STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185256	A. BUILDING _____ B. WING _____	R 09/30/2021

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PARKVIEW POST-ACUTE AND REHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501

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{F 837}	Continued From page 944 70). Beginning on 08/23/2021, the Dietary Manager will ensure and audit meals leaving the kitchen and reaching the units timely. Audits will be conducted for random meals twice daily for one (1) week, twice per week for two (2) weeks, and then weekly for one (1) month. Once meal trays arrive at the unit, management staff will assist in passing trays to ensure residents receive meal trays, and certified nursing assistants assist residents promptly. The Dietary Manager or designee will audit the time it takes to pass meal trays to residents after they arrive on the unit beginning 09/11/2021. All three (3) meals will be observed on each unit daily for two (2) weeks, two (2) meals on each unit daily for two (2) weeks, one (1) meal on each unit daily for four (4) weeks. 71). The dietary manager or designee will review admitted/re-admitted residents' food and beverage preferences within 72 hours of admission and enter them into the diet/tray card system for listing on their tray cards beginning 09/16/2021. Review of food preferences will be completed bi-annually and as needed for all residents. Physician-ordered snack intakes will be audited by the Dietary Manager daily for one (1) week, weekly for four (4) weeks, and monthly after that for four (4) months beginning 09/15/2021. 72). Daily COVID-19 screenings for staff will be audited beginning on 08/25/2021 by the Human Resources (HR) Director against time clock punches to ensure screening before beginning their shift. Audits will be completed Monday through Friday for four (4) weeks by the HR Director, and weekends audited on Mondays. Any staff not screened will be re-educated	{F 837}		

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{F 837}	Continued From page 945 immediately on the COVID-19 Screening Policy by the HR Director. The HR Director was educated on the COVID-19 policy by the Regional Nurse, an infection control preventionist. All entry doors will remain locked. Visitors must be allowed entry by staff and screened by staff at the time of entry. 73). Beginning on 09/17/2021, the DON and/or designee will round seven (7) times each week for eight (8) weeks, five (5) times weekly for four (4) weeks to audit infection control compliance on differing shifts and units. Audits will include observation of handwashing; isolation signage and zones; donning/doffing (putting on/taking off) PPE; and mask compliance. Any variance or identified concerns will be addressed immediately by the auditor. 74). The DON, ADON, and/or Designee will review all residents on narcotics with the pharmacy to ensure an active script is on file beginning 09/23/2021. Staff will notify the physician within two (2) days of the prescription's expiration. 75). The Regional Nurse Consultant, Pharmacy, and/or Director of Nursing will conduct random medication pass observations effective 09/25/2021 on random shifts daily until immediate jeopardy removed to ensure timeliness and accuracy of medications. The facility utilized the CMS Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. 76). Beginning 09/25/2021 Monday through Friday, the DON, ADON, and/or Designee will audit medication delivery tickets against ordered	{F 837}		

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{F 837}	Continued From page 946 medications daily to ensure that all narcotics needing a renewal have been sent to the pharmacy. Audits will continue until the Immediate Jeopardy is removed. 77). Beginning 09/11/2021, the Administrator and/or DON will be responsible for monitoring nursing staff daily for four (4) weeks to ensure adequate staffing is maintained. 78). Beginning 09/11/2021, the Administrator and Dietary Manager will be responsible for reviewing dietary staffing daily for four (4) weeks to maintain adequate staffing. 79). Beginning 09/11/2021, the Divisional Vice President of Operations and/or designee will monitor and audit the Administrator daily for 30 days to ensure compliance. 80). Visual rounding will be conducted beginning 09/23/2021 to monitor for residents' change of condition and identification of need for "Stop and Watch" (change of condition) communication. 81). Beginning 09/11/2021, the Administrator or designee performed interviews of residents with a BIMS score of eight (8) or greater to ensure they felt safe in the facility and had not been subjected to or witnessed abuse. No residents had any concerns. Interviews will continue to be conducted of residents by the Administrator or designees weekly until immediate jeopardy is removed. **The State Survey agency validated the facility's actions to remove the Immediate Jeopardy on 09/26/2021 as alleged by :	{F 837}		

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{F 837}	Continued From page 947 1). Review of Head-to-Toe Skin Assessments revealed staff assessed all residents in the facility on 09/11/2021. A review of the skin assessments revealed eight (8) residents (Residents #65, #324, #45, #14, #357, #27, #74, and #358) had current pressure ulcers with a total number of pressure injuries of twenty (20). A review of the comprehensive care plans for Residents #65, #324, #45, #14, #357, #27, #74, and #358 revealed staff updated the care plans to reflect the resident's current pressure injuries. The facility completed the review on 09/17/2021. A review of the facility's census on 08/28/2021 revealed staff assessed all residents at risk for pressure ulcers with the Braden Scale. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed head-to-toe skin assessment on all residents on 09/11/2021. She further revealed that the facility identified twenty (20) total pressure injuries. She further stated that the facility completed the Braden Scale assessments on all residents on 08/28/2021. Continued interviews revealed the Interdisciplinary Team utilized the skin assessments and Braden Scale assessments to update the residents' care plans. She stated that Resident #65, #324, #45, #14, #357, #27, #74 and #358's care plans were updated to reflect current pressure injuries by 09/17/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed she updated all residents' care plans to reflect current pressure injuries by 09/17/2021. In addition, she completed a review of walking rounds on 09/15/2021 with Therapy Personnel, the Registered Dietician, the Medical Director, the DON, and the MDS Nurse for Residents #65, #324, #45, #14, #357, #27, #74 and #358. A review revealed the Interdisciplinary Team	{F 837}		

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{F 837}	Continued From page 948 reviewed each resident's orders, current skin breakdown, care plan, and implemented changes as needed. 2). Review of Resident #65's medical record revealed the Medical Director assessed the resident on 08/25/2021 at 1:45 PM and noted a Stage four (4) pressure ulcer on the sacrum; a deep tissue injury (DTI) to the left and right heels; and a skin tear to the left inner leg. Review of Resident #65's wound care note dated 08/26/2021 at 9:00 AM, revealed the sacrum wound measured, "13 cm (centimeter) (length) by 12.3 cm width and 0.2 cm depth with undermining at 10 o'clock measuring 2 cm and undermining at 12 o'clock that measures 1 cm, muscle exposed. No palpable bone, slough is present, partially removed with wound cleanser." The facility continued to treat the resident's sacral pressure ulcer with Aquacel Ag. A review of a wound evaluation completed on 09/15/2021 revealed Resident #65 had six (6) pressure ulcers, including a stage two (2) to the left superior calf measuring 1.2 cm (length) by 1.4 cm (width) by 0.1 cm (depth), stage one (1) to the right hip measuring 2.5 cm by 2 cm by less than 0.1 cm, stage two (2) to left hip measuring 1.2 cm by 0.8 cm x less than 0.1 cm, stage two (2) to left scapula measuring 1 cm by 0.2 cm by less than 0.1 cm, unstageable to right heel measuring 0.6 cm by 0.6 cm. and four (4) areas to the sacrum measuring 12 cm by 11.6 cm by 0.4 cm. Interventions in place for the resident included heel protectors while in bed, diet as ordered, weekly documentation of the wound, an air mattress to bed, nutritional supplements, and turning/repositioning. Observation of wound care for the sacral pressure ulcer on 09/29/2021 at 10:21 AM revealed the wound measured 13 cm	{F 837}		

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{F 837}	Continued From page 949 by 11 cm by 0.3 cm with a scant amount of drainage and 95 percent granulation tissue. Resident #65 declined would not consent to the observation of other pressure areas. A medical record review revealed that on 09/21/2021 at 2:19 PM, Physician #1 determined the resident's weight loss and wounds were unavoidable. On 09/28/2021, Resident #65's family declined in-house wound care visits. Further review of the record revealed on 09/29/2021, staff notified the physician of the decline in the resident's wound with no new orders. The resident was diagnosed with Failure to Thrive. 3). The facility admitted Resident #355 on 09/10/2021, completed a skin assessment on 09/10/2021, completed a Braden Scale on 09/10/2021, and completed a baseline care plan on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record revealed staff developed the comprehensive care plan on 09/21/2021. A review of Resident #355's re-admission revealed the resident had an admission skin assessment completed on 09/28/2021, Braden Scale on 09/28/2021, and a baseline care plan developed on 09/28/2021. 4). Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, Resident #308 on 09/29/2021 at 11:10 AM, Resident #309 on 09/29/2021 at 11:26 AM, Resident #311 on 09/29/2021 at 11:52 AM, Resident #314 on 09/29/2021 at 11:30 AM and Resident #320 on 09/29/2021 at 11:13 AM revealed the residents appeared clean, well-kempt, and clean linens were on the residents' beds. Interviews with the residents during the time of the observations revealed no	{F 837}		

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{F 837}	Continued From page 950 identified concerns. A review of Progress Notes for Residents #45, #65, #308, #309, #311, #314, and #320) revealed the Interim Social Service Director interviewed the residents on 09/15/2021 and had no concerns with resident hygiene. Interview with the ISSD on 09/30/2021 at 2:23 PM revealed she interviewed Residents #45, #65, #308, #309, #311, #314, and #320 on 09/15/2021 with no identified concerns regarding hygiene. 5). Observation of residents during the initial tour on 09/28/2021 from 1:33 PM to 2:32 PM revealed no identified concerns. Interviews and record reviews revealed Residents #45, #65, #308, #309, #311, #314, and #320 each had their shower preference and hygiene preference obtained and included on their care plan. A review of the resident's medical record, including the comprehensive care plan and SRNA care plan, revealed staff updated each resident's plan to reflect the resident's preference. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM revealed she assisted with obtaining resident preferences. She stated each resident was interviewed for shower and hygiene preference, and the facility updated each resident's care plan. A review of resident interviews revealed their shower/hygiene preference was obtained. A review of the facility's shower schedule revealed that the resident shower/hygiene preferences were honored. 6). Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she began reviewing all resident diets on 08/28/2021. She further stated that she implemented new and/or additional recommendations for residents to address weight loss and/or wound healing. A review of the documentation revealed the Registered Dietician	{F 837}		

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{F 837}	Continued From page 951 reviewed all residents' diets, and the Regional DON reviewed all diets and recommendations. Interview with the RDO on 09/30/2021 at 4:17 PM revealed she completed the review of all diets and recommendations. 7). A review of facility assessments completed by 08/13/2021 revealed thirty-nine (39) residents with a diagnosis of Diabetes were assessed for signs and symptoms of hypoglycemia/ hyperglycemia and the need for immediate intervention. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she assessed the residents and did not identify immediate concerns. Observations of Resident #348 on 09/28/2021 at 1:36 PM, Resident #320 on 09/29/2021 at 11:13 AM, and Resident #311 on 09/29/2021 at 11:52 AM revealed no visible signs/symptoms of hypoglycemia/hyperglycemia. A review of facility assessments completed on 08/12/2021 revealed fifty (50) residents with a diagnosis of Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by Respiratory Therapist #1. Interview with Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM revealed she assessed all residents with diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Asthma, and pneumonia 08/12/2021 with no identified concerns. Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, and Resident #43 on 09/28/2021 at 2:03 PM. revealed no respiratory distress. 8). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she reviewed all residents with a diagnosis of Diabetes and the resident's orders for glucose monitoring. She	{F 837}		

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{F 837}	Continued From page 952 stated the facility amended all resident orders to include mandatory entry of glucose values on the MAR. Review of Resident #3, #41, and #357's orders revealed each order required staff to enter the glucose value on the resident's MAR. Further review revealed no concerns with residents having glucose levels less than 60 and/or greater than 400. 9). A review of audits completed on 09/11/2021 revealed meals were delivered timely. Interview with the Regional Certified Dietary Manager (RCDM) on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed lunch was observed on 09/11/2021 and arrived at the unit within five (5) to ten (10) minutes of the scheduled times. 10). A review of the facility's staffing for 09/28/2021 from 6:00 AM to 6:00 PM revealed two (2) licensed nurses and three (3) nursing assistants were scheduled for each floor of the facility. A review of the facility's staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. A review of the staffing for 09/29/2021 and 09/30/2021 revealed two (2) licensed nurses, and three (3) certified nursing assistants on each floor from 6:00 AM to 6:00 PM. Further review of staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. Observation of facility staffing on 09/28/2021 from 1:20 PM to 5:30 PM; on 09/29/2021 from 8:11 AM to approximately 6:00 PM and 09/30/2021 from 7:55 AM to 5:17 PM, revealed call lights were	{F 837}		

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{F 837}	Continued From page 953 being answered timely, residents appeared clean/well-groomed, staff was offering and assisting residents with baths/showers, turning/repositioning was being conducted timely, and meal trays were passed timely. Interviews with RN #1 on 09/29/2021 at 11:55 AM and on 09/30/2021 at 12:58 PM; RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM; LPN (Licensed Practical Nurse) #6 on 09/30/2021 at 12:44 PM; LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM; LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM; State Registered Nurse Aide (SRNA/certified nurse aide) #1 on 09/29/2021 at 3:40 PM; SRNA #11 on 09/29/2021 at 3:23 PM; SRNA #7 on 09/29/2021 at 3:29 PM; SRNA #19 on 09/29/2021 at 4:10 PM; SRNA #21 on 09/29/2021 at 3:04 PM; SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed staffing had improved, and each staff member revealed they had time to perform duties as assigned. 11). Review of the staffing schedule for 09/28/2021, 09/29/2021, and 09/30/2021 revealed each day consisted of one (1) day cook, one (1) evening cook, one (1) prep cook, two (2) day aides, and two (2) evening aides. Observation of the kitchen on 09/28/2021 at 2:26 PM reflected the staffing was accurate per the schedule. Interview with Cook #3 on 09/29/2021 at 1:12 PM, and Dietary Aide #3 on 09/30/2021 at 2:10 PM revealed kitchen staffing had improved, and they were able to complete their duties during their shift. 12). A review of assessments for being withdrawn, crying, or other abuse symptoms was	{F 837}		

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{F 837}	Continued From page 954 conducted for Residents #64, #86, and #322 on 08/11/2021. No concerns were identified. A review of skin assessments completed revealed no identified concerns. Observation and interviews conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with psychosocial and/or physical abuse, including observations of Residents #64, #86, and #322. Interview with Resident #322 on 09/29/2021 at 11:54 AM revealed no concerns with abuse. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed skin assessments on 08/11/2021, for all residents, with the assistance of licensed nursing staff. No concerns were identified. A review of audits completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified concerns. 13). A review of assessments for residents that wander, revealed all residents had received a wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident identified at risk. 14). Review of Resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she completed a comprehensive nutritional assessment on Residents #39, #65, #81, #90, #330 and #332.	{F 837}		

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{F 837}	Continued From page 955 Review of the medical record revealed the RD completed a comprehensive nutritional assessment on 09/16/2021 for Resident #39, 09/16/2021 for Resident #65, 09/16/2021 for Resident #81, 09/16/2021 for Resident #90 and 09/16/2021 for Resident #330 with no dietary recommendations made. Resident #332 was discharged. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM, the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM and DON #2 on 09/30/2021 at 3:20 PM revealed each resident had received a comprehensive nutritional assessment and review of the recommendations by nursing staff. Further interview with the RD and Regional DON revealed both the record and tray card were reviewed to reflect accurate information. 15). Observation of the third floor on 09/28/2021 at 2:22 PM, the fourth floor on 09/28/2021 at 2:00 PM and the fifth floor on 09/28/2021 at 2:06 PM revealed snacks including but not limited to oatmeal pies, goldfish crackers, cookies and drinks were present, including soda, milk, and juice. Observations on 09/29/2021 at 10:30 AM revealed snacks were being passed on third floor. Review of Resident #331, Resident #65 and Resident #14's record revealed documented intake of snacks. Interview with SRNA #19 on 09/29/2021 at 4:10 PM revealed she was educated on documentation of snacks. 16). Observation of the facility's red zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. The zones contained no residents. 17). Review of Residents #327, #328 and #329	{F 837}		

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{F 837}	Continued From page 956 revealed the residents were isolated per CDC guidance. Observation of Resident #328 on 09/29/2021 at 11:41 AM and Resident #329 on 8/30/2021 at 10:36 AM revealed no obvious signs or symptoms of COVID-19. Resident #327 had been discharged from the facility. 18). Review of facility staff testing revealed all staff working on 09/16/2021 were tested for COVID-19 with no identified new cases. Further review of resident testing for COVID-19 on 09/17/2021, revealed no new cases. 19). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2.40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed the facility is testing staff two	{F 837}		

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{F 837}	Continued From page 957 (2) times weekly. Interview with Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed she was conducting testing two (2) times weekly following CDC guidance. Review of facility staff tested revealed tested is being conducted two (2) times weekly. 20). Review of Resident #329, #328, #311, #65 and #90's medical record revealed that each resident had COVID-19 monitoring orders implemented. In addition, review of each resident's MAR revealed staff was completing the monitoring as ordered by the physician. 21). Interview with the Medical Director on 09/30/2021 at 3:25 PM revealed Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351's medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). Observation of a medication pass on 09/29/2021 at 4:35 PM on 3rd floor and 09/30/2021 at 8:09 AM on 3rd floor revealed no identified concerns with missing medications. In addition, observation of a narcotic count on 5th floor on 09/30/2021 at 12:50 PM revealed no identified concerns. Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, N #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with unavailable medications. 23. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and	{F 837}		

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{F 837}	Continued From page 958 Co-Owner/President of Pharmacy on 09/30/2021 at 3:11 PM revealed both parties made a formal agreement that the pharmacy will supply the facility with a three-day supply for medication requiring cost review. Review of the facility's pharmacy agreement revealed for any medication requiring a cost review the pharmacy would send the facility a minimum of a three-day supply of the medication while being reviewed. The facility would communicate any changes or continuance guidance to the pharmacy within 72 hours. The Director of Operations of Guardian Pharmacy and the Vice President of Operations of the facility signed the agreement. 24). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4 on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education and was aware of the process for obtaining medications from the pharmacy. In addition, they revealed they were aware that the nurse would notify the physician if the pharmacy could not deliver a medication to the facility. 25). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and Regional DON on 09/30/2021 at 4:17 PM revealed an audit was completed of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. 26). Review of a QAPI signature sheet revealed	{F 837}		

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{F 837}	Continued From page 959 the facility conducted a meeting on 08/12/2021 with the Regional DON, Regional Nurse Consultant, Human Resources, SSD #2, Medical Records, the Housekeeping Supervisor, Central Supply, MDS Nurse #1, MDS Nurse #2, the Therapy Manager, the Admissions Coordinator, the Administrator, the Activities Director, the Dietary Manager, and other members of the administration team. 27). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the facility appointed the current Interim Administrator on 09/13/2021. Further interview with the VP of Operations revealed she had provided the Interim Administrator with daily oversight since 09/10/2021. 28). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, the Medical Director on 09/30/2021 at 3:25 PM and members of the QAPI committee, including the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, revealed procedures for contacting staff for call-ins, answering call lights, ADL Care, serving and delivering meal trays timely, incontinence care and turning/repositioning were reviewed on 09/15/2021. 29). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and the Med-Net Concepts Nurse Consultant on 09/28/2021 at 3:00 PM revealed the facility conducted a conference call to review the following: (1) the outcomes of the survey, (2) expectations and roles of the Governing Body as	{F 837}		

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{F 837}	Continued From page 960 outlined in the Rules and Regulations, (3) determined a plan for the following communication/monitoring tools: Infection Control and COVID-19 isolation, enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed reviewed and revised the QAPI Plan and presented the reviews and/or revision to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The plan included pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, the hospital re-admission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns and/ or grievances, admissions, discharges, census, staff development, openings by department/position, employee orientations, dietary variance tray audit report, weight losses, work injuries, terminations, employees on family medical leave of absence or leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include	{F 837}		

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{F 837}	Continued From page 961 but not be limited to the topics presented during the meeting. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM, revealed the information was presented at the QAPI meeting held on 09/16/2021. 31). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, the Interim Administrator on 09/30/2021 at 3:40 PM, DON #2 on 09/30/2021 at 3:20 PM, and the Medical Director on 09/30/2021 at 3:25 PM revealed a meeting was conducted on 09/16/2021 regarding the duties of the Governing Body including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes of system problems, utilization of the "5 why" approach and auditing systems per the QAPI Calendar were reviewed. 32). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he collected all monitoring reports before each QAPI meeting and reviewed the data for compliance. A review of QAPI attendance sheets revealed the facility conducted meetings on 09/16/2021, 09/23/2021,	{F 837}		

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{F 837}	Continued From page 962 and 09/30/2021. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed they were members of the governing body, and QAPI meetings had been forwarded to them. 33). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed the governing body provided the Administrator with resources and education material for QAPI. Further interviews revealed the governing body would meet quarterly for the upcoming year. Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he had been provided with resources and education regarding QAPI. 34). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed QAPI meetings were conducted weekly effective 09/16/2021 to ensure the quality of care is monitored and complied with the standard of care and compliance. Further interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at	{F 837}		

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{F 837}	Continued From page 963 2:40 PM revealed they had participated in the weekly QAPI meetings conducted on 09/16/2021 and 09/23/2021. In addition, an interview with the Medical Director/Physician #1 on 09/30/2021 at 3:25 PM revealed he participated in the weekly QAPI meetings on 09/16/2021 and 09/23/2021. Further interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed the weekly QAPI meeting had been conducted on 09/30/2021. A review of the facility QAPI meeting attendance sheet reflected the above interviews with no identified concerns. 35). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2.54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3.29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician. 36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30	{F 837}		

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{F 837}	Continued From page 964 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and timely nutritional assessments to ensure diet order accuracy. When staff enter diet orders into the electronic medical record, the nurse entering the order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into the tray card system to reflect the resident's diet orders. She stated that all diet orders from the previous day would be reviewed in the clinical meeting. Interview with the Regional CDM on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she completed education with Former Activities Director/Dietary Manager #3. In addition, she stated that she had been on site to provide additional assistance during the transition to her new role. 37). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on turning/repositioning, range of motion and transferring residents from bed to chair and from chair to bed. Observations of turning, positioning, and wound care with RN #11 on 09/29/2021 at 10:21 AM for Resident #65 revealed no identified concerns. Interview with the	{F 837}		

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{F 837}	Continued From page 965 Therapy Manager on 09/30/2021 at 1:18 PM revealed she provided staff with education beginning on 08/19/2021 regarding turning/repositioning, range of motion, and transferring a resident from bed. 38). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on pressure ulcer prevention including turning and repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, MD and RP of a new skin impairment. The nurse will call or email the Registered Dietitian, the physician, and the resident's representative with any changes. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and the Regional DON on 09/30/2021 at 4:17 PM revealed they educated staff on pressure ulcer prevention including turning/repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician and RP of a new skin impairment. With any change to skin impairment, the nurse will call or email the Registered Dietitian for new recommendations,	{F 837}		

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{F 837}	Continued From page 966 MD, and resident's representative. 39). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on timely call light response. In addition, interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on timely call light response, providing timely hygiene per resident plan of care, timely toileting, ensuring staff dress residents in their choice of clean clothing and timely delivery of meal trays. Further interview with Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on meal service times.	{F 837}		

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{F 837}	Continued From page 967 40). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on ensuring new care plans were entered into the electronic medical record. Observation of RN #1 on 09/29/2021 at 11:55 AM revealed the nurse was able to demonstrate knowledge of the education with no identified concerns. 41). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on identification and assessment of residents with a change in respiratory status and on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. In addition, interviews revealed they received education on	{F 837}		

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{F 837}	Continued From page 968 documentation of glucose levels. 42). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on completing a baseline Care Plan with interventions and goals relevant to the diagnosis of diabetes and a respiratory diagnosis within forty-eight hours of admission, and reviewing and providing a copy to the resident/responsible party. 44). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA	{F 837}		

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{F 837}	Continued From page 969 #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 Aide on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they were educated on the process of identifying, preventing, and reporting abuse as well as identifying and implementing immediate interventions for wandering residents. 45). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. In addition, an interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she had received education on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy. When the diet orders are put into the electronic medical record, the nurse entering the order will send a written communication to the dietary staff that will include diet and texture. She further revealed all diet orders from the previous day are reviewed in the clinical meeting, which occurs Monday through Friday, to ensure accuracy. 46). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on facility policy regarding meal service	{F 837}		

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{F 837}	Continued From page 970 times and the use of recipes, including recipes for fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural, and ethnic needs of the population. 47). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on obtaining food preference, facility tray card system, order placement for meals, snack/hydration pass, appropriate scoop sizes and/or portion sizes, stocking snack/hydration carts and snacks and hydrations. 48). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders. 49). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, DON #2 on 09/30/2021 at 3:20 PM, Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40	{F 837}		

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{F 837}	Continued From page 971 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they had received education on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. Observation of the red facility zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. No residents were in the red or yellow zones. Observations conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), or the yellow/red zones. 50). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education entering COVID-19 symptom monitoring orders on all new admissions. A review of newly admitted Resident	{F 837}		

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{F 837}	Continued From page 972 #355 on 09/10/2021 revealed the resident had COVID-19 symptom monitoring entered in the resident orders. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had a COVID-19 symptom monitoring entered in the resident orders. In addition, a review of Resident #329, #328, #311, #65, and #90's medical records revealed each resident had COVID-19 monitoring orders implemented. 51). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the five (5) rights of medication administration including right medication, right patient, right dose, right time, and right route. In addition, they were educated on the process to follow when a medication was not available for administration, which included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notifying the physician if an ordered medication would either be omitted or given outside of the ordered medication time. The education also included following new orders given by the physician, documenting the conversation, and new orders from the MD in the electronic medical record. 52). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN)	{F 837}		

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{F 837}	Continued From page 973 #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the use of the emergency medication kit (e-kit). Observation of floor three (3) on 09/29/2021 at 3:10 PM, floor four (4) on 09/29/2021 at 2:57 PM, and floor five (5) on 09/29/2021 at 2:50 PM revealed each medication administration room was equipped with an emergency medication kit. Interview with LPN (LPN) #9 on 09/30/2021 at 2:27 PM revealed she was a new hire to the facility and had received education regarding the emergency medication kit. 53). Interview with DON #2 on 09/30/2021 at 3:20 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they were educated on the Interim Administrator's	{F 837}		

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{F 837}	Continued From page 974 contact information and role as Abuse Coordinator. Observation of the facility on 09/28/2021, 09/29/2021, and 09/30/2021 revealed signage posted with the Interim Administrator's contact information and title of Abuse Coordinator posted throughout the facility. 54). Review of audits beginning 09/17/2021 of weekly head-to-toe skin assessments revealed no identified concerns. Observation of Resident #27 skin and wound assessment on 09/30/2021 at 10:20 AM revealed no identified concerns. A review of the medical record for Resident #65, #324, #45, #14, #357, #27, #74, and #358 revealed the weekly wound assessments completed with physician and responsible party notifications. Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she was notified of new and/or worsening pressure ulcers and reviewed the residents as indicated. Interview with Medical Director on 09/30/2021 at 3:25 PM revealed that he was notified of new and/or worsening skin impairments and new interventions to prevent decline. He further revealed that he participated in QAPI meetings and discussed ongoing audits and care of residents. Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the QAPI team discussed all audits in QAPI meetings, including new and/or worsening pressure injuries and interventions implemented. 55). Interview with Central Supply on 09/29/2021 at 2:40 PM revealed she completed the audits of all laboratory supplies on 08/28/2021. She further revealed that the audits were conducted weekly for four (4) weeks and then monthly for three (3) months. A review of audits revealed no concerns. Observation of floor three (3), four (4), and five	{F 837}		

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{F 837}	Continued From page 975 (5) supplies and review of the audits revealed no identified concerns. 56). Interview with the Regional DON on 09/30/2021 at 4:17 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed progress notes were audited during morning clinical meetings to ensure all new areas of skin impairment had been care planned with interventions to address the area of concern. A review of audits revealed no identified concerns. 57). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning in addition to other leadership staff. Review of audits revealed staff were auditing nails, clothes, body odor, incontinent clean and dry, toileted as requested or every two (2) hours, hair clean and combed, sheets and blankets clean, call light within reach, facial hair shaved if applicable and turned and repositioned. 58). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed they participated in visual monitoring, and monitoring call light response times including the length of time call lights go unanswered. Interviews revealed any call activated more than five (5) minutes were addressed with the staff. A review of audits revealed they were completed on different units and different shifts. 59). Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed audits of respiratory assessments and SBAR	{F 837}		

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{F 837}	Continued From page 976 communication Monday through Friday in the clinical meeting. She further revealed that she assessed to ensure that any acute change in respiratory status and/or SBAR assessments completed had physician notification and/or implementation of physician orders. Review of Resident #315 SBAR completed on 09/26/2021, #324 SBAR completed on 09/27/2021, and #326 completed on 08/15/2021 revealed assessment, physician notification, interventions, and care plans updated as indicated. A review of audits revealed no identified concerns. 60). Review of Resident #355, who the facility admitted on 09/10/2021, revealed the resident had a baseline care plan developed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record for Resident #355 revealed staff completed the comprehensive care plan on 09/21/2021 (eleven (11) days after admission). A review of re-admission for Resident #355 revealed the resident had a baseline care plan developed on 09/28/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed all new admissions and re-admissions to the facility were being reviewed during the morning clinical meeting Monday through Friday to ensure completion. 61). Review of the admissions for the last thirty days from 07/16/2021-08/16/2021 revealed no concerns with baseline care plans. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new/admission baseline care plans were being updated as needed in morning meetings.	{F 837}		

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{F 837}	Continued From page 977 62). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new admission baseline care plans were being audited Monday-Friday for completion, accuracy, and to ensure a review was conducted with the resident and/or responsible party within 48 hours of admission/re-admission. Further interviews revealed the audits were conducted Monday through Friday. A review of the audits completed revealed they included resident name, admission date, baseline care plan completion, care plan delivered to resident and/or responsible party, and education as needed. A review of the audits revealed no identified concern with completion dates as indicated. 63). Review of the audits completed by the DM and/or CDM revealed they were completed as stated with no identified concerns. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, and Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed trays were audited for to ensure they arrived on the unit and were passed timely. 64). Review of verbal quizzes revealed ten (10) staff members were quizzed for one (1) week beginning on 8/15/2021 with no needed education. Further review of verbal quizzes revealed five (5) staff members were quizzed for four (4) weeks from 08/22/2021 and completed on 09/13/2021 with no identified concerns. A review of the verbal quiz revealed staff was quizzed on respiratory status, hypo/hyperglycemia, and SBAR/physician notification. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM, DON	{F 837}		

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{F 837}	Continued From page 978 #2 on 09/30/2021 at 3:20 PM, and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed they performed verbal quizzes for identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician orders. Interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, revealed they participated in verbal quizzes with facility staff. 65). Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed audits of documented blood glucose levels Monday through Friday in the clinical meeting. She further revealed that with any blood sugar less than 60 and/or greater than 40, the facility staff were expected to notify the physician, Responsible Party, and Registered Dietician and follow physician orders. The Regional DON stated she identified one (1) resident on 08/12/2021 to have a blood glucose level of 430 and one (1) on 09/20/2021 to have a blood glucose level of 465 with no documented evidence the licensed nurse followed the facility process. She provided education to both RN #2 and LPN #5. A Review of audits revealed no further concerns. A Review of education revealed RN #2 and LPN #5 received education regarding the facility process. 66). Review of verbal staff quizzes revealed staff was verbally asked signs and symptoms of abuse when to report, signs and symptoms of wandering and wandering interventions. A review of the	{F 837}		

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{F 837}	Continued From page 979 verbal quizzes revealed five (5) staff were verbally quizzed daily for one (1) week from 08/13/2021 to 08/19/2021 with no identified concerns. Further review revealed verbal quizzes were conducted three (3) times a week for two (2) weeks from 08/21/2021 to 09/02/2021 with no identified concerns. A review of verbal quizzes revealed that verbal quizzes were conducted one (1) time per week for four (4) weeks from the week of 09/03/2021 to 09/24/2021 with no identified concerns. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed each assisted in the completion of verbal staff quizzes. Further interview revealed that each staff member was verbally quizzed on the areas listed on the audit tool (signs and symptoms of abuse, when to report, signs and symptoms of wandering and wandering interventions), and any need for education was completed immediately with each quiz. Interviews with SRNA #11 on 09/29/2021 at 3:23 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM and Maintenance Assistant #1 on 09/30/2021 at 2:56 PM revealed they participated in verbal quizzes regarding abuse, when to report, wandering and wandering interventions. 67). Review of Resident #355 on 09/10/2021	{F 837}		

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{F 837}	Continued From page 980 revealed the resident had an admission wandering risk assessment completed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had an admission wandering risk assessment completed on 09/28/2021. The resident was not identified to be at risk for wandering. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed that MDS staff will schedule wandering risk assessments to ensure completion. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and DON #2 on 09/30/2021 at 3:20 PM revealed all-new admissions would be reviewed in the morning clinical meeting to ensure appropriate assessments, including the wandering risk assessment, had been completed. Further interviews revealed that residents identified as at risk for wandering would be discussed during this meeting and appropriate interventions implemented. 68). Review of interviews performed for residents with a BIMS score of 8 or greater revealed no identified concerns. Continued review revealed interviews were initiated on 08/13/2021 with ten (10) resident interviews completed for four (4) weeks then five (5) residents for eight (8) weeks. Interview with ISSD on 09/30/2021 at 2:23 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed they were assisting in completing audits with residents with no concerns identified. Review of audits initiated on 08/13/2021 for review of random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure there are no injuries of unknown origin revealed no identified concerns. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and	{F 837}		

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{F 837}	Continued From page 981 DON #2 on 09/30/2021 at 3:20 PM revealed they were completing audits as indicated with no identified concerns. Observation of skin assessment on 09/30/2021 of Resident #45 at 9:23 AM and on 09/30/2021 at 10:20 AM of Resident # 27 revealed no concerns with injuries of unknown origin. 69). Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she started audits on 08/25/2021 of resident diet orders from electronic medical records against orders entered in the diet/tray card software to ensure accuracy. Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334 tray card on 09/29/2021 at 12:30 PM revealed diets were served as ordered by the physician. A review of audits revealed audits were conducted weekly for four (4) weeks. 70). Review of completed audits revealed random meals were audited twice daily for one (1) week beginning 08/23/2021. Starting 08/30/2021, random meals were observed two (2) times per week for two (2) weeks and then weekly from 09/13/2021 for one (1) month. Interview with Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed audits were performed as indicated. Further interviews revealed that meals were served as scheduled, including breakfast at 7:00 AM, lunch at 12:00 PM, and dinner at 5:00 PM. Observation on 09/28/2021 at 5:03 PM revealed the evening meal had been served on the third floor. Observation on 09/29/2021 lunch meal revealed meals arrived at the third floor at approximately 12:16 PM, the	{F 837}		

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{F 837}	Continued From page 982 fourth floor at 12:16 PM and 12:24 PM, and the fifth floor at 12:34 PM and 12:49 PM. 71). Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334's tray card on 09/29/2021 at 12:30 PM revealed the meals honored resident preferences, including likes and dislikes. Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she would be responsible for obtaining food and beverage preferences within seventy-two hours of admission and entering the preferences into the system. A review of audits revealed snack intakes were audited daily for one (1) week from 09/15/2021 to 09/21/2021. Further review of the audits revealed snacks were audited weekly beginning on 09/22/2021. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she audited snack intake and had not identified any concerns. 72). Interview with the Human Resource Director (HR) on 09/30/2021 at 10:48 AM revealed she completed audits for daily staff screening against time clock punches. She revealed no identified concerns. Observation of entry doors on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no concerns. 73). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed audits were being conducted with observations of handwashing, isolation signage and zones, donning/doffing PPE, mask compliance. Any	{F 837}		

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{F 837}	Continued From page 983	{F 837}		

variance or identified concerns will be addressed immediately. A review of the audits revealed they were conducted beginning 09/17/2021 on random shifts and units.

74). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible in addition to other members to review all residents on narcotics with the pharmacy to ensure that an active script is on file beginning 09/23/2021. A review of audits revealed no identified concerns. RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with obtaining scripts for medications and/or receiving medications timely. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. In addition, observation of the narcotic count on the fifth floor on 09/30/2021 at 12:50 PM revealed no identified concerns.

75). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible for completing random medication pass observations beginning 09/25/2021. She stated she had not identified any concerns with residents not having medications or narcotic counts. A review of audits revealed the facility utilized the Centers for Medicare Services Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. A review of audits revealed a minimum of twenty-five medications were observed daily from 09/25/2021 with no

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{F 837}	Continued From page 984 identified concerns. Further review of medication observations revealed that medication administration was observed on random shifts, including 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 76). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM. The DON on 09/30/2021 at 3:20 PM revealed medication delivery tickets were being reviewed in clinical meetings Monday through Friday against ordered medications. A review of the audit revealed no identified concerns. 77). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and the DON on 09/30/2021 at 3:20 PM revealed staffing was being audited daily beginning 09/11/2021, to ensure adequate staffing was maintained. A review of the audits revealed no identified concerns. 78). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, and the Dietary Manager on 09/30/2021 at 1:30 PM revealed staffing was being monitored daily to ensure adequate staffing. A review of the audits revealed no identified concerns. 79). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interim Administrator on 09/30/2021 at 5:05 PM revealed daily audits had been conducted daily from 09/11/2021. A review of the audits revealed no identified concerns. 80). Interview with the Senior Marketing Liaison	{F 837}		

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{F 837}	Continued From page 985 on 09/30/2021 at 10:55 AM revealed he completed observations on different shifts to identify any change in resident condition. Further interviews revealed if a change in condition was identified, staff would complete a stop and watch. An audit review revealed no concerns with the change of conditions not being addressed by facility staff. 81). Review of interviews performed on 09/25/2021 for residents with a BIMS score of 8 or greater revealed no identified concerns. A review of the questionnaire completed during interviews revealed residents were asked: Is everyone treating you well? Do you feel safe here? Do you have any concerns? Interview with the Medical Records Staff on 09/29/2021 at 8:34 AM revealed she completed the interviews with residents on 09/25/2021, and she stated she identified no concerns.	{F 837}		
{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-	{F 842}		11/30/21

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{F 842}	Continued From page 986 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (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;	{F 842}		

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{F 842}	Continued From page 987 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain two (2) of fifty-seven (57) sampled residents' (Residents #321 and #323) medical records in accordance with accepted professional standards and practices that were complete and contained accurate documentation. Resident #321 had physician's orders to monitor blood glucose levels per the facility's protocol. However, the facility failed to obtain the Resident #321's blood glucose levels on 07/16/2021 and on 07/17/2021. In addition, Resident #323's Medication Administration Records (MAR) revealed staff failed to document that the resident's insulin (medication used to lower blood glucose) was administered on 07/13/2021. The findings include: Review of the facility's policy titled,	{F 842}	F 842 Resident Records Criteria 1: a) Resident #321 was discharged from the facility on 7-19-2021 b) Resident #323 was discharged from the facility on 7-20- 2021 Criteria 2: On 11/24/2021 The MARs and blood sugar documentation for current residents with the diagnosis of diabetes were reviewed by the DON/ADON/Corporate Nurse Consultants/Designee to determine that these records were complete and in accordance with the facility protocol.. Criteria 3: The DON/Designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility	

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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 842}	Continued From page 988 "Diabetes-Clinical Protocol", dated November 2020, revealed the facility would monitor a well-controlled diabetic's blood glucose level twice daily if the resident was receiving insulin. Continued review of the policy revealed the facility would monitor any resident on intensive insulin therapy or sliding scale insulin three (3) to four (4) times a day. The facility would also monitor as indicated, if a resident was fasting before a procedure, had returned to the facility after a significant absence, or had an acute illness or infection Review of the facility's policy titled "Charting and Documentation", undated, revealed changes in the resident's condition, event, incidents or accidents involving the resident and progress toward or changes in the care plan goals and objective will be documented in the medical record. Further review revealed the documentation would include care-specific details including assessment date and/or any unusual findings obtained during the procedure/treatment, notification of family, physician or other staff, if indicated, and the signature and title of the individual documenting. 1. Review of Resident #321's medical record revealed the facility admitted the resident on 07/16/2021, with diagnoses of Urosepsis, Diabetes Mellitus, and Invasive Bladder Cancer. Review of Resident #321's Minimum Data Set (MDS) assessment dated 07/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) indicating the resident was cognitively intact.	{F 842}	diabetic protocol, monitoring to ensure insulin is documented given as ordered, documenting resident change in condition, documentation of blood sugar in the medical record, documentation of administration of insulin in the medical record and notification of physician and following physician orders beginning 8-12-2021. Criteria 4 Beginning 11/24/2021 the DON or designee will review 5 random residents recorded blood sugars weekly to ensure they are within physician parameters, until substantial compliance is achieved, any blood sugar falling outside parameters will be audited to ensure that the MD/NP was notified and if new orders were received and followed. Beginning 11/24/2021 the DON/designee will audit 5 random residents weekly that are receiving insulin to ensure insulin is documented in the electronic medical record as ordered, until substantial compliance is achieved Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 11/30/2021	

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{F 842}	Continued From page 989 Review of Resident #321's baseline care plan dated 07/16/2021, revealed the care plan did not have the resident's diagnosis of diabetes listed. Further review revealed there were no interventions listed regarding obtaining or monitoring Resident #321's blood glucose levels. Review of the Physician's Orders dated 07/16/2021, revealed Resident #321 received an order for staff to obtain his/her blood glucose levels as required and as needed (PRN). Continued review of the Physician's Orders revealed staff was to administer the resident Glargine Insulin (long acting medication to lower blood sugar) every morning. Review of Resident #321's Medication Administration Record (MAR) and Treatment Administration Records (TAR) revealed no documentation that staff obtained the resident's blood glucose level after admission to the facility on 07/16/2021, until prior to breakfast on 07/18/2021. Although the resident's MAR directed staff to conduct diabetic monitoring every shift for hypoglycemia/hyperglycemia (low/high blood sugar), there was no documented evidence the staff completed the monitoring or obtained the resident's blood glucose readings on the evening of 07/16/2021, or on 07/17/2021. Interview with Licensed Practical Nurse (LPN) #6, on 07/30/2021, at 11:30 AM, revealed she admitted Resident #321 on 07/16/2021 and took care of the resident on 07/17/2021 from 7:00 AM until 7:00 PM. LPN #6 stated she checked the resident's blood glucose levels both days as ordered, and thought she documented them in the resident's medical record, but must have forgotten.	{F 842}		

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{F 842}	Continued From page 990 Interview with Registered Nurse (RN) #7 ,on 07/28/2021 at 4:25 PM, revealed that she cared for Resident #321 on night shift from 7.00 PM-7:00 AM on 07/16/2021 and 07/17/2021. RN #7 stated she obtained the resident's blood glucose levels as ordered, but could not recall what they were. The RN stated she should have documented the blood glucose results in the resident's medical record, but she guessed she forgot. Continued interview revealed that it was routinely her and one State Registered Nurse Aide (SRNA) working the entire floor, and she struggled to get the charting completed. Interview with Resident #231's Physician (Physician #1), on 08/04/2021 at 1:05 PM, revealed he expected nursing staff to obtain, document and monitor blood glucose levels for diabetic residents at a minimum every shift. He further stated his expectation was for staff to obtain blood glucose levels prior to administering diabetic medications to residents with a diagnosis of diabetes. Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing (IDON), on 08/11/2021 at 12:05 PM, revealed she expected nursing staff to obtain and document glucose levels on all diabetic residents at a minimum every shift. However, the DON stated that some residents might require more frequent monitoring. The DON stated she did not conduct any routine monitoring to ensure staff were obtaining and documenting diabetic residents' blood glucose levels. Interview with the Administrator, on 08/10/2021 at 1:50 PM, revealed she was unaware that staff	{F 842}		

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{F 842}	Continued From page 991 were not documenting blood glucose levels in the resident's medical record. The Administrator was unable to say how the facility was monitoring residents to ensure their blood glucose levels were staying within acceptable parameters if the staff were not documenting the readings. 2. Review of Resident #323's medical record revealed the facility admitted the resident on 07/06/2021 with diagnoses that included Metabolic Encephalopathy, Acute Respiratory Failure, Autistic Disorder, Sepsis, Diabetes Mellitus, Dysphagia, Pneumonia and Aphasia. Review of Resident #323's Physician's Orders dated July 2021, revealed orders to administer the resident Levemir insulin twice daily and Humulin-R insulin before meals and at bedtime. Review of Resident #323's MAR for 07/13/2021 at 9:00 AM revealed no documented evidence staff administered the resident's Levemir insulin. Further review of the MAR for 07/13/2021 at 11:30 AM and 4:30 PM revealed no documented evidence staff administered the resident Humulin-R insulin. Interview with RN #1, on 07/29/2021 at 9:55 AM, revealed she was responsible for Resident #323 on 07/13/2021 from approximately 6:30 AM to 6:30 PM. She stated that she administered Resident #323's Levemir and Humulin-R, however, must have failed to document the medication on the MAR. Interview with the ADON/IDON, on 08/11/2021 at 12:05 PM, revealed she expected staff to document on the resident's MAR when they administered any medication to a resident. The	{F 842}		

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{F 842}	Continued From page 992 ADON/IDON stated she had not identified a concern with staff documenting medication administration on the MAR. Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed she was unaware that staff were not documenting the administration of insulin on the resident's MAR.	{F 842}		
{F 867} SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy, and review of the facility's Plan of Correction submitted for the 12/12/2020 survey, it was determined the facility failed to have an effective performance improvement program which measured the success and tracked the performance of its plans to ensure interventions were implemented, deficiencies were corrected and the facility maintained substantial compliance The facility failed to ensure compliance was maintained at 42 CFR 483.80 Infection Control. Deficiencies were cited during the 07/14/2020, 09/24/2020, 11/13/2020, and 12/12/2020 surveys. On the 12/12/2020 survey, Immediate Jeopardy (IJ) was identified and cited at a Scope and	{F 867}	F 867 QAPI/QAA Improvement Activities Criteria 1: An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021 on (F580, F600, F655, F656, F684, F686, F692, F755, F880). However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified for (F725, F835, F837, F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. An acceptable allegation of compliance	12/30/21

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{F 867}	Continued From page 993 Severity of "L" due to the facility's failure to prevent the spread of COVID-19. The facility submitted a Plan of Correction and achieved compliance effective 01/20/2021. However, the facility failed to implement Quality Assurance Performance Improvement (QAPI) plans to ensure compliance was maintained. Immediate Jeopardy was identified again on 08/11/2021, at 42 CFR 483.80 Infection Control (F880). The facility failed to isolate residents who were positive for COVID-19 to prevent the spread to other residents. Two (2) residents died due to COVID-19. Refer to F880. The facility's failure to ensure an effective Quality Assurance Performance Improvement (QAPI) Program was in place has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70	{F 867}	was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 9/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to D for all tags, while the facility monitors the effectiveness of systemic changes and quality assurance activities. The Governing body has been involved in the development of the QAPI Plan and procedures and any recommended changes. Criteria 2: On 9 /15/2021 a conference call was held with Med-Net Concepts the Vice President of Operations, Director of Clinical Operations, Regional Nurse Consultants to review the following: 1) the outcomes of the survey, 2) expectations and roles of the Governing Body as outlined in the Rules and Regulations, 3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. The governing body replaced Administrator with an Interim Administrator on 9/13/21. The interim administrator educated all QAPI	

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{F 867}	Continued From page 994 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. A second acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 09/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to "D" 42 CFR 483.10 Resident Rights (F580), 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686), 42 CFR 483.35 Nursing Services (F725), and 42 CFR 483.45 Pharmacy Services (F755); and to "E" at 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.25 Quality of Care (F692), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867), and 42 CFR 483.80 Infection Control (F880), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan, dated May 2021, and the QAPI policy, last revised April 2014, revealed the facility should develop, implement and maintain an ongoing, facility wide QAPI plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality and resolve identified problems. According to the policy, QAPI	{F 867}	committee team members on QAPI Committee Processes and Procedures. A permanent administrator was placed on 10-01-2021 and he was presented the education prior to assuming the role of administrator. Criteria 3: The Regional Director of Operations and VP of Operations met with the Administrator, the DON, and the Medical Directors on 9/16/21 regarding the duties of the Governing Body including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. Also reviewed the QAPI/QAA processes, the need to participate regularly in QAPI process, the need to identify Root Cause (we will use the 5 whys) and auditing systems per the QAPI Calendar. During the Ad Hoc QAPI meeting 09-16-2021, the interim administrator presented a new QAPI agenda, dashboard, and format for QAPI Committee processes and procedures. This format included a review of the current 802/672 report, Performance Improvement Projects, staffing reported by HR, Grievance log, Resident/Family Council, Quality Reviews and Consultant Reports, Reportable Events, Regulatory Activity, Infection Control, Risk Management, Wound Care, Weight Loss, Hospitalizations, GDRs, Falls, and Catheters. On 9/15/21 and education was provided by MED-NET Healthcare Consulting, LLC for the following members Regional Directors, Divisional Vice President of Operations,	

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{F 867}	Continued From page 995 data should be gathered and used in an organized and meaningful way. Areas that might be appropriate to monitor and evaluate included: staff turnover and assignments, State surveys and deficiencies, care plans, resident/family complaints, clinical outcomes such as pressure ulcers, infections and MDS (Minimum Data Set) assessment and data. The policy also indicated input would be gathered from staff, residents, family members and individuals who were involved in the care of the residents, and staff were encouraged to identify/report quality concerns as well as opportunities for improvement. The policy stated members of the facility's leadership was accountable for QAPI efforts and systems would be in place to monitor care and services and outcomes utilizing performance indicators. The policy also stated action plans would be developed and implemented to prevent recurrence of identified adverse events. Review of the "Administrators Manual," dated May 2021, revealed the facility's corporation was committed to serving residents and their family members and would strive to create a homelike atmosphere, where the needs of the residents were of utmost importance. According to the policy, the Administrator's primary purpose was to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines and regulations that govern nursing facilities to ensure the highest degree of quality care was provided at all times to the residents. The Administrator was required to make daily rounds of the facility and evaluate the overall appearance of facility/equipment, evaluate care provided to the residents, and evaluate resident/family satisfaction. The manual also	{F 867}	Chief Nursing Officer, Regional MDS, Regional Certified Dietary Manager, and Regional Nurse Consultant. The Administrator is responsible for collecting audits and ensures the Department Heads understands the process and how to use the audit tools. Criteria 4: Beginning on 09-13-2021, the interim administrator started monitoring daily, weekly, and monthly audits for F580, F600, F655, F656, F684, F686, F692, F755, F880, F725, F835, F837, and F867. The Administrator will monitor all audits on a weekly and/or until substantial compliance is met and monthly thereafter as recommended by the QAPI committee. Any findings that were not within regulations and addressed immediate and/or not reported immediately will result in disciplinary action in accordance with facility policy and procedures that can result in termination. All findings and progress will be presented to QAPI Committee consisting of at a minimum of: Administrator, Medical Director, Director of Nursing, Dietary Manager, Social Service Director, and two other staff members to update progress and/or findings to determine recommendations or feedback to continue current plan in place. The Administrator has forwarded all QAPI Meeting minutes to the members of the Governing Body including the Vice President of Operations, Regional Vice President of Operations, and regional nurse consultant for review of all audits results. Beginning 12/15/21 the Governing	

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{F 867}	Continued From page 996 stated the Administrator's duties included developing and maintaining written policies/procedures and professional standards of practice which govern the operation of the facility. Further review revealed the Administrator's daily duties included ensuring the Interdisciplinary Team Meetings (IDT) were occurring; review/manage staffing; observe facility systems, which included dining; and ensure personal assistance was provided to the residents. The Administrator's weekly duties included monitoring residents, identified problems, and reviewing weight and pressure ulcer reports for the residents. Monthly Administrator duties included ensuring follow up had occurred for consultant reports, which included dietary reports; and to ensure QAPI meetings were conducted monthly as required. The manual also stated the Administrator would review all incident reports, would coordinate all investigations in the facility, and would ensure compliance for reporting of all events to State and Federal agencies. The Administrator should listen to and know their residents and ensure the individual needs of the residents were met. According to the manual, the Administrator should ensure menus were posted daily and that nourishments were offered to the residents. Review of the Statement of Deficiencies (SOD) for the surveys, dated 07/14/2020, 09/24/2020 and 11/13/2020, revealed the facility had been cited at 42 CFR 483.80, infection control, for failure to prevent the possible spread of COVID-19. Review of the Statement of Deficiencies (SOD) for the survey date, 12/12/2020, revealed the facility was cited Immediate Jeopardy at 42 CFR 483.80, Infection	{F 867}	Body member on site will attend the weekly QAPI committee meeting. Criteria 5: Date of compliance: 12/30/2021	

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{F 867}	Continued From page 997 Control at a Scope and Severity "L" for failure to prevent the spread of COVID-19. Review of the facility's Plan of Correction (POC), for the 12/12/2020 survey, revealed the facility educated staff on the facility's infection control program and policies, COVID emergency plan, properly wearing face mask and PPE (personal protection equipment) and handwashing. In addition, all facility staff were required to complete three (3) modules of the Nursing Home Infection Preventionist training on the Centers of Disease Control and Prevention (CDC) website and were required to view videos on "Keep COVID-19 Out", "Clean Hands Combat COVID-19; and Use Personal Protective (PPE) Equipment Correctly". Also staff, were required to review the document entitled "Responding to Coronavirus (COVID-19) in Nursing Homes" Continued review of the POC revealed the facility would monitor to ensure compliance with infection control. The POC stated staff would adhere to the facility's PPE, Infection Control, and competency checks. The Infection Preventionist with oversite from the Director of Nursing (DON) or designee would complete weekly checks of four (4) random housekeeping and nursing staff to assure compliance with the facility's policy and procedures on cross contamination for four (4) weeks or until zero negative findings were determined by the Quality Assurance (QA) Committee. Per the plan, compliance would be reviewed by the QA Committee each month for six (6) months to determine if the POC had been effective to prevent the violations from recurring. The facility alleged and achieved compliance effective 01/11/2021. However, the facility failed to ensure they	{F 867}		

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{F 867}	Continued From page 998 continued to monitor and evaluate compliance with infection control per the Plan of Correction and the facility's QAPI plan/policy. Observation of the facility's fifth floor on 08/05/2021 at 10:54 AM, revealed although two (2) residents (Resident #311 and #314) tested positive for COVID-19 on 07/28/2021 and two (2) residents (Resident #329 and #82) tested positive on 08/02/21, the facility failed to isolate and segregate the residents as required by the facility's policy. The fire doors were open, all resident room doors were open, and residents were wandering the halls of the unit. Further observation revealed no designated zones existed to separate residents. Additionally, Resident #327 tested positive on 08/07/2021 and Resident #325 tested positive on 08/08/2021. Review of the facility's COVID-19 test records, dated 07/28/2021, revealed both Resident #311 and Resident #314 tested positive for COVID-19. Continued review of COVID-19 test records revealed Resident #82 and #329 tested positive for COVID-19 on 08/02/2021. Observation on 08/05/2021 at 10:54 AM, revealed maintenance staff placed plastic zip barriers across the doorway of a room where both Resident #311 and Resident #314 resided. However, this was eight (8) days following the resident's positive COVID-19 results. In addition, observation of Resident #325, on 08/05/2021 at 10:54 AM, revealed the resident was wandering the hall walking past the red biohazard waste containers where staff were doffing COVID contaminated PPE on the outside of the residents' rooms who were COVID positive. Further observations, on 08/05/2021 at 11:00 AM, revealed Resident #325 was sitting in a chair in the hallway of the fifth floor with no facemask.	{F 867}		

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{F 867}	Continued From page 999 This resident was seated adjacent to COVID positive residents' rooms. Further observation on the fifth (5th) floor, on 08/05/2021 at 10:54 AM, revealed large red biohazard cans in the hallway on each end of the floor. These cans contained large amounts of contaminated PPE, which had been used by staff while in residents' rooms who were COVID positive. Interview with SRNA #19, on 08/05/2021 at 11:15 AM, SRNA #16, on 08/09/2021 at 11:47 AM, and SRNA #3 on 08/05/2021 at 12:30 PM, revealed staff were doffing (remove) contaminated PPE from COVID-19 positive rooms in a red bio-hazard can in the hallway. Review of the facility's COVID-19 test records, dated 08/07/2021, revealed Resident #327 tested positive for COVID-19. Review of Resident #327's Nurse Notes, dated 08/09/2021 at 5:19 PM, revealed the resident had two (2) episodes of diarrhea. The physician was notified and the resident was encouraged to increase oral fluid intake. Further review of Nurse Notes, dated 08/14/2021 at 12:05 AM, during routine vital signs, staff found Resident #327 to have a low blood pressure, low heart rate, and low oxygen saturation. The physician was notified and Resident #327 was sent to the emergency room via an ambulance for further evaluation. Review of Resident #327's hospital discharge summary, dated 08/15/2021 PM, revealed the resident expired at the hospital on 08/15/2021. The resident's admission diagnoses included Sepsis and COVID-19 Pneumonia. Per the	{F 867}		

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{F 867}	Continued From page 1,000 discharge summary, the resident's Sepsis was likely due to the COVID-19 Pneumonia. The resident's diagnosis was COVID-19 Viral Pneumonia. Review of the facility's COVID-19 test records, dated 08/08/2021, revealed Resident #325 tested positive for COVID-19 on 08/08/2021. Review of the Nurse's Notes, dated 08/09/2021 at 2:45 PM, revealed Resident #325 had a change in condition and had cough, congestion and developed a fever of 100.2 F (Fahrenheit) and respiratory distress requiring transfer to the emergency room for evaluation. Review of a Nursing Readmission Assessment, dated 08/12/2021 at 4:40 PM, revealed Resident #325 was readmitted to the facility from the hospital. Continued review of the Nurse's Notes, dated 08/19/2021 at 1:30 PM, revealed Resident #325 developed a low oxygen saturation of 89% and physician and resident representative were notified. The Physician ordered palliative care and a Fentanyl patch (pain medication skin patch) related to the resident's declined condition and a Do Not Resuscitate (DNR) status. Per the note, staff discussed the resident's condition, palliative care, DNR status, and new orders from the physician with resident representative. The resident's representative requested the facility send Resident #325 back to the hospital. The physician and DON were notified of request and an ambulance transported the resident to the emergency room for evaluation. Review of hospital discharge summary, dated	{F 867}		

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{F 867}	Continued From page 1,001 08/26/2021, revealed Resident #325 expired at the hospital on 08/26/2021 and the resident's diagnoses included Acute Hypoxic Respiratory Failure secondary to COVID-19 Pneumonia. On 08/23/2021 at 2:10 PM, an interview was conducted with a previous Administrator, who resigned effective 06/01/2021. The former Administrator stated prior to leaving, he continued to monitor all deficiencies cited during the December 2020 survey. He stated they continued to review all monitoring through Quality Assurance (QA) and when he left, he had not identified any concerns with information gathered. He stated he lead QA. Per the Former Administrator, the Director of Nursing, the Assistant Director of Nursing (ADON) and he worked together on QA by gathering the data and reviewing records. The Former Administrator stated the former DON quit right after he did. Interview with the ADON/Interim Director of Nursing (IDON), on 08/18/2021 at 9:50 PM, revealed she had been the ADON at the facility for approximately one (1) year. The ADON stated she was also serving as the Infection Control Nurse since December 2020, and had assumed the role of Interim DON around 07/23/2021, she was unable to recall the exact date during the interview. She stated since she had been employed as the ADON, she had worked the floor as a staff nurse more than she had functioned as an ADON, due to the ongoing short staffing in the facility. She also stated the facility had no Unit Managers, no Staff Development Coordinator and no QA Nurse since she had worked at the facility. She stated she recalled one (1) Unit Manager being hired a few months ago, but the nurse left after the first week or so, because she was	{F 867}		

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{F 867}	Continued From page 1,002 mandated to work the floor due to the ongoing staffing problems in the facility. According to the ADON, she was unaware of any monitoring conducted by the DON, prior to her leaving employment at the facility. She stated, "She (the former DON) always worked the floor too, due to short staffing." The ADON stated she was not currently and had never monitored any QA processes or gathered any data related to QA processes in the facility. Further interview revealed she had not attended any meetings, weekly or monthly, to discuss quality processes since her employment at the facility. According to the ADON, she was also responsible to monitor infection control processes in the facility. However, she stated at the time of the interview, she had worked the last six (6) out of seven (7) nights on the floor and was unable to complete the required monitoring. Interview with the Administrator, on 08/10/2021 at 1:50 PM, revealed she was not made aware of any ongoing audits of quality processes that were in place at the facility when she became the Administrator in June 2021. She also stated there had been no QA meetings conducted since she became Administrator in June 2021. The Administrator also stated she was the QA Coordinator and was responsible for the QA Program/Processes in the facility. However, she stated she had not conducted any monitoring in the facility related to infection control, because she expected the ADON to complete infection control monitoring. The Administrator also acknowledged the facility had no Unit Managers, no Staff Development or QA Nurse. She stated those positions were posted and have been posted for hire since she had been at the facility; however, no qualified applicants had expressed	{F 867}		

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{F 867}	Continued From page 1,003 interests in those positions. She also acknowledged the ADON worked the floor as a staff nurse frequently. During the interview, when asked how the ADON could monitor, when she was working the floor as a staff nurse, she stated "Well I don't know." **The facility alleged the following was implemented to remove Immediate Jeopardy effective 09/26/2021: 1). Braden Scale Assessments were completed on all residents by facility nurses on 08/28/2021 and comprehensive full body skin assessments were completed on all residents on 09/11/2021. The facility utilized the Braden Scale Assessment and comprehensive full body skin assessment to review and update care plans of residents who had pressure injuries by 09/17/2021. 2). The wound care physician evaluated Resident #65 on 08/25/2021. Staff assessed and measured all pressure injuries, and staff evaluated all current treatments and reported them to the Medical Director/Physician #1 by 09/17/2021. 3). Beginning 09/17/2021, upon admission a skin assessment and Braden Scale assessment will be completed, and the baseline care plan will be developed within 48 hours to include any pressure ulcer or potential for pressure ulcer. A comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcers and include interventions to prevent pressure ulcer development or worsening of pressure ulcers. 4). Residents #45, #65, #308, #309, #311, #314	{F 867}		

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{F 867}	Continued From page 1,004 and #320 were bathed including a shower, nail care and moisturizing lotion applied post shower, and assisted with dressing in clean appropriate clothing. Clean linens were placed on the residents' beds on 09/11/2021. The residents were evaluated by social services on 09/15/2021. 5). All residents were offered a shower and interviewed to obtain shower/hygiene preferences by the Director of Nursing (DON) or designee. New bath/shower schedules were implemented by nursing staff to accommodate resident preference. Resident preferences for hygiene were obtained and incorporated into resident care plans and State Registered Nurse Aide (SRNA) care plans by the Regional Nurse Consultant were completed on 09/13/2021. 6). On 08/28/2021, the Registered Dietitian (RD) began reviewing all residents' diets and made recommendations for meal changes or supplements to promote healing and to address any weight loss issues. 7). All residents with the diagnoses of Diabetes and Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by licensed nurse and/or Respiratory Therapist with no concerns were identified completed 08/13/2021. 8). The Regional Nurse reviewed all residents with orders for glucose monitoring by 07/30/2021 and orders were amended to include mandatory entry of glucose values on the Medication Administration Record (MAR). 9). The Regional Certified Dietary Manager (CDM) observed the meal service for breakfast,	{F 867}		

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{F 867}	Continued From page 1,005 lunch and dinner on 09/11/2021, all three meals were delivered on time. 10). Direct Care staffing was increased through recruitment efforts with additional staffing provided through agency and travel contracts. Direct care nursing staff schedules for the next day will be reviewed daily by the Director of Nursing and the Administrator to ensure staffing levels are adequate to meet the acuity of the residents. The staff will be validated as present on the unit at the start of each shift by the Director of Nursing, Nursing Supervisor, Administrator or designee. Direct care nursing staff call offs will be replaced by calling other qualified staff to see if they can fill the opening, and/or calling agencies to see if they have qualified staff to fill the opening. If direct care staff cannot be replaced the Director of Nursing, Assistant Director of Nursing, or member of the nursing management team will fill the shift. If appropriate staffing levels cannot be met, the center will prioritize resident care that can be achieved during emergency staffing, prioritize required task including administration of medication, no showers- sponge baths, care provided to incontinent residents, turn residents that cannot turn self, meals served timely, and assist residents with meal if needed. 11). The facility has increased dietary staffing through recruitment efforts and appropriate staffing levels have been achieved to ensure meals are prepared and delivered timely. 12). On 08/11/2021, all residents including #64, #86 and #322, were reassessed for psychosocial and physical forms of abuse with Brief Interview for Mental Status (BIMS) score of eight (8) or	{F 867}		

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{F 867}	Continued From page 1,006 above and skin integrity reviews for residents with BIMS less than eight (8) were completed by Licensed Nurse. Residents with a diagnosis of Dementia had their Care Plan reviewed and revised, as necessary by the Minimum Data Set (MDS) Coordinator on 09/07/2021. No new residents were identified as indicating any psychosocial and/or physical harm. 13). The Regional Nurse Consultant completed a wandering risk assessment on all residents by 08/16/2021. All residents who were identified as at risk for wandering had care plans reviewed and updated by the MDS Coordinator. A list of all identified active wander risk residents were placed at each nursing station with a list of potential interventions for nursing to reference. 14). Residents #39, #65, #81, #90, #330 and #332 were weighed by 09/17/2021. The Registered Dietician (RD) completed a comprehensive nutrition assessment and RD recommendations were reviewed for recommendations by the Director of Nursing (DON) or designee on 09/17/2021. Further, the DON or designee, spoke with the attending Medical Doctor (MD) and validated the diet orders and recommendations. Recommendations were entered into the electronic medical record and on the tray card. The Registered Dietician and Director of Nursing (DON), reviewed diet orders in electronic medical record to ensure both the record and tray card reflected accurate information on 09/17/2021. 15). Beginning 09/15/2021, staff began offering snacks to all residents daily in the morning and afternoon by the restorative nurse aide, activity aides, or designee. Snacks ordered by a	{F 867}		

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{F 867}	Continued From page 1,007 physician will be documented by the restorative aide, dietary aides and/or licensed nursing staff. 16). The facility evaluated the COVID-19 unit on 08/11/2021, located on the 5th floor of the facility for compliance with CDC guidelines and implemented yellow and red zones. The DON identified two (2) residents who had been exposed to positive residents and a yellow zone was designated with erection of a plastic zip wall barrier and those two (2) residents were moved to this zone on 08/11/2021. 17). The facility had three (3) residents who were in the red zone on 08/11/2021(Residents #327, #328 and #329). Residents #327, #328 and #329 have completed quarantine per facility policy and physician orders. Residents #311 and #314 completed quarantine per COVID-19 policy and physician's order. Residents #311 and #314 were no longer in isolation. 18). All staff eligible for testing were tested for COVID-19 on 09/16/2021. The facility did not identify any new cases based on the employee testing on 09/16/2021. All residents eligible were tested for COVID-19 on 09/17/2021. The facility did not identify any new positive cases. 19). The facility was conducting ongoing surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In	{F 867}		

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{F 867}	Continued From page 1,008	{F 867}		

addition, any resident exposed will be placed in droplet precaution in isolation zone (yellow). The facility will provide physician notification, family notification and care plan revisions. The facility employee testing protocol will be twice weekly on designated days effective 08/16/2021. The facility requires all staff must be tested on designated days. If the employee is not tested, the facility will not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas.

20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021.

21). Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021.

22). The facility stated all residents will receive their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the physician regarding the unavailable medication.

23). The facility formulated an agreement on 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of

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{F 867}	Continued From page 1,009 medications that requires the facility's approval for cost authorization while pending cost review. 24). New admissions and re-admissions entering the facility after normal business hours and on weekends will have discharge orders submitted, entered into the electronic medical record and submitted to pharmacy through pharmacy integration. The facility implemented the use of fax transmittal as a backup to the electronic pharmacy integration by entering the order in the electronic medical record to receive medications. If the facility does not receive medications in a timely manner the pharmacy will be notified, and the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. 26). The facility conducted a Quality Assurance Performance Improvement (QAPI) meeting on 08/12/2021. The facility reviewed education, facility process, and audited implementation to ensure compliance with the AOC and all audits. The Administrator oversees the QAPI committee. The QAPI committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the	{F 867}		

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{F 867}	Continued From page 1,010 current Administrator. The facility's Interim Administrator will receive daily oversight and guidance from the Regional Vice President or Regional Director of Operations and Regional Clinical Nurse for 30 days. Upon completion of the thirty-day oversight, the Regional Administrative Team will audit the Administrator to determine if continued daily oversight is needed. The administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. 28). The Administrator, Medical Director, and QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee.	{F 867}		

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{F 867}	Continued From page 1,011 30). The Administrator and Regional Nurse Consultant reviewed and revised the QAPI Plan beginning 09/16/2021 and presented the reviews and/or revisions to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The agenda included reviewing pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, hospital readmission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns, grievances, admissions, discharges, census, staff development, vacant positions, employee orientation, dietary variances, tray audit report, weight loss, work injuries, terminations, employees on family medical leave, a leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include, but not limited to, the topics presented during the meeting. 31). The Regional Director of Operations and Vice President of Operations met with the Administrator, the DON, and the Medical Director on 09/16/2021 regarding the duties of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes with the utilization of the five (5) why approaches and, auditing systems per the QAPI	{F 867}		

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{F 867}	Continued From page 1,012 Calendar. The Administrator will notify the medical Director of future QAPI Committee meetings. 32). The Administrator will collect all monitoring reports before each QAPI Committee meeting beginning 09/15/2021 for review to ensure compliance with the deficiencies cited during the 09/10/2021 survey. QAPI Meetings were held on 09/16/2021 to discuss abatement and develop interventions to remove the jeopardy. The facility implemented QAPI meetings weekly, times four (4) weeks, as needed, and monthly. The Administrator will forward all QAPI Meeting minutes to the Governing Body members, including the Vice President of Operations, Regional Vice President of Operations, and the Regional Nurse Consultant, to review the audit results. The QAPI committee will review the audits at the QAPI meetings. Committee for review. The Administrator oversees the QAPI Committee. The QAPI Committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 33). The Governing Body will provide the facility's Administrator with resources and education materials for QAPI, including but not limited to the QAPI Tool Kit, QAPI at a Glance, and a resource guide to effectively implement the QAPI plan beginning 09/16/2021. The Governing Body will meet quarterly for the upcoming year and reevaluate for frequency after one (1) year. 34). The Administrator will increase the frequency of QAPI Committee meetings to weekly for four (4) weeks and, as needed effective 09/16/2021,	{F 867}		

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{F 867}	Continued From page 1,013 to ensure the quality of care is monitored and complies with the standard of care and compliance with State and Federal requirements is demonstrated. 35). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. 36). On 09/13/2021, the Regional Certified Dietary Manager (CDM) educated the Dietary Manager on the provision of timely nutritional assessment to ensure diet order accuracy, on diet order accuracy, and on when to enter diet orders into the electronic medical record. The CDM educated the Dietary Manager to enter resident diet orders into the tray care system. If the nurse enters the order, the nurse will send a written communication to the dietary staff, including diet and texture. In the morning clinical meetings, staff will review diet orders from the previous day to ensure accuracy. 37). Therapy provided education to all nursing staff on turning and positioning range of motion, and transfer of resident from bed to chair and chair to bed beginning on 08/19/2021 and completed on 09/17/2021. The facility employed and assigned additional staff through recruitment and agency contracts to ensure adequate staff to turn and reposition all residents who cannot reposition themselves. 38). The Regional Director of Nursing educated all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate	{F 867}		

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{F 867}	Continued From page 1,014 hydration and nutrition, positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician, and RP of a new skin impairment by 09/17/2021. The facility nursing staff will call or email the Registered Dietitian, Physician, and Resident Representative of any new skin changes. 39). The DON or designee educated all staff on timely call light response. In addition, direct care staff, including nurses and certified nursing assistants, were provided education on providing timely hygiene per the resident's plan of care, timely toileting, dressing residents in their choice of clean clothing, and timely delivery of meal trays. The DON or designee will educate any facility staff not working during education upon returning to work. 40). On 08/31/2021, The Regional Director of Nursing educated all licensed nursing staff, the Registered Dietician, the Social Service Director, and the MDS Nurses on entering new care plans into the electronic medical record, including goals and interventions. In addition, the Regional Director of Nursing educated staff to update the existing care plan in the electronic medical record with new goals and interventions for any new skin impairments identified during their shift. 41). The facility's Respiratory Therapist educated Licensed nurses on identifying and assessing residents with a change in respiratory status on 08/12/2021. In addition, on 08/12/2021, the DON and/or designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a resident's	{F 867}		

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{F 867}	Continued From page 1,015 change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. The facility licensed nursing staff will not be allowed to work until they have received this education. The DON educated all clinical staff on documentation of glucose levels on 08/19/2021 and 08/20/2021 during mandatory in-services. 42). Beginning 08/12/2021, the DON educated licensed nurses on completing a baseline Care Plan with interventions and goals relevant to diabetes and a respiratory diagnosis within 48 hours of admission, reviewing and providing a copy to the resident and/or the responsible party. Licensed nursing staff not working during education was notified of ongoing education and will not be allowed to work until they have received this education. 43). Beginning 08/12/2021, the DON educated all staff on the facility's "call off" procedure. The call-off procedure for the facility included: in the event a person needs to call out of work for dayshift, they are to notify their immediate supervisor two hours before the start of the shift. If staff needs to call off on the night shift, they are to notify their immediate supervisor four hours before the start of their shift. If the facility does not have appropriate staffing levels, the immediate supervisor and/or designee will call other qualified staff to replace the person calling off. If emergency staffing is required, the Administrator and/or designee will call for assistance from staffing companies. Staff not working will be in-serviced upon return to work. 44). All staff were provided re-education by the Administrator and/or designee on 08/12/2021 on	{F 867}		

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{F 867}	Continued From page 1,016 the process of identifying, preventing, and reporting abuse, as well as identifying and implementing immediate interventions for wandering residents. 45). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. On 09/13/2021, the CDM educated the Dietary Manager on diet order accuracy and timely nutritional assessment to ensure diet order accuracy. When staff enters diet orders into the electronic medical record, the nurse entering the order will send the written communication to the dietary staff. The Dietary Manager will enter the order into the tray care system. The facility will review diet orders from the previous day in the clinical meeting to ensure accuracy. 46). The Regional CDM educated the Dietary Manager on 09/13/2021 on facility policy regarding meal service times and the use of recipes including recipes for those requiring fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural and ethnic needs of the population. 47). As of 09/15/2021, the Regional CDM completed education with the dietary manager on obtaining food preferences, the facility's tray card system, ordering food based on menus, stocking snack/hydration carts, snacks, and hydrations procedures, appropriate scoop sizes, and/or portion sizes. 48). The Director of Nursing or Regional Director	{F 867}		

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(F 867)	Continued From page 1,017 of Nursing educated nurses and the Dietary Manager on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders on 09/17/2021. 49). All staff were provided re-education by the DON and/or designee by 09/17/2021 on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. In addition, the DON/designee educated, licensed staff on monitoring residents for Covid-19 symptoms beginning. 08/12/2021, the DON/designee educated all staff, including contract staff, who were not working. During the QAPI meeting on 08/12/2021, the Covid-19 policy, the handwashing policy, donning and doffing PPE, red and yellow zones, and monitoring residents for signs/symptoms of the Covid-19 were reviewed. 50). Staff were provided re-education on 08/20/2021 by the DON, Regional DON, or Regional Nurse Consultant to enter COVID-19 symptom monitoring orders on all new admissions into the resident's record. 51). All licensed nursing staff have been educated on the five (5) rights of medication administration, including right medication, right patient, right dose, right time, and right route. The Regional DON/DON/designee educated all licensed nursing staff working on 09/23/2021 on the process to follow when a medication was not available for administration as ordered. The education included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notify the MD if an	(F 867)		

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{F 867}	Continued From page 1,018 ordered medication will either be omitted or given outside of the ordered medication time. The education also included following new orders given by the MD, documenting the conversation, and new orders from the MD in the electronic medical record. All other licensed nursing staff will be provided training as scheduled for shifts. 52). On 09/25/2021, the DON /Regional Nurse Consultant educated all licensed nursing staff, including new hires and/or agency staff, on the use of the emergency medication kit, the system in place for ensuring medications are in-house, or notifying the physician for new orders for new or re-admitting residents, including on weekend and after-hours. 53). The Interim Administrator educated all staff on his contact information and role as the Abuse Coordinator from 09/13/2021 through 09/17/2021. In addition, education on staffing schedules and who to notify if unable to work their scheduled shift. 54). The facility will audit weekly resident head-to-toe skin assessments daily, Monday through Friday, for three (3) months effective 09/17/2021 to ensure they have been completed weekly on each resident. In addition, the facility will notify the physician, Registered Dietician, and Responsible Party of any new skin impairment and those new interventions have been put in place to prevent decline. 55). Central supply audited all lab supplies for the expiration date on 08/28/2021. Audits will be conducted weekly for all lab supplies for four (4) weeks effective 09/17/2021 and then monthly for three (3) months.	{F 867}		

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{F 867}	Continued From page 1,019 56). The Director of Nursing, Assistant Director of Nursing (ADON), or Nursing Supervisor will audit resident progress notes for daily four (4) weeks effective 09/13/2021, then weekly for one (1) month. Staff will review Progress notes for Saturday and Sunday on Monday. The Nursing Supervisor conducted audits to ensure any new areas of skin impairment identified had a care plan implemented to include new interventions. 57). Beginning on 09/11/2021, the facility's leadership staff and/or designee began visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning. All residents will be visually rounding on once each shift daily for two (2) weeks, fifty percent of the residents each shift for four (4) weeks, and twenty-five percent of residents each shift for four (4) weeks. The facility has two (2) shifts, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 58). On 09/11/2021, the facility's leadership staff began visual monitoring and timing of call light response times, including the length of time call lights are answered, across all shifts. Leadership staff will conduct ten (10) call light observations each shift for two (2) weeks and then five (5) call light observations each shift for eight (8) weeks. 59). On 08/13/2021, the DON and/or Designee began monitoring respiratory assessments and Situation Background Assessment and Recommendation (SBAR) communications for acute change in respiratory status Monday through Friday in the clinical morning meeting. The facility reviewed any acute change in respiratory status for Physician notification and implementation of any physician order. Care	{F 867}		

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{F 867}	Continued From page 1,020 Plans were reviewed and updated as needed. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 60). The MDS Nurse, DON, and/or Designee began audits on 09/15/2021 of baseline care plan completion for all new admissions and re-admissions to ensure staff completed the baseline Care Plan within 48 hours of admission. 61). All residents admitted within the last thirty days with a diagnosis of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Asthma, or current Pneumonia had their baseline Care Plan reviewed and updated as needed by the MDS Nurse(s) and/or designee. New interventions will be added to the care plan in the morning meeting by the DON, ADON, and/or nursing designee. 62). Beginning on 08/19/2021, the MDS Nurse, DON, and/or Designee will monitor new admissions and re-admissions to audit baseline care plans for completion, accuracy, and review with the resident and/or responsible party. Any variance or identified concern was addressed immediately. Audits will be conducted Monday through Friday for all admissions/re-admissions to the facility for four (4) weeks, fifty percent of admissions for a week for two (2) weeks, and then ten percent of admissions weekly for four (4) weeks. 63). On 09/11/2021, the Dietary Manager and/or designee began auditing how long it took to pass meal trays to residents after arriving at the unit. All three (3) meals will be observed on all three (3) units daily for two (2) weeks, two (2) meals on all three (3) units daily for two (2) weeks, and one	{F 867}		

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{F 867}	Continued From page 1,021 (1) meal on all three (3) units daily for four (4) weeks. 64). On 08/15/2021, the DON and/or Designee began audits of staff's knowledge with a verbal quiz of identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician's orders. Leadership will quiz staff randomly across all shifts; ten (10) staff for one (1) week and five (5) staff a week for four (4) weeks. 65). On 08/13/2021, the DON and/or Designee began monitoring all documented blood sugar results Monday through Friday in the clinical morning meeting. The DON/designee will review any blood sugar results outside of the normal range for MD notification and implementation of any Physician's Orders. Care plans will be reviewed and updated as needed. The DON or designee will complete a visual rounding on diabetic residents across both shifts and all three (3) units to identify any resident with apparent signs and symptoms of hypoglycemia/hyperglycemia to ensure the resident was immediately assessed by licensed staff. Any variance or identified concerns will be addressed immediately. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 66). On 08/13/2021, the Administrator and/or designee implemented an employee questionnaire on abuse and identification of residents with wandering behavior to determine the proper reporting of abuse across all shifts and	{F 867}		

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{F 867}	Continued From page 1,022 units. The employee questionnaire will be completed for five (5) staff daily for one (1) week, then three (3) times a week for two (2) weeks, and then weekly for four (4) weeks. Any variance or identified concerns will be addressed immediately. 67). Beginning on 08/13/2021, the Director of Nursing and/or designee will review each resident's wandering risk assessment upon admission and quarterly with their Minimum Data Set (MDS) assessment. Any resident identified as wandering will be discussed in the clinical morning meeting to review and initiate new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing, or nursing designee. 68). Beginning on 08/13/2021, the Social Services Director or designee will perform random interviews of residents with a BIMS score of eight (8) or greater to ensure they feel safe in the facility and have not been subject to or witnessed abuse. The DON or designee will review random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure no injuries of unknown origin beginning 08/13/2021. Any variance or identified concerns will be addressed immediately. 69). On 08/25/2021, the Registered Dietician conducted audits of resident diet orders from the electronic medical record against orders entered in the diet/tray card software to ensure accuracy. 70). Beginning on 08/23/2021, the Dietary Manager will ensure and audit meals leaving the	{F 867}		

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{F 867}	Continued From page 1,023 kitchen and reaching the units timely. Audits will be conducted for random meals twice daily for one (1) week, twice per week for two (2) weeks, and then weekly for one (1) month. Once meal trays arrive at the unit, management staff will assist in passing trays to ensure residents receive meal trays, and certified nursing assistants assist residents promptly. The Dietary Manager or designee will audit the time it takes to pass meal trays to residents after they arrive on the unit beginning 09/11/2021. All three (3) meals will be observed on each unit daily for two (2) weeks, two (2) meals on each unit daily for two (2) weeks, one (1) meal on each unit daily for four (4) weeks. 71). The dietary manager or designee will review admitted/re-admitted residents' food and beverage preferences within 72 hours of admission and enter them into the diet/tray card system for listing on their tray cards beginning 09/16/2021. Review of food preferences will be completed bi-annually and as needed for all residents. Physician-ordered snack intakes will be audited by the Dietary Manager daily for one (1) week, weekly for four (4) weeks, and monthly after that for four (4) months beginning 09/15/2021. 72). Daily COVID-19 screenings for staff will be audited beginning on 08/25/2021 by the Human Resources (HR) Director against time clock punches to ensure screening before beginning their shift. Audits will be completed Monday through Friday for four (4) weeks by the HR Director, and weekends audited on Mondays. Any staff not screened will be re-educated immediately on the COVID-19 Screening Policy by the HR Director. The HR Director was	{F 867}		

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{F 867}	Continued From page 1,024 educated on the COVID-19 policy by the Regional Nurse, an infection control preventionist. All entry doors will remain locked. Visitors must be allowed entry by staff and screened by staff at the time of entry. 73). Beginning on 09/17/2021, the DON and/or designee will round seven (7) times each week for eight (8) weeks, five (5) times weekly for four (4) weeks to audit infection control compliance on differing shifts and units. Audits will include observation of handwashing; isolation signage and zones; donning/doffing (putting on/taking off) PPE; and mask compliance. Any variance or identified concerns will be addressed immediately by the auditor. 74). The DON, ADON, and/or Designee will review all residents on narcotics with the pharmacy to ensure an active script is on file beginning 09/23/2021. Staff will notify the physician within two (2) days of the prescription's expiration. 75). The Regional Nurse Consultant, Pharmacy, and/or Director of Nursing will conduct random medication pass observations effective 09/25/2021 on random shifts daily until immediate jeopardy removed to ensure timeliness and accuracy of medications. The facility utilized the CMS Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. 76). Beginning 09/25/2021 Monday through Friday, the DON, ADON, and/or Designee will audit medication delivery tickets against ordered medications daily to ensure that all narcotics needing a renewal have been sent to the	{F 867}		

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{F 867}	Continued From page 1,025 pharmacy. Audits will continue until the Immediate Jeopardy is removed. 77). Beginning 09/11/2021, the Administrator and/or DON will be responsible for monitoring nursing staff daily for four (4) weeks to ensure adequate staffing is maintained. 78). Beginning 09/11/2021, the Administrator and Dietary Manager will be responsible for reviewing dietary staffing daily for four (4) weeks to maintain adequate staffing. 79). Beginning 09/11/2021, the Divisional Vice President of Operations and/or designee will monitor and audit the Administrator daily for 30 days to ensure compliance. 80). Visual rounding will be conducted beginning 09/23/2021 to monitor for residents' change of condition and identification of need for "Stop and Watch" (change of condition) communication. 81). Beginning 09/11/2021, the Administrator or designee performed interviews of residents with a BIMS score of eight (8) or greater to ensure they felt safe in the facility and had not been subjected to or witnessed abuse. No residents had any concerns. Interviews will continue to be conducted of residents by the Administrator or designees weekly until immediate jeopardy is removed. **The State Survey agency validated the facility's actions to remove the Immediate Jeopardy on 09/26/2021 as alleged by : 1). Review of Head-to-Toe Skin Assessments revealed staff assessed all residents in the facility	{F 867}		

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{F 867}	Continued From page 1,026 on 09/11/2021. A review of the skin assessments revealed eight (8) residents (Residents #65, #324, #45, #14, #357, #27, #74, and #358) had current pressure ulcers with a total number of pressure injuries of twenty (20). A review of the comprehensive care plans for Residents #65, #324, #45, #14, #357, #27, #74, and #358 revealed staff updated the care plans to reflect the resident's current pressure injuries. The facility completed the review on 09/17/2021. A review of the facility's census on 08/28/2021 revealed staff assessed all residents at risk for pressure ulcers with the Braden Scale. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed head-to-toe skin assessment on all residents on 09/11/2021. She further revealed that the facility identified twenty (20) total pressure injuries. She further stated that the facility completed the Braden Scale assessments on all residents on 08/28/2021. Continued interviews revealed the Interdisciplinary Team utilized the skin assessments and Braden Scale assessments to update the residents' care plans. She stated that Resident #65, #324, #45, #14, #357, #27, #74 and #358's care plans were updated to reflect current pressure injuries by 09/17/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed she updated all residents' care plans to reflect current pressure injuries by 09/17/2021. In addition, she completed a review of walking rounds on 09/15/2021 with Therapy Personnel, the Registered Dietician, the Medical Director, the DON, and the MDS Nurse for Residents #65, #324, #45, #14, #357, #27, #74 and #358. A review revealed the Interdisciplinary Team reviewed each resident's orders, current skin breakdown,	{F 867}		

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{F 867}	Continued From page 1,027 care plan, and implemented changes as needed. 2). Review of Resident #65's medical record revealed the Medical Director assessed the resident on 08/25/2021 at 1:45 PM and noted a Stage four (4) pressure ulcer on the sacrum; a deep tissue injury (DTI) to the left and right heels; and a skin tear to the left inner leg. Review of Resident #65's wound care note dated 08/26/2021 at 9:00 AM, revealed the sacrum wound measured, "13 cm (centimeter) (length) by 12.3 cm width and 0.2 cm depth with undermining at 10 o'clock measuring 2 cm and undermining at 12 o'clock that measures 1 cm, muscle exposed. No palpable bone, slough is present, partially removed with wound cleanser." The facility continued to treat the resident's sacral pressure ulcer with Aquacel Ag. A review of a wound evaluation completed on 09/15/2021 revealed Resident #65 had six (6) pressure ulcers, including a stage two (2) to the left superior calf measuring 1.2 cm (length) by 1.4 cm (width) by 0.1 cm (depth), stage one (1) to the right hip measuring 2.5 cm by 2 cm by less than 0.1 cm, stage two (2) to left hip measuring 1.2 cm by 0.8 cm x less than 0.1 cm, stage two (2) to left scapula measuring 1 cm by 0.2 cm by less than 0.1 cm, unstageable to right heel measuring 0.6 cm by 0.6 cm. and four (4) areas to the sacrum measuring 12 cm by 11.6 cm by 0.4 cm. Interventions in place for the resident included heel protectors while in bed, diet as ordered, weekly documentation of the wound, an air mattress to bed, nutritional supplements, and turning/repositioning. Observation of wound care for the sacral pressure ulcer on 09/29/2021 at 10:21 AM revealed the wound measured 13 cm by 11 cm by 0.3 cm with a scant amount of drainage and 95 percent granulation tissue.	{F 867}		

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{F 867}	Continued From page 1,028 Resident #65 declined would not consent to the observation of other pressure areas. A medical record review revealed that on 09/21/2021 at 2:19 PM, Physician #1 determined the resident's weight loss and wounds were unavoidable. On 09/28/2021, Resident #65's family declined in-house wound care visits. Further review of the record revealed on 09/29/2021, staff notified the physician of the decline in the resident's wound with no new orders. The resident was diagnosed with Failure to Thrive. 3). The facility admitted Resident #355 on 09/10/2021, completed a skin assessment on 09/10/2021, completed a Braden Scale on 09/10/2021, and completed a baseline care plan on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record revealed staff developed the comprehensive care plan on 09/21/2021. A review of Resident #355's re-admission revealed the resident had an admission skin assessment completed on 09/28/2021, Braden Scale on 09/28/2021, and a baseline care plan developed on 09/28/2021. 4). Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, Resident #308 on 09/29/2021 at 11:10 AM, Resident #309 on 09/29/2021 at 11:26 AM, Resident #311 on 09/29/2021 at 11:52 AM, Resident #314 on 09/29/2021 at 11:30 AM and Resident #320 on 09/29/2021 at 11:13 AM revealed the residents appeared clean, well-kempt, and clean linens were on the residents' beds. Interviews with the residents during the time of the observations revealed no identified concerns. A review of Progress Notes for Residents #45, #65, #308, #309, #311, #314,	{F 867}		

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{F 867}	Continued From page 1,029 and #320) revealed the Interim Social Service Director interviewed the residents on 09/15/2021 and had no concerns with resident hygiene. Interview with the ISSD on 09/30/2021 at 2:23 PM revealed she interviewed Residents #45, #65, #308, #309, #311, #314, and #320 on 09/15/2021 with no identified concerns regarding hygiene. 5). Observation of residents during the initial tour on 09/28/2021 from 1:33 PM to 2:32 PM revealed no identified concerns. Interviews and record reviews revealed Residents #45, #65, #308, #309, #311, #314, and #320 each had their shower preference and hygiene preference obtained and included on their care plan. A review of the resident's medical record, including the comprehensive care plan and SRNA care plan, revealed staff updated each resident's plan to reflect the resident's preference. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM revealed she assisted with obtaining resident preferences. She stated each resident was interviewed for shower and hygiene preference, and the facility updated each resident's care plan. A review of resident interviews revealed their shower/hygiene preference was obtained. A review of the facility's shower schedule revealed that the resident shower/hygiene preferences were honored. 6). Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she began reviewing all resident diets on 08/28/2021. She further stated that she implemented new and/or additional recommendations for residents to address weight loss and/or wound healing. A review of the documentation revealed the Registered Dietician reviewed all residents' diets, and the Regional DON reviewed all diets and recommendations.	{F 867}		

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{F 867}	Continued From page 1,030 Interview with the RDO on 09/30/2021 at 4:17 PM revealed she completed the review of all diets and recommendations. 7). A review of facility assessments completed by 08/13/2021 revealed thirty-nine (39) residents with a diagnosis of Diabetes were assessed for signs and symptoms of hypoglycemia/ hyperglycemia and the need for immediate intervention. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she assessed the residents and did not identify immediate concerns. Observations of Resident #348 on 09/28/2021 at 1:36 PM, Resident #320 on 09/29/2021 at 11:13 AM, and Resident #311 on 09/29/2021 at 11:52 AM revealed no visible signs/symptoms of hypoglycemia/hyperglycemia. A review of facility assessments completed on 08/12/2021 revealed fifty (50) residents with a diagnosis of Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by Respiratory Therapist #1. Interview with Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM revealed she assessed all residents with diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Asthma, and pneumonia 08/12/2021 with no identified concerns. Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, and Resident #43 on 09/28/2021 at 2:03 PM. revealed no respiratory distress. 8). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she reviewed all residents with a diagnosis of Diabetes and the resident's orders for glucose monitoring. She stated the facility amended all resident orders to include mandatory entry of glucose values on the	{F 867}		

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{F 867}	Continued From page 1,031 MAR. Review of Resident #3, #41, and #357's orders revealed each order required staff to enter the glucose value on the resident's MAR. Further review revealed no concerns with residents having glucose levels less than 60 and/or greater than 400. 9). A review of audits completed on 09/11/2021 revealed meals were delivered timely. Interview with the Regional Certified Dietary Manager (RCDM) on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed lunch was observed on 09/11/2021 and arrived at the unit within five (5) to ten (10) minutes of the scheduled times. 10). A review of the facility's staffing for 09/28/2021 from 6:00 AM to 6:00 PM revealed two (2) licensed nurses and three (3) nursing assistants were scheduled for each floor of the facility. A review of the facility's staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. A review of the staffing for 09/29/2021 and 09/30/2021 revealed two (2) licensed nurses, and three (3) certified nursing assistants on each floor from 6:00 AM to 6:00 PM. Further review of staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. Observation of facility staffing on 09/28/2021 from 1:20 PM to 5:30 PM; on 09/29/2021 from 8:11 AM to approximately 6:00 PM and 09/30/2021 from 7:55 AM to 5:17 PM, revealed call lights were being answered timely, residents appeared clean/well-groomed, staff was offering and	{F 867}		

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{F 867}	Continued From page 1,032 assisting residents with baths/showers, turning/repositioning was being conducted timely, and meal trays were passed timely. Interviews with RN #1 on 09/29/2021 at 11:55 AM and on 09/30/2021 at 12:58 PM; RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM; LPN (Licensed Practical Nurse) #6 on 09/30/2021 at 12:44 PM; LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM; LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM; State Registered Nurse Aide (SRNA/certified nurse aide) #1 on 09/29/2021 at 3:40 PM; SRNA #11 on 09/29/2021 at 3:23 PM; SRNA #7 on 09/29/2021 at 3:29 PM; SRNA #19 on 09/29/2021 at 4:10 PM; SRNA #21 on 09/29/2021 at 3:04 PM; SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed staffing had improved, and each staff member revealed they had time to perform duties as assigned. 11). Review of the staffing schedule for 09/28/2021, 09/29/2021, and 09/30/2021 revealed each day consisted of one (1) day cook, one (1) evening cook, one (1) prep cook, two (2) day aides, and two (2) evening aides. Observation of the kitchen on 09/28/2021 at 2:26 PM reflected the staffing was accurate per the schedule. Interview with Cook #3 on 09/29/2021 at 1:12 PM, and Dietary Aide #3 on 09/30/2021 at 2:10 PM revealed kitchen staffing had improved, and they were able to complete their duties during their shift. 12). A review of assessments for being withdrawn, crying, or other abuse symptoms was conducted for Residents #64, #86, and #322 on 08/11/2021. No concerns were identified. A	{F 867}		

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{F 867}	Continued From page 1,033 review of skin assessments completed revealed no identified concerns. Observation and interviews conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with psychosocial and/or physical abuse, including observations of Residents #64, #86, and #322. Interview with Resident #322 on 09/29/2021 at 11:54 AM revealed no concerns with abuse. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed skin assessments on 08/11/2021, for all residents, with the assistance of licensed nursing staff. No concerns were identified. A review of audits completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified concerns. 13). A review of assessments for residents that wander, revealed all residents had received a wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident identified at risk. 14). Review of Resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she completed a comprehensive nutritional assessment on Residents #39, #65, #81, #90, #330 and #332. Review of the medical record revealed the RD completed a comprehensive nutritional	{F 867}		

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{F 867}	Continued From page 1,034 assessment on 09/16/2021 for Resident #39, 09/16/2021 for Resident #65, 09/16/2021 for Resident #81, 09/16/2021 for Resident #90 and 09/16/2021 for Resident #330 with no dietary recommendations made. Resident #332 was discharged. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM, the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM and DON #2 on 09/30/2021 at 3:20 PM revealed each resident had received a comprehensive nutritional assessment and review of the recommendations by nursing staff. Further interview with the RD and Regional DON revealed both the record and tray card were reviewed to reflect accurate information. 15). Observation of the third floor on 09/28/2021 at 2:22 PM, the fourth floor on 09/28/2021 at 2:00 PM and the fifth floor on 09/28/2021 at 2:06 PM revealed snacks including but not limited to oatmeal pies, goldfish crackers, cookies and drinks were present, including soda, milk, and juice. Observations on 09/29/2021 at 10:30 AM revealed snacks were being passed on third floor. Review of Resident #331, Resident #65 and Resident #14's record revealed documented intake of snacks. Interview with SRNA #19 on 09/29/2021 at 4:10 PM revealed she was educated on documentation of snacks. 16). Observation of the facility's red zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. The zones contained no residents. 17). Review of Residents #327, #328 and #329 revealed the residents were isolated per CDC guidance. Observation of Resident #328 on	{F 867}		

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{F 867}	Continued From page 1,035 09/29/2021 at 11:41 AM and Resident #329 on 8/30/2021 at 10:36 AM revealed no obvious signs or symptoms of COVID-19. Resident #327 had been discharged from the facility. 18). Review of facility staff testing revealed all staff working on 09/16/2021 were tested for COVID-19 with no identified new cases. Further review of resident testing for COVID-19 on 09/17/2021, revealed no new cases. 19). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed the facility is testing staff two (2) times weekly. Interview with Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed	{F 867}		

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{F 867}	Continued From page 1,036 she was conducting testing two (2) times weekly following CDC guidance. Review of facility staff tested revealed tested is being conducted two (2) times weekly. 20). Review of Resident #329, #328, #311, #65 and #90's medical record revealed that each resident had COVID-19 monitoring orders implemented. In addition, review of each resident's MAR revealed staff was completing the monitoring as ordered by the physician. 21). Interview with the Medical Director on 09/30/2021 at 3:25 PM revealed Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351's medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). Observation of a medication pass on 09/29/2021 at 4:35 PM on 3rd floor and 09/30/2021 at 8:09 AM on 3rd floor revealed no identified concerns with missing medications. In addition, observation of a narcotic count on 5th floor on 09/30/2021 at 12:50 PM revealed no identified concerns. Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, N #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with unavailable medications. 23. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Co-Owner/President of Pharmacy on 09/30/2021 at 3:11 PM revealed both parties made a formal	{F 867}		

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{F 867}	Continued From page 1,037	{F 867}		

agreement that the pharmacy will supply the facility with a three-day supply for medication requiring cost review. Review of the facility's pharmacy agreement revealed for any medication requiring a cost review the pharmacy would send the facility a minimum of a three-day supply of the medication while being reviewed. The facility would communicate any changes or continuance guidance to the pharmacy within 72 hours. The Director of Operations of Guardian Pharmacy and the Vice President of Operations of the facility signed the agreement.

24). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4 on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education and was aware of the process for obtaining medications from the pharmacy. In addition, they revealed they were aware that the nurse would notify the physician if the pharmacy could not deliver a medication to the facility.

25). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and Regional DON on 09/30/2021 at 4:17 PM revealed an audit was completed of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications.

26). Review of a QAPI signature sheet revealed the facility conducted a meeting on 08/12/2021 with the Regional DON, Regional Nurse

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{F 867}	Continued From page 1,038 Consultant, Human Resources, SSD #2, Medical Records, the Housekeeping Supervisor, Central Supply, MDS Nurse #1, MDS Nurse #2, the Therapy Manager, the Admissions Coordinator, the Administrator, the Activities Director, the Dietary Manager, and other members of the administration team. 27). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the facility appointed the current Interim Administrator on 09/13/2021. Further interview with the VP of Operations revealed she had provided the Interim Administrator with daily oversight since 09/10/2021. 28). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, the Medical Director on 09/30/2021 at 3:25 PM and members of the QAPI committee, including the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, revealed procedures for contacting staff for call-ins, answering call lights, ADL Care, serving and delivering meal trays timely, incontinence care and turning/repositioning were reviewed on 09/15/2021. 29). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and the Med-Net Concepts Nurse Consultant on 09/28/2021 at 3:00 PM revealed the facility conducted a conference call to review the following: (1) the outcomes of the survey, (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations, (3) determined a plan for the following	{F 867}		

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{F 867}	Continued From page 1,039 communication/monitoring tools: Infection Control and COVID-19 isolation, enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed reviewed and revised the QAPI Plan and presented the reviews and/or revision to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The plan included pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, the hospital re-admission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns and/ or grievances, admissions, discharges, census, staff development, openings by department/position, employee orientations, dietary variance tray audit report, weight losses, work injuries, terminations, employees on family medical leave of absence or leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include but not be limited to the topics presented during the meeting. Interview with MDS Nurse #1 on	{F 867}		

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{F 867}	Continued From page 1,040 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM, revealed the information was presented at the QAPI meeting held on 09/16/2021. 31). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, the Interim Administrator on 09/30/2021 at 3:40 PM, DON #2 on 09/30/2021 at 3:20 PM, and the Medical Director on 09/30/2021 at 3:25 PM revealed a meeting was conducted on 09/16/2021 regarding the duties of the Governing Body including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes of system problems, utilization of the "5 why" approach and auditing systems per the QAPI Calendar were reviewed. 32). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he collected all monitoring reports before each QAPI meeting and reviewed the data for compliance. A review of QAPI attendance sheets revealed the facility conducted meetings on 09/16/2021, 09/23/2021, and 09/30/2021. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and	{F 867}		

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{F 867}	Continued From page 1,041 Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed they were members of the governing body, and QAPI meetings had been forwarded to them. 33). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed the governing body provided the Administrator with resources and education material for QAPI. Further interviews revealed the governing body would meet quarterly for the upcoming year. Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he had been provided with resources and education regarding QAPI. 34). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed QAPI meetings were conducted weekly effective 09/16/2021 to ensure the quality of care is monitored and complied with the standard of care and compliance. Further interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM revealed they had participated in the weekly QAPI meetings conducted on 09/16/2021	{F 867}		

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{F 867}	Continued From page 1,042 and 09/23/2021. In addition, an interview with the Medical Director/Physician #1 on 09/30/2021 at 3:25 PM revealed he participated in the weekly QAPI meetings on 09/16/2021 and 09/23/2021. Further interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed the weekly QAPI meeting had been conducted on 09/30/2021. A review of the facility QAPI meeting attendance sheet reflected the above interviews with no identified concerns. 35). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician. 36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary	{F 867}		

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{F 867}	Continued From page 1,043 Manager (CDM) on diet order accuracy and timely nutritional assessments to ensure diet order accuracy. When staff enter diet orders into the electronic medical record, the nurse entering the order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into the tray card system to reflect the resident's diet orders. She stated that all diet orders from the previous day would be reviewed in the clinical meeting. Interview with the Regional CDM on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she completed education with Former Activities Director/Dietary Manager #3. In addition, she stated that she had been on site to provide additional assistance during the transition to her new role. 37). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on turning/repositioning, range of motion and transferring residents from bed to chair and from chair to bed. Observations of turning, positioning, and wound care with RN #11 on 09/29/2021 at 10:21 AM for Resident #65 revealed no identified concerns. Interview with the Therapy Manager on 09/30/2021 at 1:18 PM revealed she provided staff with education	{F 867}		

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{F 867}	Continued From page 1,044 beginning on 08/19/2021 regarding turning/repositioning, range of motion, and transferring a resident from bed. 38). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on pressure ulcer prevention including turning and repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, MD and RP of a new skin impairment. The nurse will call or email the Registered Dietitian, the physician, and the resident's representative with any changes. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and the Regional DON on 09/30/2021 at 4:17 PM revealed they educated staff on pressure ulcer prevention including turning/repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician and RP of a new skin impairment. With any change to skin impairment, the nurse will call or email the Registered Dietitian for new recommendations, MD, and resident's representative.	{F 867}		

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{F 867}	Continued From page 1,045 39). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on timely call light response. In addition, interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on timely call light response, providing timely hygiene per resident plan of care, timely toileting, ensuring staff dress residents in their choice of clean clothing and timely delivery of meal trays. Further interview with Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on meal service times. 40). Interview with MDS Nurse #1 on 09/30/2021	{F 867}		

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{F 867}	Continued From page 1,046 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on ensuring new care plans were entered into the electronic medical record. Observation of RN #1 on 09/29/2021 at 11:55 AM revealed the nurse was able to demonstrate knowledge of the education with no identified concerns. 41). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on identification and assessment of residents with a change in respiratory status and on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. In addition, interviews revealed they received education on documentation of glucose levels.	{F 867}		

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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 867}	Continued From page 1,047 42). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on completing a baseline Care Plan with interventions and goals relevant to the diagnosis of diabetes and a respiratory diagnosis within forty-eight hours of admission, and reviewing and providing a copy to the resident/responsible party. 44). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 Aide on	{F 867}		

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	185256	A. BUILDING _____ B. WING _____	R 09/30/2021

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{F 867}	Continued From page 1,048 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they were educated on the process of identifying, preventing, and reporting abuse as well as identifying and implementing immediate interventions for wandering residents. 45). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. In addition, an interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she had received education on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy. When the diet orders are put into the electronic medical record, the nurse entering the order will send a written communication to the dietary staff that will include diet and texture. She further revealed all diet orders from the previous day are reviewed in the clinical meeting, which occurs Monday through Friday, to ensure accuracy. 46). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on facility policy regarding meal service times and the use of recipes, including recipes for fortified diets to ensure all meals meet the	{F 867}		

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{F 867}	Continued From page 1,049 nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural, and ethnic needs of the population. 47). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on obtaining food preference, facility tray card system, order placement for meals, snack/hydration pass, appropriate scoop sizes and/or portion sizes, stocking snack/hydration carts and snacks and hydrations. 48). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders. 49). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, DON #2 on 09/30/2021 at 3:20 PM, Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care	{F 867}		

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{F 867}	Continued From page 1,050 Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they had received education on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. Observation of the red facility zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. No residents were in the red or yellow zones. Observations conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), or the yellow/red zones. 50). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education entering COVID-19 symptom monitoring orders on all new admissions. A review of newly admitted Resident #355 on 09/10/2021 revealed the resident had COVID-19 symptom monitoring entered in the	{F 867}		

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{F 867}	Continued From page 1,051 resident orders. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had a COVID-19 symptom monitoring entered in the resident orders. In addition, a review of Resident #329, #328, #311, #65, and #90's medical records revealed each resident had COVID-19 monitoring orders implemented. 51). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the five (5) rights of medication administration including right medication, right patient, right dose, right time, and right route. In addition, they were educated on the process to follow when a medication was not available for administration, which included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notifying the physician if an ordered medication would either be omitted or given outside of the ordered medication time. The education also included following new orders given by the physician, documenting the conversation, and new orders from the MD in the electronic medical record. 52). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM,	{F 867}		

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{F 867}	Continued From page 1,052 LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the use of the emergency medication kit (e-kit). Observation of floor three (3) on 09/29/2021 at 3:10 PM, floor four (4) on 09/29/2021 at 2:57 PM, and floor five (5) on 09/29/2021 at 2:50 PM revealed each medication administration room was equipped with an emergency medication kit. Interview with LPN (LPN) #9 on 09/30/2021 at 2:27 PM revealed she was a new hire to the facility and had received education regarding the emergency medication kit. 53). Interview with DON #2 on 09/30/2021 at 3:20 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they were educated on the Interim Administrator's contact information and role as Abuse Coordinator. Observation of the facility on	{F 867}		

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{F 867}	Continued From page 1,053 09/28/2021, 09/29/2021, and 09/30/2021 revealed signage posted with the Interim Administrator's contact information and title of Abuse Coordinator posted throughout the facility. 54). Review of audits beginning 09/17/2021 of weekly head-to-toe skin assessments revealed no identified concerns. Observation of Resident #27 skin and wound assessment on 09/30/2021 at 10:20 AM revealed no identified concerns. A review of the medical record for Resident #65, #324, #45, #14, #357, #27, #74, and #358 revealed the weekly wound assessments completed with physician and responsible party notifications. Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she was notified of new and/or worsening pressure ulcers and reviewed the residents as indicated. Interview with Medical Director on 09/30/2021 at 3:25 PM revealed that he was notified of new and/or worsening skin impairments and new interventions to prevent decline. He further revealed that he participated in QAPI meetings and discussed ongoing audits and care of residents. Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the QAPI team discussed all audits in QAPI meetings, including new and/or worsening pressure injuries and interventions implemented. 55). Interview with Central Supply on 09/29/2021 at 2:40 PM revealed she completed the audits of all laboratory supplies on 08/28/2021. She further revealed that the audits were conducted weekly for four (4) weeks and then monthly for three (3) months. A review of audits revealed no concerns. Observation of floor three (3), four (4), and five (5) supplies and review of the audits revealed no identified concerns.	{F 867}		

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{F 867}	Continued From page 1,054 56). Interview with the Regional DON on 09/30/2021 at 4:17 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed progress notes were audited during morning clinical meetings to ensure all new areas of skin impairment had been care planned with interventions to address the area of concern. A review of audits revealed no identified concerns. 57). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning in addition to other leadership staff. Review of audits revealed staff were auditing nails, clothes, body odor, incontinent clean and dry, toileted as requested or every two (2) hours, hair clean and combed, sheets and blankets clean, call light within reach, facial hair shaved if applicable and turned and repositioned. 58). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed they participated in visual monitoring, and monitoring call light response times including the length of time call lights go unanswered. Interviews revealed any call activated more than five (5) minutes were addressed with the staff. A review of audits revealed they were completed on different units and different shifts. 59). Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed audits of respiratory assessments and SBAR communication Monday through Friday in the clinical meeting. She further revealed that she	{F 867}		

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{F 867}	Continued From page 1,055 assessed to ensure that any acute change in respiratory status and/or SBAR assessments completed had physician notification and/or implementation of physician orders. Review of Resident #315 SBAR completed on 09/26/2021, #324 SBAR completed on 09/27/2021, and #326 completed on 08/15/2021 revealed assessment, physician notification, interventions, and care plans updated as indicated. A review of audits revealed no identified concerns. 60). Review of Resident #355, who the facility admitted on 09/10/2021, revealed the resident had a baseline care plan developed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record for Resident #355 revealed staff completed the comprehensive care plan on 09/21/2021 (eleven (11) days after admission). A review of re-admission for Resident #355 revealed the resident had a baseline care plan developed on 09/28/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed all new admissions and re-admissions to the facility were being reviewed during the morning clinical meeting Monday through Friday to ensure completion. 61). Review of the admissions for the last thirty days from 07/16/2021-08/16/2021 revealed no concerns with baseline care plans. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new/admission baseline care plans were being updated as needed in morning meetings. 62). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new admission baseline care	{F 867}		

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{F 867}	Continued From page 1,056 plans were being audited Monday-Friday for completion, accuracy, and to ensure a review was conducted with the resident and/or responsible party within 48 hours of admission/re-admission. Further interviews revealed the audits were conducted Monday through Friday. A review of the audits completed revealed they included resident name, admission date, baseline care plan completion, care plan delivered to resident and/or responsible party, and education as needed. A review of the audits revealed no identified concern with completion dates as indicated. 63). Review of the audits completed by the DM and/or CDM revealed they were completed as stated with no identified concerns. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, and Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed trays were audited for to ensure they arrived on the unit and were passed timely. 64). Review of verbal quizzes revealed ten (10) staff members were quizzed for one (1) week beginning on 8/15/2021 with no needed education. Further review of verbal quizzes revealed five (5) staff members were quizzed for four (4) weeks from 08/22/2021 and completed on 09/13/2021 with no identified concerns. A review of the verbal quiz revealed staff was quizzed on respiratory status, hypo/hyperglycemia, and SBAR/physician notification. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed they	{F 867}		

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{F 867}	Continued From page 1,057 performed verbal quizzes for identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician orders. Interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, revealed they participated in verbal quizzes with facility staff. 65). Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed audits of documented blood glucose levels Monday through Friday in the clinical meeting. She further revealed that with any blood sugar less than 60 and/or greater than 40, the facility staff were expected to notify the physician, Responsible Party, and Registered Dietician and follow physician orders. The Regional DON stated she identified one (1) resident on 08/12/2021 to have a blood glucose level of 430 and one (1) on 09/20/2021 to have a blood glucose level of 465 with no documented evidence the licensed nurse followed the facility process. She provided education to both RN #2 and LPN #5. A Review of audits revealed no further concerns. A Review of education revealed RN #2 and LPN #5 received education regarding the facility process. 66). Review of verbal staff quizzes revealed staff was verbally asked signs and symptoms of abuse when to report, signs and symptoms of wandering and wandering interventions. A review of the verbal quizzes revealed five (5) staff were verbally quizzed daily for one (1) week from 08/13/2021 to	{F 867}		

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{F 867}	Continued From page 1,058 08/19/2021 with no identified concerns. Further review revealed verbal quizzes were conducted three (3) times a week for two (2) weeks from 08/21/2021 to 09/02/2021 with no identified concerns. A review of verbal quizzes revealed that verbal quizzes were conducted one (1) time per week for four (4) weeks from the week of 09/03/2021 to 09/24/2021 with no identified concerns. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed each assisted in the completion of verbal staff quizzes. Further interview revealed that each staff member was verbally quizzed on the areas listed on the audit tool (signs and symptoms of abuse, when to report, signs and symptoms of wandering and wandering interventions), and any need for education was completed immediately with each quiz. Interviews with SRNA #11 on 09/29/2021 at 3:23 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM and Maintenance Assistant #1 on 09/30/2021 at 2:56 PM revealed they participated in verbal quizzes regarding abuse, when to report, wandering and wandering interventions. 67). Review of Resident #355 on 09/10/2021 revealed the resident had an admission wandering risk assessment completed on	{F 867}		

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{F 867}	Continued From page 1,059 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had an admission wandering risk assessment completed on 09/28/2021. The resident was not identified to be at risk for wandering. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed that MDS staff will schedule wandering risk assessments to ensure completion. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and DON #2 on 09/30/2021 at 3:20 PM revealed all-new admissions would be reviewed in the morning clinical meeting to ensure appropriate assessments, including the wandering risk assessment, had been completed. Further interviews revealed that residents identified as at risk for wandering would be discussed during this meeting and appropriate interventions implemented. 68). Review of interviews performed for residents with a BIMS score of 8 or greater revealed no identified concerns. Continued review revealed interviews were initiated on 08/13/2021 with ten (10) resident interviews completed for four (4) weeks then five (5) residents for eight (8) weeks. Interview with ISSD on 09/30/2021 at 2:23 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed they were assisting in completing audits with residents with no concerns identified. Review of audits initiated on 08/13/2021 for review of random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure there are no injuries of unknown origin revealed no identified concerns. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed they were completing audits as indicated with no	{F 867}		

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{F 867}	Continued From page 1,060 identified concerns. Observation of skin assessment on 09/30/2021 of Resident #45 at 9:23 AM and on 09/30/2021 at 10:20 AM of Resident # 27 revealed no concerns with injuries of unknown origin. 69). Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she started audits on 08/25/2021 of resident diet orders from electronic medical records against orders entered in the diet/tray card software to ensure accuracy. Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334 tray card on 09/29/2021 at 12:30 PM revealed diets were served as ordered by the physician. A review of audits revealed audits were conducted weekly for four (4) weeks. 70). Review of completed audits revealed random meals were audited twice daily for one (1) week beginning 08/23/2021. Starting 08/30/2021, random meals were observed two (2) times per week for two (2) weeks and then weekly from 09/13/2021 for one (1) month. Interview with Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed audits were performed as indicated. Further interviews revealed that meals were served as scheduled, including breakfast at 7:00 AM, lunch at 12:00 PM, and dinner at 5:00 PM. Observation on 09/28/2021 at 5:03 PM revealed the evening meal had been served on the third floor. Observation on 09/29/2021 lunch meal revealed meals arrived at the third floor at approximately 12:16 PM, the fourth floor at 12:16 PM and 12:24 PM, and the fifth floor at 12:34 PM and 12:49 PM.	{F 867}		

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{F 867}	Continued From page 1,061 71). Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334's tray card on 09/29/2021 at 12:30 PM revealed the meals honored resident preferences, including likes and dislikes. Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she would be responsible for obtaining food and beverage preferences within seventy-two hours of admission and entering the preferences into the system. A review of audits revealed snack intakes were audited daily for one (1) week from 09/15/2021 to 09/21/2021. Further review of the audits revealed snacks were audited weekly beginning on 09/22/2021. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she audited snack intake and had not identified any concerns. 72). Interview with the Human Resource Director (HR) on 09/30/2021 at 10:48 AM revealed she completed audits for daily staff screening against time clock punches. She revealed no identified concerns. Observation of entry doors on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no concerns. 73). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed audits were being conducted with observations of handwashing, isolation signage and zones, donning/doffing PPE, mask compliance. Any variance or identified concerns will be addressed immediately. A review of the audits revealed they	{F 867}		

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{F 867}	Continued From page 1,062 were conducted beginning 09/17/2021 on random shifts and units. 74). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible in addition to other members to review all residents on narcotics with the pharmacy to ensure that an active script is on file beginning 09/23/2021. A review of audits revealed no identified concerns. RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with obtaining scripts for medications and/or receiving medications timely. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. In addition, observation of the narcotic count on the fifth floor on 09/30/2021 at 12:50 PM revealed no identified concerns. 75). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible for completing random medication pass observations beginning 09/25/2021. She stated she had not identified any concerns with residents not having medications or narcotic counts. A review of audits revealed the facility utilized the Centers for Medicare Services Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. A review of audits revealed a minimum of twenty-five medications were observed daily from 09/25/2021 with no identified concerns. Further review of medication observations revealed that medication	{F 867}		

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{F 867}	Continued From page 1,063 administration was observed on random shifts, including 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 76). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM. The DON on 09/30/2021 at 3:20 PM revealed medication delivery tickets were being reviewed in clinical meetings Monday through Friday against ordered medications. A review of the audit revealed no identified concerns. 77). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and the DON on 09/30/2021 at 3:20 PM revealed staffing was being audited daily beginning 09/11/2021, to ensure adequate staffing was maintained. A review of the audits revealed no identified concerns. 78). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, and the Dietary Manager on 09/30/2021 at 1:30 PM revealed staffing was being monitored daily to ensure adequate staffing. A review of the audits revealed no identified concerns. 79). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interim Administrator on 09/30/2021 at 5:05 PM revealed daily audits had been conducted daily from 09/11/2021. A review of the audits revealed no identified concerns. 80). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed observations on different shifts to	{F 867}		

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{F 867}	Continued From page 1,064 identify any change in resident condition. Further interviews revealed if a change in condition was identified, staff would complete a stop and watch. An audit review revealed no concerns with the change of conditions not being addressed by facility staff. 81). Review of interviews performed on 09/25/2021 for residents with a BIMS score of 8 or greater revealed no identified concerns. A review of the questionnaire completed during interviews revealed residents were asked: Is everyone treating you well? Do you feel safe here? Do you have any concerns? Interview with the Medical Records Staff on 09/29/2021 at 8:34 AM revealed she completed the interviews with residents on 09/25/2021, and she stated she identified no concerns.	{F 867}		
{F 880} SS=E	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,	{F 880}		12/30/21

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{F 880}	Continued From page 1,065 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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.	{F 880}		

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{F 880}	Continued From page 1,066 §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, interview, record review, and review of the facility's policies, it was determined the facility failed to establish and maintain an infection prevention and control program to properly prevent and contain the spread of COVID-19 for seven (7) of 57 sampled residents (Resident #325, #314, Resident #311, Resident #327, Resident #82, Resident #328 and Resident #329. On 07/22/2021, the facility conducted routine COVID-19 testing of staff and residents and they were all negative. On 07/24/2021, two (2) staff members tested positive for COVID-19 at an outpatient clinic/hospital. Although, the facility was aware the staff tested positive, there was no attempt by the facility to determine which residents were exposed to the infected staff in an effort to isolate the residents to prevent further spread of the virus. In addition, the facility failed to immediately test residents for COVID-19 per the facility's policy. Residents were not tested until 07/28/2021, four (4) days after the staff members tested positive. During the 07/28/2021 resident testing, Resident #314 and Resident #311 tested positive for	{F 880}	F 880 Infection Prevention and Control Criteria 1: a) Resident #314 and #311 have completed quarantine for Covid-19 and are no longer in isolation. b) Resident #325 was discharged to hospital on 8-9-2021 c) Resident #82 was discharged to hospital on 8-9-2021 d) There are no current residents with Covid-19 diagnosis. Criteria 2: a) All residents are assessed for sign and symptoms of Covid-19 by staff nurse and documented on the MAR every shift. Physician will be notified for any resident exhibiting any signs/symptoms of covid and staff will place them in isolation and test per our Covid policy for monitoring and treatment. Criteria 3: The infection preventionist educated Facility staff on the following modules of the Nursing Home Infection Preventionist Training available on the CDC website at https://www.train.org/cdctrain/training-plan	

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{F 880}	Continued From page 1,067 COVID-19. However, the facility did not isolate the residents to prevent the spread of infection to others. Interviews with staff revealed they were unable to isolate Resident #311 due to his/her behavior of wandering; subsequently, the resident continued to wander the hallways without a mask. The facility made no attempts to isolate the residents until 08/05/2021, eight (8) days after the residents tested positive. Further, the facility documented staff were routinely tested for COVID-19 on 07/30/2021. However, State Registered Nurse Aide (SRNA) #13 stated she was not tested prior to starting her scheduled shift on 07/30/2021 from 6:00 PM through 6:00 AM on 07/31/2021. During her shift, at approximately 12:00 AM on 07/31/2021, she stated she started feeling sick while caring for residents. She stated she reported her symptoms to the nurse who conducted a rapid COVID-19 test, which was positive. From 07/28/2021 through 08/05/2021, an additional three (3 residents) tested positive for COVID-19. Prior to the barrier being placed on 08/05/2021, Resident #325, who resided across the hall from COVID-19 positive residents, was observed walking in the hallways and sitting in a chair in the hallway adjacent to COVID-19 positive rooms. Resident #325 was not wearing a mask. Record review revealed on 08/08/2021, Resident #325 tested positive for COVID-19. On 08/09/2021, Resident #325 developed respiratory distress and was transferred to the emergency room and hospitalized. Resident #325 was readmitted from the hospital to the facility on	{F 880}	/3814 as outlined below: a. Module 1: Infection Prevention and Control Program-Licensed Staff to complete b. Module 2: The Infection Preventionist-Licensed Staff to complete c. Module 3: Integrating Infection Prevention and Control into the Quality Assurance Performance Improvement Program- Licensed Staff to complete d. Module 4: Infection Surveillance-Licensed Staff to complete e. Module 5: Outbreaks- Licensed Staff to complete f. Module 6A: Principles of Standard Precautions-All staff to complete g. Module 6B: Principles of Transmission Based Precaution-All staff to complete h. Module 7: Hand Hygiene-All staff to complete i Module 11D: Linen Management-All staff to complete The Directed Training was conducted by an Infection Preventionist, and an attestation statement is attached of the completion. The credentials of the Infection Preventionist on staff is attached. See Attestation statement and the Credentials of ICP. All facility staff shall complete a review of the document entitled, Responding to Coronavirus (COVID-19) in Nursing Homes located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html; and	

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{F 880}	Continued From page 1,068 08/12/2021. Further review revealed on 08/19/2021, Resident #325 developed respiratory distress, had a decline in condition and was sent back to the hospital and expired on 08/26/2021. Interview with the Infection Control Preventionist/ADON/Acting Interim DON on 08/11/2021 revealed she was aware residents should have been tested immediately after the first COVID-19 positive staff member. She also stated she was aware residents who had COVID-19 should have been isolated. She stated not isolating residents with COVID-19 put others at risk for death. One (1) additional resident (Resident #327) tested positive for COVID-19 on 08/07/2021 and was hospitalized on 08/14/2021, and expired on 08/15/2021 at the hospital. Resident #82 and Resident #329 had also been hospitalized due to COVID-19. The facility's failure to maintain an infection prevention and control program has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655), (F656), 42 CFR 483.25 Quality of Care (F684) (F686), (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged	{F 880}	Keep COVID-19 Out! https://www.youtube.com/watch?v=7srwrF9MGdw; and Use Personal Protective Equipment (PPE) correctly for COVID-19 https://www.youtube.com/watch?v=YYTATw9yav4 All staff will completed the infection control modules as assigned by 11/24/2021. If a staff member has not completed them by 11/24/2021 they will complete the assigned modules before their next scheduled shift. New employees hired after 11/24/2021 will view assigned modules during the new employee orientation period. A consultant Infection Control Nurse (ICN)/ Infection Preventionist, with specialized training in infection prevention and control has been contracted for twelve months starting on 11/23/2021. See the attached contract of the contract Dated 11/15/21 and 12/17/2021. " The Infection Preventionist consultant/infection preventionist/ DON/ Medical Director/ Nurse Practitioner and Regional Nurse consultant completed the LTC infection control RISK assessment on 11/23/2021 " A Root Cause Analysis (RCA) was conducted with assistance from the Infection Preventionist, members of the Quality Assurance and Performance Improvement (QAPI) committee and members of Governing Body on	

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{F 880}	Continued From page 1,069 removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. A second acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 09/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to "D" 42 CFR 483.10 Resident Rights (F580), 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686), 42 CFR 483.35 Nursing Services (F725), and 42 CFR 483.45 Pharmacy Services (F755); and to "E" at 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.25 Quality of Care (F692), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867), and 42 CFR 483.80 Infection Control (F880), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled, "COVID-19-Pandemic Plan", dated 06/23/2020, revealed staff will be trained on the facility's	{F 880}	11/11/2021. See attached copy of the Root Cause Analysis. Beginning 12/7/2021 the Infection Preventionist updated the staff guidelines for Isolation precautions to include that residents who are on precautions do not share a restroom with the resident who are not on precautions. A bedside commode is in the room of the resident on precautions if they cannot have a dedicated bathroom. Beginning 12/7/2021 the infection preventionist educated all nursing staff on the updated staff guidelines. Criteria 4: Beginning on 12/18/2021 Infection Control Round Audits are conducted by the DON and/or designee daily on random units. The audits is done by observation and includes 1. Employees & Visitors enter Center through only one entrance. 2. Respiratory Hygiene/Cough Etiquette & Hand Hygiene signs are posted□ Is this observed during rounding. 3. Visitor Infection Control Instructions are posted at screening location. 4. All staff/visitors are screened using the most recent log upon entering the center. 5. Adequate amount of hand sanitizer readily available. 6. Immediately upon entrance to center, all staff performs hand hygiene and then	

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{F 880}	Continued From page 1,070 Pandemic COVID-19 plan and related policies and procedures. Staff will be re-trained in Hand Hygiene and proper use of Personal Protective Equipment (PPE) including competency, and residents exhibiting signs and symptoms of COVID-19 will be isolated in a private room with the door closed and initiate transmission based precautions (TBP) based on CDC (Centers for Disease Control and Prevention) guidelines. Review of the facility's policy titled, "COVID-19 Emergency Operations Plan", undated, revealed in the event of an outbreak of COVID-19, the positive residents will be segregated away from the rest of the population and the resident unit will be separated into Red, Yellow, and Green zones. Further review revealed zipper walls will be utilized to divide Red, Yellow and Green Zones, along with privacy curtains in semi-private rooms to act as a barrier and fire doors will be closed and remain closed. Assigned staff will work Red, Yellow, and Green zones, so multiple staff members are not assigned. Further review of the policy revealed staff were to be dedicated to work in a designated area (e.g. red zone). Review of the facility's policy titled, "CORONAVIRUS DISEASE (COVID-19)-TESTING RESIDENTS", (undated) revealed residents were tested for the SARS-CoV-2 virus to detect the presence of current infections (viral testing) and to help prevent the transmission of COVID-19 in the facility. Further review revealed all residents were screened daily for signs and symptoms of COVID-19, viral testing of all residents will be conducted if there is an outbreak in the facility. An outbreak is defined as any single new onset of SARS-CoV-2 infection in a resident or a single case of infection in healthcare	{F 880}	immediately apply a new surgical face mask. 7. Rooms of residents on precautions are clearly marked with correct patient-specific precautions signs. 8. Staff perform hand hygiene before & after resident care and/or contact with the resident□s environment (even if gloves worn). 9. PPE is readily available. Ask staff where it is located and who do they contact if unavailable. 10. Staff perform hand hygiene and PPE is donned appropriately (refer to poster) □ gloves, gown, N95 respirator, face shield. 11. PPE removed appropriately (refer to poster) and placed in waste container. Container is covered. Staff perform hand hygiene. 12. If aerosol-generating procedure performed□appropriate PPE worn, door closed, limited number of staff in room and surfaces cleaned and disinfected at end of procedure, doff gown. 13. Resident water cups are replaced/sanitized. 14. Resident hand hygiene performed before meals. Ask staff to explain how they remind residents to do so. 15. Gowns/Gloves are be donned and doffed at the door prior to entering to care for a resident on precautions. 16. Gowns are single use and are not stored/saved for later use.	

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(F 880)	Continued From page 1,071 personnel and, testing will be conducted as soon as a new confirmed case is confirmed. Residents who test positive, including asymptomatic and pre-symptomatic residents are cohorted and viral testing of all previously negative residents will be repeated every 3 to 7 days until testing identifies no new cases of SARS-CoV-2 infection among residents or healthcare personnel for at least 14 days since the most recent positive result. 1. Review of the facility's COVID-19 testing records revealed on 07/24/2021, Registered Nurse (RN) #2 and State Registered Nurse Aide (SRNA) #16 tested positive for COVID-19. Attempts to reach RN #2 for interview were unsuccessful. Interview with SRNA #16, on 08/09/2021 at 11:47 AM, revealed she worked on the fifth floor and cared for residents throughout the unit. The SRNA stated she tested positive for COVID-19 on 07/24/2021. She stated she did not think staff were being tested regularly or prior to working if they had been off several days. SRNA #16 further stated her family member and coworker SRNA #13 tested positive while at work after being exposed to her. The SRNA stated SRNA #13 was not tested prior to starting her shift the night she became ill. Review of the facility's testing schedule revealed the next scheduled testing for staff was on 07/30/2021. However, SRNA #13 was not tested prior to starting her shift at 6:00 PM on 07/30/2021 Interview with SRNA #13 on 08/01/2021 at 5:40 PM revealed she tested positive for COVID-19 on 07/30/2021 while working at the facility She	(F 880)	17. Staff follow procedures for disposal of PPE (mask, N95) at end of shift. 18. CPR Code Carts include required PPE and plastic sheet. 19. Staff change gloves between each patient and perform hand hygiene. Gloves not worn in hallway. 20. Non-resident specific equipment is cleaned & disinfected between residents (scales, mech lifts, vital machines, stethoscopes, etc.) including ancillary staff visits (phlebotomy, X-ray). If not able to be observed, ask for verbalization of process. 21. High touch surfaces (hand rails, elevator buttons, door knobs, etc.) are observed being cleaned and disinfected. 22. Food service workers are performing hand washing & proper PPE when storing, preparing and handling food, and when cleaning dishes, food utensils and other cookware after the meal. 23. Resident who are on precautions do not share restroom with residents who are not on precautions. A bedside commode is in the room of the resident on precautions if they cannot have a dedicated bathroom. I have attached a copy of the Audit form use by the DON or designee. We have copies of daily audits completed from the beginning of 11/18/21. See attach copy of the audit form.	

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{F 880}	Continued From page 1,072 stated SRNA #16 was a family member and coworker and had tested positive on 07/24/2021. Although the facility reported screening all staff and visitors prior to entry to the facility, the SRNA stated the facility did not ask her any questions related to contact tracing or being exposed to SRNA #16. Per the SRNA, she worked on the fifth floor and cared for all residents on the floor. She further stated she began her shift at 6:00 PM on 07/30/2021 and began feeling ill in the middle of her shift. The SRNA stated she reported to the nurse that she felt ill. She stated she tested positive for COVID-19 and was sent home. Interview with Registered Nurse (RN) #9, on 08/09/2021 at 10:55 PM revealed she worked night shift on the fifth floor and cared for all residents on the floor. The RN stated the facility did not require staff to be tested prior to coming on shift or after being off for several days. RN #9 stated the facility was not testing staff on any specific days. Interview with the Corporate Nurse Consultant, on 08/09/2021 at 10:45 AM, revealed the facility was conducting COVID-19 testing two (2) times weekly on Mondays and Thursdays for both staff and residents. She stated the nurses on the floor were responsible for testing residents on their floor/unit and the Infection Control/ADON/Interim DON tests all staff. She further stated staff used a roster to check off as the residents were tested and a staff list was checked off as staff came in for testing. However, the ADON was on leave on 07/30/2021 and it was unclear who was providing staff testing on night shift. 2. Continued review of the facility's COVID-19 testing records revealed the facility failed to	{F 880}	Also attached are the Infection Control monitoring being done for infection control surveillance. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance Criteria 5: Date of compliance: 12/30/2021	

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{F 880}	Continued From page 1,073 immediately test residents for COVID-19, and did not initiate resident testing until 07/28/2021, four (4) days after the staff members tested positive. (a) Record review revealed on 07/28/2021, Resident #311 (who resides on the fifth floor) tested positive for COVID-19. Record review revealed the facility admitted Resident #311 on 06/28/2021 with diagnoses of Dementia, Alzheimer Disease, and Atrial Fibrillation. Review of the Minimum Data Set (MDS) dated 07/04/2021, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident was moderately cognitively impaired. Review of the Nurse's Notes dated 07/30/2021, revealed staff had to redirect Resident #311 to keep him/her in his/her room for isolation and the resident became upset, though no cough or congestion was noted. Continued review of Nurse's Notes revealed on 08/10/2021, Resident #311 was doing well and was out of isolation. Interview with RN #9 on 08/09/2021 at 10:55 PM revealed Resident #311 wandered the halls of the unit after testing positive on 07/28/2021 and was difficult to redirect and would get upset. (b) Continued review of the facility's COVID-19 testing records revealed on 07/28/2021, Resident #314 (who resided in the same room as Resident #311) tested positive for COVID-19. Record review revealed the facility admitted Resident #314 on 06/03/2021 with diagnoses of Dementia and Cerebral Infarction. Review of the	{F 880}		

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{F 880}	Continued From page 1,074 Minimum Data Set (MDS) dated 07/30/2021 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of ten (10), indicating the resident was moderately cognitively impaired. Review of Nurse's Notes dated 07/29/2021, revealed Resident #314 had no complaints and no cough or congestion noted. Further review of Nurse's notes dated 08/10/2021, revealed Resident #314 was out of isolation and doing well with no cough or congestion noted. (c) Review of COVID-19 testing records revealed Resident #329 tested positive for COVID-19 on 08/02/2021. Resident #329's room was next door to Resident #311 and #314's room on the fifth floor. Record review revealed the facility admitted Resident #329 on 05/07/2021 with diagnoses of Parkinson's Disease, Congestive Heart failure and Dementia. Review of Minimum Data Set (MDS) dated 05/14/2021 revealed the facility assessed the resident to have a Brief Interview of Mental Status (BIMS) score of zero (0), indicating the resident was severely cognitively impaired. Review of Resident #329 Nurse's Notes dated 08/07/2021 at 5:29 AM revealed the resident developed at fever of 106.2 and was transported to the emergency room for further evaluation. Continued review of Nurse's Notes dated 08/10/2021 at 9:01 PM revealed Resident #329 was readmitted to the facility following hospitalization and treatment for Hypotension related to COVID-19.	{F 880}		

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{F 880}	Continued From page 1,075 (d) Review of COVID-19 testing records revealed Resident #82 also tested positive for COVID-19 on 08/02/2021. Resident #82's room was located on the fifth floor, next to Resident #329's room. Record review revealed the facility admitted Resident #82 on 05/12/2021 with diagnoses of Parkinson Disease and Alzheimer Disease. Review of the Minimum Data Set (MDS) revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero (0), indicating the resident was severely cognitively impaired. Review of Resident #82 Nurse's Notes dated 08/09/2021 at 12:55 PM revealed the resident developed tachypnea (rapid respirations). Resident #82 had a low oxygen saturation rate of 89-91% (95-100% normal reference range. The facility sent the resident to the emergency room for further evaluation and treatment. Continued review of Resident #82 clinical record revealed the resident did not return for readmission to the facility following discharge from the hospital. The resident was admitted to another facility. Interview with the Infection Control Coordinator, at the local Health Department on 08/09/2021 at 10:40 AM, revealed she was in contact with the facility approximately every other week in regards to newly diagnosed COVID-19 cases among facility staff and residents. She stated she was not responsible to conduct contact tracing inside the facility for residents or staff. The Infection Control Coordinator stated the facility was responsible for conducting the contact tracing	{F 880}		

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{F 880}	Continued From page 1,076 inside the facility. She stated she was not aware staff was not conducting contact tracing for residents and staff inside the facility. The Infection Control Coordinator stated, "That is a big problem that they're not conducting contact tracing properly." Per the Infection Control Coordinator, the facility's failure to conduct contact tracing for residents and staff inside the facility could lead to an outbreak of COVID-19 amongst residents and staff. Interview with the Infection Control/ADON/Interim DON, on 08/11/2021 at 12:05 PM, revealed she thought the local health department did contact tracing in the facility. She stated she was not aware the facility was responsible to do their own contact tracing within the facility. Per the Infection Control Nurse/ADON/DON, she was aware residents should have been tested immediately for COVID-19 following the initial staff member testing positive. However, she had no response as to why testing was delayed for four (4) days after staff tested positive in July, 2021. Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed she thought the local health department did contact tracing in the facility. She stated she was unaware the facility was responsible for completing their own contact tracing. 3. Observation of the facility's fifth floor on 08/05/2021 at 10:54 AM, revealed although two (2) residents tested positive for COVID-19 on 07/28/2021 and 08/02/2021, the facility failed to isolate and segregate the residents as required by the facility's policy. The fire doors were open, all resident room doors were open, and residents	{F 880}		

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{F 880}	Continued From page 1,077 were wandering the halls of the unit at will. Further observation revealed no designated zones existed to separate residents. Continued observation, on 08/05/2021 at 10:54 AM, revealed maintenance staff placed plastic zip barriers across the doorway of the room where both Resident #311 and Resident #314 resided. However, this was eight (8) days following the first resident on the floor testing positive for COVID-19. Interview with Maintenance Assistant (MA) #1, on 08/11/2021 at 11:30 AM, revealed he placed the plastic zip barriers across the doorways of all COVID-19 positive resident rooms. MA #1 stated no none had instructed the Maintenance Department to install the barriers prior to 08/05/2021, and that was the first day the facility utilized the barriers. MA #1 stated staff was to notify the Maintenance Department if a resident in another room converted to positive so they could place one of the plastic zip barriers over the resident's doorway. Interview with SRNA #3, on 08/05/2021 at 12:30 PM, revealed she denied having received any training related to PPE (personal protective equipment) or COVID-19 at the facility since the second wave of outbreaks began in late July. The SRNA stated she routinely worked the fifth floor caring for both COVID -19 positive and negative residents simultaneously. SRNA #3 stated the floor had no designated zones such as red for positive, yellow for quarantined or green for negative residents. Continued interview with SRNA #16, on 08/09/2021 at 11:47 AM, revealed she routinely	{F 880}		

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{F 880}	Continued From page 1,078 worked on the fifth floor. The SRNA stated as new residents became infected on the floor, they were not isolated or segregated to one area. She stated they continued to be interspersed with negative residents. SRNA #16 stated she cared for both COVID-19 positive and negative residents all at the same time. The SRNA stated the floor was the "unofficial dementia" floor and many of the residents who lived on the floor wandered. She stated many of the residents wander the hallways, in and out of other residents' rooms. Interview with Certified Medication Aide (CMA) #1, on 08/05/2021 at 11:45 AM, revealed staff who worked on the fifth floor attempted to keep residents isolated in their rooms, but they were unable to do so, because the residents did not understand and wanted to leave their rooms. The CMA stated maintenance placing the plastic zip barriers over the doorways of COVID-19 positive resident rooms, was the first time to her knowledge the facility had taken any action to isolate residents since the second wave of COVID-19 infections began. Interview with RN #9, on 08/09/2021 at 10:55 PM, revealed COVID positive rooms "now" had plastic zip covers on the doorways, but not initially. She stated the only identifiers prior to the zip covers on the residents' doors was a hand written paper taped on the door saying if it was a red or yellow room. She stated the fire doors on that hall had never been closed. The RN stated she cared for residents on the entire unit, both positive for COVID-19 and those who were not. Interview with the Infection Control/ADON/Interim DON, on 08/11/2021 at 12:05 PM, revealed the	{F 880}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 880}	Continued From page 1,079 facility had initially attempted to isolate the positive residents in their rooms. Observations, of residents who were positive for COVID wandering on the fifth floor and not isolated in one area, were discussed with the Infection Control Nurse/ADON/DON. She stated the facility tried to keep positive residents in one area on the floor. However, the Infection Control Nurse/ADON/DON stated the COVID virus could spread if positive residents were not in a closed off unit (isolated). Per the Infection Control Nurse/ADON/DON, she expected nursing staff to redirect residents to the closed off area on the unit if they were wandering and to ask them to wear a facemask if they were not wearing one. However, she mentioned no further actions for nursing staff to utilize if redirection was not effective. Interview with the facility's Nurse Consultant, on 08/09/2021 at 10:45 AM, revealed the facility has a red zone where COVID positive residents resided, a yellow zone for non-vaccinated, new admits or residents who had been out of the facility more than twenty-four (24) hours. She stated when a resident was COVID-19 positive, both the resident and their roommate were quarantined; a sign was placed on the door identifying the room as red zone; and, a plastic zip barrier curtain was immediately placed on the doorway of the room to isolate the room. The Nurse Consultant stated the positive rooms on the 5th floor were designated as red zone and all other rooms on the 5th floor should be yellow zone. She stated she was not aware yellow zone rooms were not designated or staff had not designated red zone room barriers after the initial positive cases.	{F 880}		

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{F 880}	Continued From page 1,080 Observation on 08/05/2021 at 6:02 PM revealed Resident #42 was wandering the hall on the fifth floor outside the rooms of residents who were COVID-19 positive. The resident was not wearing a facemask. 4. Observation of the fifth (5th) floor on 08/05/2021 at 10:54 AM revealed large red biohazard cans in the hallway on each end of the floor containing large amounts of contaminated PPE, which had been used by staff while in COVID positive residents' rooms. Resident #325 was observed wandering the hall walking past the containers and staff were observed doffing COVID contaminated PPE into the red biohazard containers on the outside of the COVID positive residents' rooms. Interview with SRNA #19, on 08/05/2021 at 11:15 AM, revealed staff were doffing contaminated PPE from COVID-19 positive rooms in the red bio-hazard can in the hallway. The SRNA stated she was unsure why staff were not doffing PPE inside the resident's room. She further stated only a couple of rooms had cans inside the room to doff PPE. Continued interview with SRNA #19, on 08/05/2021 at 12:25 PM, revealed she had not received recent training on donning and doffing PPE or COVID-19 since the outbreak began this time. SRNA #19 stated she did not routinely work on the fifth floor, but was pulled on 08/05/2021 to work on that floor. The SRNA stated she was a restorative aide and worked with residents throughout the building. Interview with SRNA #3, on 08/05/2021 at 12:30 PM, revealed she had not received any training on PPE or COVID-19 since the outbreak began this time. She stated staff doffed PPE in red	{F 880}		

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{F 880}	Continued From page 1,081 bio-hazard cans in the hallway. Continued interview with SRNA #16, on 08/09/2021 at 11:47 AM, revealed she worked on the fifth floor caring for residents who had the COVID-19 virus and those who did not have the virus. The SRNA stated she had not received training recently on PPE, handwashing, or COVID-19. She further stated staff were doffing COVID contaminated PPE in large red biohazard containers in the hallway with no PPE receptacle in the rooms. SRNA #16 stated the only receptacles in the COVID positive resident rooms were the small personal trash cans. Interview with Certified Medication Aide #1, on 08/05/2021 at 11:45 AM, revealed she had not received recent training on COVID-19 or training on PPE donning and doffing since this outbreak began. She further stated she was unsure whether to doff contaminated PPE inside or outside of resident rooms who were COVID positive, or where to place contaminated PPE, so she and other staff had been placing it in the hallway in the provided red biohazard containers. She stated the only containers in the COVID positive rooms were for soiled linens and small personal trash receptacles. Interview with RN #1, on 08/05/2021 at 11:50 AM, revealed she had not received training on COVID-19 and had not been re-trained on donning and doffing PPE. She stated there were containers with bags in the COVID rooms for soiled linens and trash. RN #1 stated staff had been doffing contaminated COVID PPE into the containers in the hallway. She further stated staff should doff PPE in the room.	{F 880}		

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{F 880}	Continued From page 1,082 Continued interview with RN #9, on 08/09/2021 at 10:55 PM, revealed she had not received any training on donning and doffing PPE, and had not been inserviced since COVID-19 outbreak began this time. She further stated the facility provided a large red bio-hazard can in the hallway and that was the only place for staff to doff COVID contaminated PPE. Interview with the facility's Nurse Consultant, on 08/09/2021 at 10:45 AM, revealed the red biohazard containers in the hallway on the fifth floor were not for the disposal of contaminated PPE. The Nurse Consultant stated she was not aware there were no trash containers in the residents' rooms for staff to doff PPE. She stated she could not explain the intended use of the red biohazards containers in the hallway. Interview with the Infection Control/ADON/Interim DON on 08/11/2021 at 12:05 PM, revealed staff had not received new or recent training or education on PPE or COVID-19 since the outbreak began in the facility. She stated staff were evaluated on donning and doffing PPE by supervisory and visual observation of competency. She stated she was not aware staff were doffing PPE in the hallway in the red biohazard containers. She stated staff should be doffing inside the residents' room. She further stated she had not been up on the 5th floor much since the COVID-19 outbreak began. Continued interview revealed residents wandering in the hall could touch contaminated PPE containers and spread COVID-19. Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed the facility ensured staff were competent in utilizing PPE through observation	{F 880}		

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{F 880}	Continued From page 1,083 and trained using CDC (Centers for Disease Control and Prevention) guidelines. She stated she was unsure if any retraining had been conducted with staff since this COVID-19 outbreak began. Per the Administrator, she was also unaware staff were doffing contaminated PPE in red biohazard containers in the hallway where other residents were wandering. She stated there should be containers in COVID rooms to doff PPE. She further stated there was no specific auditing or documentation the facility was using to monitor infection control other than observational monitoring. 5. (a) Continued review of the COVID-19 testing records revealed on 08/05/2021 Resident #328 tested positive for COVID-19. Resident #328 resided on the fifth floor on the opposite end of the unit from the other residents who were positive for COVID-19. Record review revealed the facility admitted Resident #328 on 04/14/2021 with diagnoses of Transient Cerebral Ischemic Attack, Dementia and Alzheimer Disease. Review of the Minimum Data Set (MDS) dated 07/05/2021 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero (0), indicating the resident was severely cognitively impaired. Review of Resident #328 Nurse's Notes dated 08/05/2021 at 8:15 AM revealed the resident stated to staff that he/she wasn't feeling well and had a fever of 100.3 degrees Fahrenheit (F). The facility administered the resident a COVID-19 test. Resident #328 tested positive for COVID-19. Further review of the Nurse's Notes	{F 880}		

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{F 880}	Continued From page 1,084 revealed on 08/09/2021 at 5:17 PM, Resident #328 stated to staff he/she was feeling better and ambulating in his/her room while continuing on isolation. Continued review of Nurse's Notes revealed on 08/10/2021 at 7:52 AM, Resident #328 was awake and alert with no cough or congestion noted. (b) Review of the facility's COVID-19 test records revealed on 08/07/2021, an additional resident (Resident #327) tested positive for COVID-19. Resident #327's room was located on the fifth floor near Resident #82's room Record review revealed the facility admitted Resident #327 on 03/15/2021 with diagnoses of Dementia, Anemia and Chronic Peptic Ulcers. Review of the Minimum Data Set (MDS) dated 07/22/2021 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of zero (0), indicating the resident was severely cognitively impaired. Review of Resident #327's Nurse's Notes dated 08/09/2021 at 5:19 PM revealed the resident had two (2) episodes of diarrhea. The physician was notified and the resident was encouraged to increase oral fluid intake and was drinking well. Further review of the Nurse's Notes revealed on 08/14/2021 at 12:05 AM during routine vital signs, staff found Resident #327 to have a low blood pressure, low heart rate, and low oxygen saturation. The physician was notified and Resident #327 was sent to the emergency room via an ambulance for further evaluation. Review of Resident #327 vital signs dated 08/14/2021 revealed the resident had a blood	{F 880}		

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{F 880}	Continued From page 1,085 pressure of 75/44 (normal range 120/80), heart rate of 46 (normal range 60-100), and oxygen saturation of 80% (normal range 95-100%) on five (5) liters of oxygen. The resident's temperature was 100.1F (normal temperature 98.6) prior to being sent to emergency room. Review of Resident #327 hospital discharge summary reviewed the resident expired at the hospital on 08/15/2021. The resident's admission diagnoses included Sepsis and COVID-19 Pneumonia. Per the discharge summary, the resident's Sepsis was likely due to the COVID-19 Pneumonia. The resident's discharge diagnosis was COVID-19 Viral Pneumonia. Interview with SRNA #3, on 08/05/2021 at 12:30 PM, revealed she worked the fifth floor caring for all residents on the floor, both residents who were COVID positive and those who were negative. She stated there was no designated yellow zone or green zone, only individual rooms designated as red zone rooms. Continued interview with SRNA #16, on 08/09/2021 at 11:47 AM, revealed she worked on the fifth floor caring for residents who had the COVID-19 virus and those who did not have the virus. The SRNA stated many residents wandered on the fifth floor and had to be redirected. However, they did not stay in their rooms and wandered the hallways on the unit. Interview with RN #9, on 08/09/2021 at 10:55 PM, revealed the only identifiers prior to the zip covers on the resident doors was a hand written paper taped on door saying if it was a red or yellow room and the fire doors on that hall had never been closed. The RN stated she cared for	{F 880}		

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{F 880}	Continued From page 1,086 residents on the entire unit, both positive for COVID-19 and those who are not. 6. Continued observations on 08/05/2021 at 11:00 AM revealed Resident #325 sat in the hallway on the fifth floor in a chair with no facemask. The resident was seated adjacent to COVID positive residents' rooms while maintenance placed plastic zip barrier to a doorway. In addition, the resident was observed on 08/05/2021 at 10:54 AM wandering the hall walking past the red biohazard waste containers where staff were doffing COVID contaminated PPE. Review of the facility's COVID-19 test records revealed Resident #325 tested positive for COVID-19 on 08/08/2021. Record review revealed the facility admitted Resident #325 on 09/15/2017 with diagnoses of Dementia, Polyosteoarthritis, and Psychotic Disorder. Review of Minimum Data Set (MDS) dated 06/26/2021 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of ten (10), indicating the resident was moderately cognitively impaired. An attempt to interview Resident #325 08/05/2021 at 11:05 AM was unsuccessful. Resident #325 was reluctant to engage in conversation. Resident #325 went into his/her room to lie down. Review of the Nurse's Note dated 08/09/2021 at 2:45 PM, revealed Resident #325 had a change in condition and had a cough, congestion and developed a fever of 100.2 F. Further review revealed the resident was in respiratory distress and required transfer to the emergency room for	{F 880}		

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{F 880}	Continued From page 1,087 evaluation. Review of the Nursing Readmission Assessment dated 08/12/2021 at 4:40 PM revealed Resident #325 was readmitted to the facility from the hospital. Continued review of the Nurse's Notes dated 08/19/2021 at 1:30 PM revealed Resident #325 developed a low oxygen saturation rate of 89% and the physician and resident's representative were notified. The physician ordered palliative care and Fentanyl patch (pain medication skin patch) related to resident's declined condition and "Do Not Resuscitate" (DNR) status. Per the note, staff discussed the resident's condition, palliative care, DNR status, and new orders from the physician with the resident's representative. The resident's representative requested the facility send Resident #325 back to the hospital. The physician and DON were notified of the request and an ambulance transported the resident to the emergency room for evaluation. Review of the Hospital Discharge Summary revealed Resident #325 expired at the hospital on 08/26/2021 and the discharge diagnoses included Acute Hypoxic Respiratory Failure secondary to COVID-19 Pneumonia. Continued interview with SRNA #16, on 08/09/2021 at 11:47 AM, revealed many residents on the fifth floor would not stay in their rooms and wandered the hallways on the unit. The SRNA stated Resident #325 had torn down the plastic covering on his/her room doorway wanting to get out of the room. Continued interview with RN #9, on 08/09/2021 at	{F 880}		

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{F 880}	Continued From page 1,088 10:55 PM, revealed Resident #325 roamed the halls, and residents were not staying in their rooms and fire doors were not closed to isolate positive residents to one end of the unit. Interview with Physician #1, who is also the Medical Director, on 08/04/2021 at 1:05 PM, revealed he expected the facility to isolate residents on the COVID Unit and monitor them for decompensation and signs and symptoms of COVID-19. He stated he was aware there were difficulties isolating residents due to cognitive dysfunction, lack of following directions and lack of wearing masks. He further stated he did not recall when he was made aware COVID-19 was back in the facility, but those residents who were positive were expected to be isolated in an area away from non-positive residents on the floor. The physician stated he was not aware residents who were positive for COVID-19 were not isolated to one area of the unit. Interview with the Infection Control/ADON/Interim DON, on 08/11/2021 at 12:05 PM, revealed staff had not received new or recent training or education on PPE or COVID-19 since the outbreak began in the facility. She stated staff were evaluated on donning and doffing PPE by supervisory and visual observation of their competency. She stated she was not aware staff were doffing PPE in the hallway in the red biohazard containers. She stated staff should be doffing inside the resident's room. She further stated she had not been up on the 5th floor much since the COVID-19 outbreak began. The ADON stated residents who wandered in the hall could touch contaminated PPE containers and spread COVID-19. She further stated she was aware plastic zip barriers were not on COVID-19 positive	{F 880}		

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{F 880}	Continued From page 1,089 residents' rooms until 08/05/2021. The Infection Control/ADON/DON stated the facility had initially attempted to isolate the positive residents in their rooms. Observations of residents, who were positive for COVID, wandering on the fifth floor and not isolated in one area, were discussed with the Infection Control Nurse/ADON/DON. She stated the facility tried to keep COVID positive residents in one area on the floor. However, the Infection Control Nurse/ADON/DON stated the COVID virus could spread if positive residents were not in a closed off unit and she stated a closed off area of the floor/unit could prevent the spread of COVID-19. Per the Infection Control Nurse/ADON/DON, she expected nursing staff to redirect residents to the closed off area on the unit if they were wandering and to ask them to wear a facemask if they were not wearing one. However, she mentioned no further actions for nursing staff to utilize if redirection was not effective. Interview with the Administrator, on 08/10/2021 at 1:50 PM, revealed the facility ensured staff were competent in utilizing PPE through observation and trained using CDC guidelines. She stated she was unsure if any retraining had been conducted with staff since this COVID-19 outbreak began. When asked how many residents were currently hospitalized with COVID-19, she responded there were initially four (4) residents hospitalized with COVID-19, but two (2) of those residents were back in the facility. She stated COVID positive residents were kept on one end of the 5th floor in the red zone and the Infection Control/ADON/ Interim DON was responsible for monitoring to ensure infection control practices were in place. The Administrator stated she was unaware that all COVID 19	{F 880}		

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{F 880}	Continued From page 1,090 positive residents were not on one end of the 5th floor. Per the Administrator, she was also unaware staff were doffing contaminated PPE in red biohazard containers in the hallway where other residents were wandering. She stated there should be containers in COVID rooms to doff PPE. She further stated there was no specific auditing or documentation the facility was using to monitor infection control other than observation monitoring. 7. Review of Resident #317's record revealed the facility admitted the resident on 07/23/2020 with diagnoses, which included Dementia and Hypertension. According to his/her Annual Minimum Data Set Assessment (MDS) dated 07/27/2021, revealed the resident was not interviewable and had a Brief Interview for Mental Status (BIMS) score of four (4). Per the MDS assessment, the resident required assistance of one staff member with transfers and toileting. Continued review of Resident #317's record revealed on 07/27/2021 at 9:35 AM, the resident was noted to require more assistance than normal, had wheezes in his/her lung fields and had a non-productive cough. Review of his/her record revealed the physician was notified of the change in his/her condition and directed staff to test the resident daily for COVID-19; administer nebulizer treatments twice a day for seven (7) days; obtain his/her vital signs every four (4) hours for three (3) days; and, isolate the resident to his/her room for "now". Resident #317's vital signs were noted to be 97.7 F (normal 98.6 F) temperature, heart rate was 86 (normal range 60-100), respirations were 20 (normal 12-20) and blood pressure was 150/77 (normal range 120/80).	{F 880}		

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{F 880}	Continued From page 1,091 Observations conducted on 07/27/2021 on the 5th floor, at 11:25 AM and 3:50 PM revealed the resident was ambulating in the hallway, passing by other residents with no mask in use or noted on his/her person. Staff were close by; however, staff were not observed to offer Resident #317 a mask and no staff were observed to attempt to isolate him/her to his/her room as ordered by the physician. Further observations conducted on 07/28/2021 at 11:20 AM revealed Resident #317 was ambulating around the nurse's station, conversing with staff, with no mask on his/her person. Staff was not observed to offer/encourage him/her to wear a mask and no attempts to isolate him/her to his/her room for isolation due to a potential COVID-19 infection was observed. Observations of Resident #317's room on 07/27/2021 and 07/28/2021 revealed no signage had been placed on his/her door to indicate he/she should have been isolated due to a potential COVID-19 infection. Interview with Registered Nurse (RN) #1, on 07/30/2021 at 9:50 AM, revealed she contacted Resident #317's physician on 07/27/2021 at 9:35 AM due to the resident's change in condition and a potential COVID-19 infection. According to the RN, the physician ordered medications/treatments for the resident, COVID testing and ordered he/she be isolated to his/her room. The RN stated she tested him/her and he/she was negative. However, she acknowledged she failed to place signage on his/her door, and failed to take actions in attempts to isolate him/her to his/her room as ordered by the physician, but stated she should have. RN #1 also stated she had not provided the resident with a mask, because she did not think he/she would wear it. RN #1 stated she informed	{F 880}		

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the ADON of the Physician's Orders to isolate the resident and the ADON just stated, "OK". She stated the ADON never directed any further testing of other residents to occur, and she gave the RN no further actions to take to protect the other residents.

Interview with Physician #1, on 08/04/2021 at 1:00 PM, confirmed he was Resident #317's physician and was notified of the resident's change in condition. Physician #1 had given orders for staff to test and isolate the resident for a potential COVID-19 infection. He stated he was informed of staff's difficulty in isolating residents, especially those with dementia. However, he stated he expected staff to isolate sick residents away from the other residents to decrease the likelihood of the virus spreading in the facility and should follow their policy.

8. Observations conducted in the dietary department on 08/05/2021 at approximately 4:00 PM revealed Dietary Aide (DA) #1 was observed to retrieve a food tray cart from the 5th floor where COVID-19 positive residents resided. Further observations revealed no one cleaned/sanitized the cart before the cart was taken from the 5th floor, onto the elevator and back to the kitchen soiled dish area, where other tray carts were observed. Continued observations revealed the DA utilized a surgical mask and had no other PPE in use while cleaning the cart, which had been on the COVID-19 Unit in the facility. Observations also indicated the DA used "Silver Power" to clean/sanitize the carts.

Interview with DA #1, on 08/05/2021 at 4:15 PM, revealed he was informed that facility residents had tested positive for COVID-19 on the fifth

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{F 880}	Continued From page 1,093 floor. However, he had not been directed to do anything different when carts were retrieved from the COVID-19 unit in the facility. He stated he always utilized the "Silver Power" degreaser to clean the food carts in the facility, and had not been directed to change any dietary processes. Review of the Safety Data Sheet for Silver Power indicated the agent was utilized as a "presoak" and further review of the sheet provided no evidence it was an effective disinfectant for the COVID-19 virus. Interview with the Registered Dietician (RD), on 08/18/2021 10:30 AM, revealed she would have expected dietary staff to sanitize the food carts, with an effective agent for COVID-19 before the carts were brought back into the kitchen to prevent the potential spread of COVID-19. She stated she had not conducted training with staff related to COVID-19 infection control processes and had not been directed to do so. Interview with the Infection Control Nurse/ADON/Interim DON, on 08/18/2021 at 9:50 PM, revealed she was not aware dietary staff had not disinfected food carts with an effective agent for COVID-19, before they were brought back in the kitchen, after being on the COVID-19. However, she stated she would have expected them to do so. She acknowledged reeducation was required to be conducted in the facility, when new cases of the virus were identified for residents/staff as outlined in the facility's policy. However, she stated she had not conducted facility wide training because she had been working the floor as a staff nurse. **The facility alleged the following was	{F 880}		

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{F 880}	Continued From page 1,094 implemented to remove Immediate Jeopardy effective 09/26/2021: 1). Braden Scale Assessments were completed on all residents by facility nurses on 08/28/2021 and comprehensive full body skin assessments were completed on all residents on 09/11/2021. The facility utilized the Braden Scale Assessment and comprehensive full body skin assessment to review and update care plans of residents who had pressure injuries by 09/17/2021. 2). The wound care physician evaluated Resident #65 on 08/25/2021. Staff assessed and measured all pressure injuries, and staff evaluated all current treatments and reported them to the Medical Director/Physician #1 by 09/17/2021. 3). Beginning 09/17/2021, upon admission a skin assessment and Braden Scale assessment will be completed, and the baseline care plan will be developed within 48 hours to include any pressure ulcer or potential for pressure ulcer. A comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcers and include interventions to prevent pressure ulcer development or worsening of pressure ulcers. 4). Residents #45, #65, #308, #309, #311, #314 and #320 were bathed including a shower, nail care and moisturizing lotion applied post shower, and assisted with dressing in clean appropriate clothing. Clean linens were placed on the residents' beds on 09/11/2021. The residents were evaluated by social services on 09/15/2021. 5). All residents were offered a shower and	{F 880}		

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{F 880}	Continued From page 1,095 interviewed to obtain shower/hygiene preferences by the Director of Nursing (DON) or designee. New bath/shower schedules were implemented by nursing staff to accommodate resident preference. Resident preferences for hygiene were obtained and incorporated into resident care plans and State Registered Nurse Aide (SRNA) care plans by the Regional Nurse Consultant were completed on 09/13/2021. 6). On 08/28/2021, the Registered Dietitian (RD) began reviewing all residents' diets and made recommendations for meal changes or supplements to promote healing and to address any weight loss issues. 7). All residents with the diagnoses of Diabetes and Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by licensed nurse and/or Respiratory Therapist with no concerns were identified completed 08/13/2021. 8). The Regional Nurse reviewed all residents with orders for glucose monitoring by 07/30/2021 and orders were amended to include mandatory entry of glucose values on the Medication Administration Record (MAR). 9). The Regional Certified Dietary Manager (CDM) observed the meal service for breakfast, lunch and dinner on 09/11/2021, all three meals were delivered on time. 10). Direct Care staffing was increased through recruitment efforts with additional staffing provided through agency and travel contracts. Direct care nursing staff schedules for the next day will be reviewed daily by the Director of	{F 880}		

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{F 880}	Continued From page 1,096 Nursing and the Administrator to ensure staffing levels are adequate to meet the acuity of the residents. The staff will be validated as present on the unit at the start of each shift by the Director of Nursing, Nursing Supervisor, Administrator or designee. Direct care nursing staff call offs will be replaced by calling other qualified staff to see if they can fill the opening, and/or calling agencies to see if they have qualified staff to fill the opening. If direct care staff cannot be replaced the Director of Nursing, Assistant Director of Nursing, or member of the nursing management team will fill the shift. If appropriate staffing levels cannot be met, the center will prioritize resident care that can be achieved during emergency staffing, prioritize required task including administration of medication, no showers- sponge baths, care provided to incontinent residents, turn residents that cannot turn self, meals served timely, and assist residents with meal if needed. 11). The facility has increased dietary staffing through recruitment efforts and appropriate staffing levels have been achieved to ensure meals are prepared and delivered timely. 12). On 08/11/2021, all residents including #64, #86 and #322, were reassessed for psychosocial and physical forms of abuse with Brief Interview for Mental Status (BIMS) score of eight (8) or above and skin integrity reviews for residents with BIMS less than eight (8) were completed by Licensed Nurse. Residents with a diagnosis of Dementia had their Care Plan reviewed and revised, as necessary by the Minimum Data Set (MDS) Coordinator on 09/07/2021. No new residents were identified as indicating any psychosocial and/or physical harm.	{F 880}		

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{F 880}	Continued From page 1,097 13). The Regional Nurse Consultant completed a wandering risk assessment on all residents by 08/16/2021. All residents who were identified as at risk for wandering had care plans reviewed and updated by the MDS Coordinator. A list of all identified active wander risk residents were placed at each nursing station with a list of potential interventions for nursing to reference. 14). Residents #39, #65, #81, #90, #330 and #332 were weighed by 09/17/2021. The Registered Dietician (RD) completed a comprehensive nutrition assessment and RD recommendations were reviewed for recommendations by the Director of Nursing (DON) or designee on 09/17/2021. Further, the DON or designee, spoke with the attending Medical Doctor (MD) and validated the diet orders and recommendations. Recommendations were entered into the electronic medical record and on the tray card. The Registered Dietician and Director of Nursing (DON), reviewed diet orders in electronic medical record to ensure both the record and tray card reflected accurate information on 09/17/2021. 15). Beginning 09/15/2021, staff began offering snacks to all residents daily in the morning and afternoon by the restorative nurse aide, activity aides, or designee. Snacks ordered by a physician will be documented by the restorative aide, dietary aides and/or licensed nursing staff. 16). The facility evaluated the COVID-19 unit on 08/11/2021, located on the 5th floor of the facility for compliance with CDC guidelines and implemented yellow and red zones. The DON identified two (2) residents who had been	{F 880}		

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{F 880}	Continued From page 1,098 exposed to positive residents and a yellow zone was designated with erection of a plastic zip wall barrier and those two (2) residents were moved to this zone on 08/11/2021. 17). The facility had three (3) residents who were in the red zone on 08/11/2021(Residents #327, #328 and #329). Residents #327, #328 and #329 have completed quarantine per facility policy and physician orders. Residents #311 and #314 completed quarantine per COVID-19 policy and physician's order. Residents #311 and #314 were no longer in isolation. 18). All staff eligible for testing were tested for COVID-19 on 09/16/2021. The facility did not identify any new cases based on the employee testing on 09/16/2021. All residents eligible were tested for COVID-19 on 09/17/2021. The facility did not identify any new positive cases. 19). The facility was conducting ongoing surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in droplet precaution in isolation zone (yellow). The facility will provide physician notification, family notification and care plan revisions. The facility employee testing protocol will be twice weekly on designated days effective 08/16/2021. The facility requires all staff must be tested on designated days. If the employee is not tested, the facility will	{F 880}		

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{F 880}	Continued From page 1,099 not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas. 20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021. 21). Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). The facility stated all residents will receive their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the physician regarding the unavailable medication. 23). The facility formulated an agreement on 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of medications that requires the facility's approval for cost authorization while pending cost review. 24). New admissions and re-admissions entering the facility after normal business hours and on weekends will have discharge orders submitted, entered into the electronic medical record and submitted to pharmacy through pharmacy	{F 880}		

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{F 880}	Continued From page 1,100 integration. The facility implemented the use of fax transmittal as a backup to the electronic pharmacy integration by entering the order in the electronic medical record to receive medications. If the facility does not receive medications in a timely manner the pharmacy will be notified, and the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. 26). The facility conducted a Quality Assurance Performance Improvement (QAPI) meeting on 08/12/2021. The facility reviewed education, facility process, and audited implementation to ensure compliance with the AOC and all audits. The Administrator oversees the QAPI committee. The QAPI committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the current Administrator. The facility's Interim Administrator will receive daily oversight and guidance from the Regional Vice President or Regional Director of Operations and Regional Clinical Nurse for 30 days. Upon completion of the thirty-day oversight, the Regional Administrative Team will audit the Administrator to determine if continued daily oversight is needed.	{F 880}		

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{F 880}	Continued From page 1,101 The administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. 28). The Administrator, Medical Director, and QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). The Administrator and Regional Nurse Consultant reviewed and revised the QAPI Plan beginning 09/16/2021 and presented the reviews and/or revisions to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The agenda included reviewing pressure ulcers, Foley	{F 880}		