with regulations) was investigated during the survey. The census in this 312 certified bed facility was 192 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 3 closed record reviews.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and during a medication pass and pour the facility staff failed to follow professional standards of practice for the administration of medications. The findings included:	F 658	Resident #77's medications are crushed and given individually. 3/8/2023 Resident #140's medications are crushed and given individually. 3/8/2023 LPN #2 has received inservice education	4/21/23

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

Electronically Signed | 03/29/2023

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F 658	Continued From page 1 During a medication pass and pour observation, the facility staff crushed medications and administered together for 2 of 6 Residents, Resident #140, and Resident #77 Surveyor observed licensed practical nurse (LPN) #2 on 03/07/23 during a medication pass and pour at 8:20 am. LPN #2 prepared medications (4 medications) for Resident #140, crushing all medications together, placing in ice cream and administering together. LPN #2 them prepared medications (7 medications) for Resident #7, crushing all medications together, placing in ice cream and administering together. Surveyor requested and was provided with a facility policy entitled "Medication Administration", which read in part "C. ...Crushed medications must be given one at a time, oral or via peg tube." Surveyor spoke with staff development coordinator (SDC) and director of nursing (DON) on 03/07/23 regarding the combined crushing/administering of the medications on 03/07/23 at 10:30 am. The concern of not following professional standards of practice was discussed with the administrator, assistant administrator, DON, and quality assurance nurse on 03/07/23 at 4:45 pm. No further information was provided prior to exit.	F 658	from the Staff Development Coordinator on how to correctly crush and administer medications. 3/8/2023 The Director of Nursing will ensure compliance. 3/8/2023 All licensed nursing staff will be inserviced on how to correctly administer crushed medications separately by the Staff Development Coordinator. 4/7/2023 The Director of Nursing will ensure compliance. 4/7/2023 A 100% audit of all licensed nurses who administer crushed medication will be conducted by the pharmacist or RN Supervisor to ensure compliance with correct crushing of medications and administration (see attached form). Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/18/2023 The Director of Nursing and Quality Assurance Coordinator will ensure compliance. 4/18/2023 Quarterly, 10 % of all nurses who administer crushed medications will be audited by the pharmacist or RN Supervisor to ensure compliance with correct crushing of medications and administration separately. Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/21/2023	

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F 658	Continued From page 2	F 658	The Director of Nursing and Quality Assurance Coordinator will ensure compliance. 4/21/2023 These systemic changes will ensure compliance with regulation. 4/21/2023	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review and during a medication pass and pour the facility staff failed to ensure 1 of 38 residents was free from significant medication errors, Resident #140. The findings included: For Resident #140 the facility staff crushed and administered the non-crushable medication potassium chloride (KCl). Resident #140's face sheet listed diagnoses including but not limited to hypokalemia, hypertension, and anxiety. Resident #140's most recent minimum data set with an assessment reference date of 01/25/23 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Surveyor observed licensed practical nurse (LPN)	F 760	Resident #140's potassium chloride is now administered in liquid form. 3/8/2023 LPN #2 has received inservice education on administering tablet form potassium chloride, which is non-crushable. Education was provided by the Staff Development Coordinator. 3/7/2023 The Director of Nursing will ensure compliance. 3/7/2023 All licensed nurses who administer non-crushable tablet form potassium chloride will receive education regarding administration. The Staff Development Coordinator will provide education. 4/3/2023 The Director of Nursing will ensure compliance. 4/3/2023 A 100% audit of all licensed nurses who administer non-crushable tablet form	4/21/23

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F 760	Continued From page 3 #2 administer medications to Resident #140 during a medication pass and pour on 03/07/23 at 8:20 am. LPN #2 prepared Resident #140's medications, including a 20 mEq (milliequivalent) KCl tablet, crushing all medications together, placing them all together in ice cream and then administering them to Resident #140. Resident #140's medications were reconciled with the clinical record on 03/07/23 at 9:15 am. Resident #140's clinical record contained a physician's order summary for the month of March 2023 which read in part "Potassium CL (chloride) ER (extended release) 20 MEQ (milliequivalent)-One tablet PO (by mouth) daily for supplement." Surveyor requested and was provided with a facility policy entitled "Medication Administration" which read in part "Time-release and enteric coated medications should not be crushed. Contact Pharmacist to determine if alternative available. Specific order from physician for alternative or crush medications must be obtained." Surveyor spoke with the staff development coordinator (SCD) and director of nursing (DON) on 03/07/23 at 10:30 am. Surveyor asked SDC and DON if the medication KCl should have been crushed, and DON stated the facility has a list of non-crushable medications, and they would check with pharmacy for clarification. SDC provided surveyor with a copy of a list of "Meds That Should Not Be Crushed" on 03/07/23 at 10:45 am and stated to surveyor that the KCl should not have been crushed per the list and facility pharmacy. Surveyor reviewed the list, and	F 760	potassium chloride will be conducted by the pharmacist or RN Supervisor to ensure compliance with correct administration of non-crushable tablet form potassium chloride (see attached form). Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/18/2023 The Director of Nursing and Quality Assurance Coordinator will ensure compliance. 4/18/2023 Quarterly, a 10% audit of licensed nurses who administer non-crushable tablet form potassium chloride will be conducted by the pharmacist or RN Supervisor to ensure compliance with correct administration of potassium chloride. Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/21/2023 The Director of Nursing and Quality Assurance Coordinator will ensure compliance. 4/21/2023 These systemic changes will ensure compliance with regulation. 4/21/2023	

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F 760	Continued From page 4 it contained the medication KCl. The concern of the facility staff crushing a non-crushable medication was discussed with the administrator, assistant administrator DON, and quality assurance nurse on 03/07/23 at 4:45 pm. No further information was provided prior to exit.	F 760		
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:	F 761		4/21/23

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F 761	Continued From page 5 Based on observation, staff interview, facility document review and during a medication pass and pour the facility staff failed to ensure medications were stored in a secure manner for 1 of 9 medication carts. The findings included: Facility staff failed to secure medications during a medication pass and pour. Surveyor observed licensed practical nurse (LPN) #2 on 03/07/23 during a medication pass and pour. LPN #2 removed a medication bin from the medication cart, placed it on top of the medication cart and prepared resident's medication. After preparing medication, LPN #2 entered resident's room, leaving the medication bin on top of the medication cart, and leaving cart unlocked. Upon returning to the cart, LPN #2 replaced the bin in the cart. Surveyor asked LPN #2 if they normally left the bin on top of the cart, and LPN #2 stated they did not and "Can you tell I'm a little nervous?" Surveyor requested and was provided with a facility policy entitled "Medication Administration" which read in part, "4. Other A. Security of cart and med room/privacy-Medicine refrigerator, cabinets, and med cart locked when the nurse's back is turned or leaved the cart." The concern of failing to secure medications was discussed with the administrator, assistant administrator DON, and quality assurance nurse on 03/07/23 at 4:45 pm. No further information was provided prior to exit.	F 761	LPN #2 locks and secures all medication when away from medication cart. 3/8/2023 LPN #2 has received inservice education on properly storing bins of medications and securing them on the medication cart. Education was provided by the Staff Development Coordinator. 3/8/2023 The Director of Nursing ensured compliance. 3/8/2023 All licensed nursing staff will be inserviced on properly storing and securing medications on the medication cart by the Staff Development Coordinator. 4/7/2023 The Director of Nursing will ensure compliance. 4/7/2023 A 100% audit of all licensed nurses who administer medication will be conducted by the RN Supervisor and/or pharmacist to ensure all medications are properly secured and stored with medication cart locked when the nurse is away from the medication cart (see attached form). Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/18/2023 The Director of Nursing and Quality Assurance Coordinator will ensure compliance. 4/18/2023 Quarterly 10 % of all licensed nurses who administer medications will be audited by the Pharmacist and/or RN Nurse	

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F 761	Continued From page 6	F 761	Supervisors to ensure medications are stored and secured properly when nurse is away from cart. Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/21/2023 The Director of Nursing and Quality Assurance Coordinator will ensure compliance. 4/21/2023 These systemic changes will ensure compliance with regulation. 4/21/2023	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		4/21/23

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

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 8 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to maintain a complete and accurate clinical record for 2 of 38 residents, Resident #389 and #110. The findings included: 1. For Resident #389, the facility nursing staff failed to accurately document in the clinical record for the medication Xanax. Resident #389's diagnoses included, but were not limited to, generalized anxiety disorder and major depressive disorder. There was no completed minimum data set (MDS) assessment for this resident. Resident #389's clinical record included an order for Xanax 0.5 mg by mouth three times a day for generalized anxiety disorder. The administration times on the medication administration record were documented as 8:00 a.m., 2:00 p.m., and 8:00 p.m. On 03/03/23 5:28 p.m., Registered Nurse (RN) #2 documented Xanax scheduled for 03/03/23 at 2:00 p.m. not available. 03/07/23 11:37 a.m., RN #2 stated they took over the hall this resident resided on at 2:45 p.m. and did not give any Xanax to this resident as the	F 842	Resident #389's Xanax administration is accurately documented in the clinical record. 3/8/2023 Resident #110's Novolog administration is accurately documented in the clinical record. 3/8/2023 LPN #3 and RN #2 have received inservice education on medication administration documentation. The Staff Development Coordinator provided the education. 3/9/2023 The Director of Nursing will ensure compliance. 3/9/2023 All licensed nurses will receive inservice education on correct medication administration documentation. 4/7/2023 The Director of Nursing will ensure compliance. 4/7/2023 A 100% audit of all residents MAR documentation will be conducted by the RN Supervisor to ensure accurate documentation (see attached form). Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/18/2023 The Director of Nursing and Quality	

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F 842	Continued From page 9 medication was scheduled at 2:00 p.m. After reviewing their documentation RN #2 stated they began administering medications at 4:00 p.m. and they had documented the Xanax was not available in error. 03/07/23 12:06 p.m., RN #3 stated we moved all the patients to another hall, a family member was in the room, Resident #389 was becoming frustrated stated don't even worry about it and they had forgot to document that the resident refused. 03/07/23 3:00 p.m., the facility staff provided the surveyor with a copy of their policy titled, "DOCUMENTATION OF NURSING CARE." This policy read in part, "It is the policy of this facility to keep an accurate record of each resident's care...Documentation must be pertinent, concise, reflect the resident's status and include nursing interventions and resident responses..." 03/07/23 4:45 p.m., the Administrator, Director of Nursing, Assistant Administrator, and Quality Assurance Nurse were made aware of the issue regarding the documentation of Resident #389's Xanax on 03/03/23. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #110 the facility staff failed to document medication refusals. Resident #110's face sheet listed diagnoses which included but not limited to type 2 diabetes mellitus, chronic kidney disease and depression.	F 842	Assurance Coordinator will ensure compliance. 4/18/2023 Quarterly, a 10 % audit of all residents MAR documentation will be conducted by the RN Supervisor to ensure accurate documentation. Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/21/2023 The Director of Nursing and Quality Assurance Coordinator will ensure compliance. 4/21/2023 These systemic changes will ensure compliance with regulation. 4/21/2023	

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F 842	Continued From page 10	F 842		

Resident #110's most recent minimum data set with an assessment reference date of 01/14/23 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #110's clinical record was reviewed and contained a physician's order summary for the month of March 2023, which read in part "Novolog 100 unit/ml vial-Give 8 units sq (subcutaneously) with meals for DM (diabetes mellitus)"

Resident #110's electronic medication administration record (eMAR) for the month of March 2023 was reviewed and contained an entry as above. This entry was coded "N" on 03/02/23 at 12:00 pm. Per the eMAR, chart code "N" equates not administered. The administration notes section of the eMAR contained an entry which read in part, "11:22AM, 3/02/23 (Scheduled: 12:00PM, 3/02/23; Novolog 100 unit/ml vial) Novolog 100 unit/ml vial-give 8 units S... scheduled for 03/02/2023 12:00PM.accuchec 113 // 03/02/2023 11:22 AM". This entry was electronically signed by licensed practical nurse (LPN) #3.

Surveyor spoke with LPN #3 on 03/07/23 at 1:35 pm. Surveyor asked LPN #3 why they had not administered Resident #110's insulin on 03/02/23 at 12:00 pm, and LPN #3 stated that resident's blood sugar was outside of parameters for sliding scale insulin administration. Surveyor then had LPN #3 read resident's insulin order and pointed out that resident is not on sliding scale insulin. LPN #3 then stated that resident refused insulin, and they had just forgotten to chart the refusal.

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F 842	Continued From page 11 During review of Resident #110's clinical record, several instances of medication refusals were documented. The concern of the facility staff failing to document a medication refusal was discussed with the administrator, assistant administrator DON, and quality assurance nurse on 03/07/23 at 4:45 pm. No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		4/21/23

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F 880	Continued From page 12	F 880		

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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F 880	Continued From page 13 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and during a medication pass and pour the facility staff failed to follow established infection control guidelines. The findings included: For one of 9 medication carts, the facility staff left ice cream and ginger ale open/uncovered on top of medication cart. Medication cart was soiled. On 03/07/23, during a medication pass and pour observation, surveyor observed an opened, uncovered cup of ice cream on top of the medication cart. Surveyor also observed an opened bottle of ginger ale, used pill crusher cups, and a white powder-like substance on top of the medication cart. Surveyor requested and was provided with a facility policy entitled "Medication Administration" which read in part,"2. Technique I. CART PROPERLY CLEANED-Cart surfaces and medication containers kept clean. Spills wiped immediately and the cart cleaned before and after the med pass. 4. Other E. Infection Control/Aseptic Technique-Juice/applesauce covered?" The concern of facility staff not following infection control guidelines was discussed with the administrator, assistant administrator DON, and quality assurance nurse on 03/07/23 at 4:45 pm. No further information was provided prior to exit.	F 880	LPN #2 administers medications with her cart being free and clear of residue and trash, ice cream covered when not in use (single servings per resident) and liquids (ginger ale) sealed when not in use. 3/8/2023 LPN #2 was inserviced by the Staff Development Coordinator on correct infection control practices while administering medications. 3/8/2023 The Director of Nursing will ensure compliance. 3/8/2023 All licensed staff will be inserviced by the Staff Development Coordinator on correct infection control practices while administering medications. 4/18/2023 The Director of Nursing will ensure compliance. 4/18/2023 The local health department (consisting of 2 epidemiologists for Pittsylvania County and City of Danville) was contacted and assistance given with correction of deficiency, according to our RCA regarding infection control during med pass. We informed the local health department that they could have immediate access for onsite visits. 3/24/2023 A Root Cause Analysis has been completed (see attached). 3/24/2023	

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F 880	Continued From page 14	F 880	All infection control policies and procedures have been reviewed and updated as necessary (see attached). 3/24/2023 A 100% audit of all medication carts while nurse is administering medication will be conducted to ensure cart is cleaned and all liquids and ice cream is covered when not in use (see attached forms). Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/18/2023 The Director of Nursing and Quality Assurance Coordinator will ensure compliance. 4/18/2023 Quarterly, a 10 % audit of all medication carts while nurse is administering medication will be conducted by the RN Supervisor to ensure cart is cleaned and all liquids and ice cream is covered when not in use. Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/21/2023 The Director of Nursing and Quality Assurance Coordinator will ensure compliance. 4/21/2023 These systemic changes will ensure compliance with regulation. 4/21/2023	
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2)	F 919		4/21/23

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F 919	Continued From page 15 §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review, the facility staff failed to ensure two (2) common bathrooms were equipped with a call system. These two (2) bathrooms were located near the lobby area of the facility; one had a sign reading "MEN" and the other had a sign reading "WOMEN". The findings include: On 3/6/23 at 3:10 p.m., it was observed that a common bathroom with a sign reading "MEN" was not equipped with a call system. This bathroom was unlocked and accessible to residents, staff, and visitors. This bathroom was able to be locked from the inside. On 3/6/23 at 4:19 p.m., it was observed that a common bathroom with a sign reading "WOMEN" was not equipped with a call system. This bathroom was unlocked and accessible to residents, staff, and visitors. This bathroom was able to be locked from the inside. On 3/7/23 at 4:49 p.m., the survey team met with the facility's Administrator, Assistant Administrator, DON, and Quality Assurance Coordinator (QAC). The two (2) common	F 919	The two common bathrooms remained locked until they were equipped with a call system by maintenance. 3/17/2023 The Administrator ensured compliance. 3/17/2023 A 100% audit of all common bathrooms will be conducted by maintenance to ensure a working call system is in all common bathrooms (see attached form). Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/18/2023 The Administrator will ensure compliance and corrections will be made as necessary. 4/18/2023 Quarterly, a 10 % audit of all common bathrooms will be conducted by maintenance to ensure a working call system is in all common bathrooms. Results of the audit will be reviewed by the Quality Assurance Coordinator with appropriate action taken. 4/21/2023 The Administrator will ensure compliance.	

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F 919	Continued From page 16 bathrooms, which were not equipped with a call system, was discussed. The two (2) bathrooms had been locked and closed, by facility staff members, while the facility staff decided how to address the issue with no call system. On 3/8/23 at 8:02 a.m., the Director of Nursing (DON) provided a policy which addressed responding to resident call system/lights; the DON reported the facility did not have a policy that addressed the location of call system/lights.	F 919	4/21/2023 These systemic changes will ensure compliance with regulation. 4/21/2023	