STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November, 4, 5, 8, 9, 10 and 12, 2021 Facility number: 000523 Provider number: 155496 AIM number: 100266930 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 2 Medicaid: 77 Other: 6 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/19/21.	F 0000	Preparation execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The plan of correction is submitted in order to respond to the annual survey recertification cited during survey on November 4, 5, 8, 9, 10, and 12th, 2021. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to request a desk review for this survey.	
F 0574 SS=C Bldg. 00	483.10(g)(4)(i)-(vi) Required Notices and Contact Information §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;			

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

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	(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and			

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	Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. Based on record review and interview, the facility failed to ensure residents were informed of the name of the current Ombudsman and were given information on how to file a complaint to the state agency about the care they received. This had the potential to affect 63 of 86 residents who resided in the facility. Finding includes: During the Resident Council meeting, on 11/8/21 at 11:00 A.M., many of the residents indicated they were unaware of the contact information for the Ombudsman and the telephone number to file a complaint to the state agency. The Resident Council indicated this information had been posted at one time but was no longer posted in the facility. During an observation, on 11/8/21 at 11:49 A.M., the Administrator walked the facility to look for the contact information of the Ombudsman and	F 0574	**F 574** **Notices and Contact Information** **CFR(s): 483.10(g)(4)(i)-(vi)** Residents will be given the Long-term Care Ombudsman name, contact information and how to make a formal complaint to the state agency about their care. No harm occurred due to alleged deficient practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** The Executive Director will ensure that the contact information for the Long-term Care Ombudsman is posted. Residents will receive information during the next resident council meeting 11/30/21	12/09/2021

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	state agency. This information could not be located. At the same time, during an interview, the Administrator indicated he would need to provide a wall hanging of the contact information of the Ombudsman and state agency. The Administrator indicated this information should be available for the residents. A policy was provided, on 11/10/21 at 3:25 P.M., entitled, "Resident Rights", by the Regional Nurse. The policy indicated, " ...iii. See any person who provides assistance to help with health, social, legal or other services may at any time. 1. This includes the resident' doctor, a representative from the health department, and the Long-Term Care Ombudsman, among others ...." 3.1-4(j)(3)		the Long-term Care Ombudsman name, contact information and how to make a formal complaint to the state agency about their care on or before the date of compliance. **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** The Executive Director will in-service the Activity Director on Required Notices and Contact Information in Resident Facility and Policy: “Residents Right” on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows:** The Activity Director/Designee will use the “required notices and contact information audit tool” for monitoring posting for contact information. Once a week for 4 weeks then once a month going forward x 6 months. The Executive Director will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	

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F 0576 SS=C Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide			

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	such access to the resident. (iii) Such use must comply with State and Federal law. Based on interview, the facility failed to provide mail delivery on Saturdays and unopened mail. This deficient practice had the potential to affected 86 of 86 resident who reside in the facility. Findings include: During the resident council meeting, on 11/8/21 at 11:00 A.M., the participating residents indicated that they do not receive mail on Saturday and personal mail has been opened at times. Resident 69 indicated she received mail from the courthouse concerning her daughter and the mail was always opened. Resident 69 stated she had brought this to the attention of the business office. Resident 69 indicated she received a response that it was a mistake when her mail was opened. During an interview, on 11/10/21 at 2:54 P.M., the Regional Director of Finance, indicated the receptionist received the mail and separated the resident mail from the facility mail. The Regional Director of Finance indicated business sized envelopes go to the business office and then are sent to the resident's power of attorney (POA) if the resident is not cognitively intact. If the resident was cognitively intact, the mail should go to the resident unopened. If a court document was opened, it may have been mistaken for facility business. During an interview, on 11/10/21 at 3:05 P.M., the Activity Director indicated mail was placed into her mailbox daily and was delivered daily. She indicated she does not work on Saturday, and	F 0576	**F 576** **Right to Forms of Communication w/ Privacy** **CFR(s): 483**.10(g)(6)-(9) Resident #69 received their mail and indicated that they had received a response that it had been a mistake when her mail was opened. No harm occurred due to alleged deficient practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** All Residents who receive mail have the potential to be affected by the alleged deficient practice. Residents will receive information during the next resident council meeting 11/30/2021 regarding mail delivery schedule and weekend delivery. **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** The Executive Director will in-service the Business Office Manager on Right to Forms of Communication w/ Privacy and Policy: "Resident Rights" on or before the date of compliance. The Executive Director will in-service Activities Director on Follow up in Resident Council on a	12/09/2021

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	Saturday mail is delivered on Monday. A policy was provided, on 11/10/21 at 3:25 P.M., entitled, "Resident Rights", by the Regional Nurse. The policy indicated, " ...Privacy concerning their Privacy, Property, and Living Arrangements including but not limited to: 4. Have privacy in sending and getting mail ...." 3.1-3(s)(1)		monthly basis utilizing the questions found on her monthly resident council form to ensure on-going compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows:** Utilizing “Angel Rounds- Mail Delivery Audit Tool” for monitoring The Business Office Manager/Designee will ask 5 residents weekly x4 weeks, then Manager/Designee will ask 3 residents weekly x4 weeks, and then Manager/Designee will ask 2 residents weekly x4 weeks for at least 6 months, then will be maintained per policy: 1. If they have received their mail timely and 2. If they received their mail unopened. The Executive Director will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in			

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	or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			

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	Based on observation, interview and record review, the facility failed to ensure that Advanced Directives were signed by the physician for 1 out of 1 records reviewed. (Resident 238) Finding includes: A clinical review was completed, on 11/9/2021 at 9:40 A.M., and indicated Resident 238's diagnoses included but were not limited to: malignant brain neoplasm of the brain, dysphagia, displaced fracture of 2nd cervical vertebrae, systemic lupus, restless leg syndrome and anxiety. The resident was admitted on 10/11/2021. An Admission MDS (Minimum Data Set) assessment, dated 10/19/2021, indicated Resident 238's BIMS (Brief Interview for Mental Status - cognitive assessment) score was 6, indicating severely cognitively impaired. An Advanced Directive indicating CPR (Cardiopulmonary Resuscitation) status, signed by the spouse on 10/11/2021, indicated Resident 238 chose a CPR status, but no physician signature was present. During an interview, on 11/09/2021 at 10:45 A.M., the Admission Director indicated the Advance Directive should have been signed by the doctor. On 11/09/2021 at 3:56 P.M., the Regional Nurse provided a policy titled, "INDIANA Physician-Order-for-Scope-of-Treatment, dated 5/01/2018, and indicated the policy was the one currently used by the facility. The policy indicated"...Requirements for a valid code status must include at least the completion of the following sections/areas of the form: i. the resident's name, ii. residents date of birth, iii. code	F 0578	**F 578** **Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir** **CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)** Resident #238 medical record was updated to include resident's code status with physician's signature. No harm occurred due to alleged deficient practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** All current residents' have the potential to be affected by alleged deficient practice. The Director of Nursing/Designee will audit all resident's code status documentation to ensure a physician's signature utilizing "Code Status Audit Tool" on or before the date of compliance. Any residents identified as not having the appropriate code status documentation have had their physician and family notified and the appropriate documentation has been completed and their plan of care updated accordingly **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** The Executive Director will educate the Social Service Director on Request/Refused/ Discontinue Treatment and Formulate Advance Directive and	12/09/2021

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	status order selection, iv. signature of resident or authorized representative, v. signature of the physician...." 3.1-4(d)		Policy: "INDIANA Physician-Order-for-Scope-of-Treatment" on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows:** Utilizing the "Code Status Audit Tool" the Social Service Director/Designee will audit M-F all new admissions x4 weeks, resident's code status documentation to ensure Physician signature is obtained. To ensure compliance is maintained Social Service Director/Designee will continue to monitor MWF x 4 Weeks, then every Friday x 4 weeks, then monthly for 6 months. The Executive Director will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	
F 0585 SS=E Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as			

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	well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;			

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	(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed			

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	by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on observation and interview, the facility failed to provide readily available grievance forms and the ability to voice a grievance anonymously. This deficient practice had the potential to affect the 63 cognitively intact residents who reside in the facility. Findings include: During the resident council meeting, on 11/8/21 at 11:00 A.M., the participating residents indicated that they do not know where to find a grievance form or have the ability to file a grievance anonymously. At one time, the forms were located outside the business office in a wall folder but were no longer there. During an observation, on 11/8/21 at 11:49 A.M. with the Administrator, the grievance forms were located in a wall folder at the back of a table in the business office copier room. The grievance forms were folded over and not identifiable. During an interview, on 11/8/21 at 11:49 A.M., the Administrator indicated the business office copier room door is always open. Recent construction had happened at the facility and the wall folder may have been removed.	F 0585	**F585** **Grievances** **CFR(s): 483.10(j)(1)-(4)** The facility will educate the residents and provide the residents readily available grievance forms to be able to voice grievances anonymously on or before the date of compliance. No harm occurred due to alleged deficient practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** The alleged deficient practice has the potential to affect all cognitively intact residents who reside in the facility. Cognitively intact residents will be educated by the ED/Designee where the grievance forms are kept and where to submit them anonymously at the next Resident Council meeting on or before the date of compliance. Families of residents who are identified as not being cognitively intact will be informed of the location of	12/09/2021

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	During an interview, on 11/10/21 at 2:50 P.M., the Social Service Director (SSD) indicated the grievance forms were located in the social service office and the activity room office upon request. The residents can ask anyone from management for a grievance form. The SSD indicated grievance forms were not available anonymously for the residents to complete. A policy was provided, on 11/10/21 at 3:25 P.M., entitled "Resident Rights" by the Regional Nurse. The policy indicated, " ...vii. Receive proper medical care including but not limited to: 8. To express any complaints (sometimes called "grievances") about care or treatment ...." 3.1-7(a)(1)		grievance forms and how to submit anonymously. No harm occurred with alleged deficient practice. The executive Director will ensure that the grievance forms and box are placed in an accessible and private place for the residents/families to be able to file anonymous **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** The Executive Director/Designee will in-service the Interdisciplinary Team on the Grievance Process, and the Policy: "Resident Rights" on or before the date of compliance. The Executive Director/Designee will educate the Social Worker on the grievance log/process and completion utilizing the "Grievance Log Audit Tool" on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows:** Utilizing "Angel Rounds- Grievance Audit Tool." Social Service will ask 5 cognitively intact residents weekly x4 weeks, then monthly x6 months: 1. If they are aware where the grievance forms are located.	

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			2. If they feel their grievances can be submitted anonymously. To ensure compliance is maintained Social Service Director/Designee will continue to monitor MWF x 4 Weeks, then every Friday x 4 weeks. Social Service will provide education to the resident at the time of questioning if needed. The Executive Director will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the			

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	participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review, and interview, the facility failed to ensure care plans were revised related to fluid restrictions for 1 of 23 residents whose care plans were reviewed. (Resident 42) Fining includes: A clinical record review was completed on 11/08/2021 at 10:00 A.M., and indicated Resident 42's diagnoses included, but were not limited to: anemia, renal insufficiency, diabetes, and seizure disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 9/3/2021 indicated Resident 42 required extensive assist with bed mobility, transfers dressing and toilet use and received dialysis. A current care plan, dated, 12/04/2020 and revised on 10/28/2021, indicated the resident had impaired nutrition related to diabetes and obesity, planned significant weight loss x 30 days using diuretic, dialysis and 1500 ml (milliliter) fluid restriction. Approaches included provide 1500 ml /day fluid restriction with nursing controlling all fluids. No fluids served from kitchen on meal trays.	F 0657	**F 657** **Care Plan Timing and Revision** Resident #42 Care Plan was updated to discontinue fluid restriction Care Plan. No harm occurred due to alleged deficient practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** All Residents with fluid restriction physician orders have the potential to be affected by alleged deficient practice. All residents identified with fluid restriction physician orders will be reviewed for orders and care plans for fluid restrictions to ensure that care plans are consistent with orders utilizing “Fluid Restriction Audit Tool” on or before the date of compliance. **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:**	12/09/2021

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	The current physician orders lacked an order for the fluid restriction. During an interview on 11/12/2021 at 9:37 A.M., LPN (Licensed Practical Nurse) 5 indicated the resident was not on a fluid restriction and the care plan was not updated. On 11/9/2021 at 11:39 A.M., Regional Nurse 2 provided the policy titled,"Plan of Care Overview", dated 7/26/2018, and indicated the policy was the one currently used by the facility. The policy indicated"...d. iii. Review care plans quarterly and/or with significant changes in care...II. 2. Nurses are expected to participate in the resident plan of care for reviewing and revising the care plan of residents they provide care for as the resident's condition warrants...." 3.1-35(d)(2)(B)		The Regional RAC Nurse/Designee will in-service the MDS nurse on the policy: "Plan of Care Overview" on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows:** The DON/MDS will monitor M-F for any d/c orders relating to fluid restrictions and ensure that care plans are updated accordingly. This will be an ongoing practice for no less than 6 months. The Director of Nursing will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry			

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	out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, record review and interview, the facility failed to provide the ability for a resident to effectively communicate and participate in social conversations for 1 of 4 residents reviewed for communication difficulty and/or sensory problems. (Resident 46) Findings include: During an interview on 11/4/21 at 10:06 A.M., Resident 46 answered questions with a response of, "No English." Resident 46 was observed sitting in her room on 11/4/21 at 10:06 A.M. The room had no lights illuminated and no television or radio playing. At	F 0676	**F676** **Activities Daily Living (ADLs)/Mntn Abilities** **CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)** Resident #46 will receive a new device for continued assistance with translation for preferred cultural language preference for effective communication and help participate in social conversations. No harm occurred with alleged deficient practice. **The facility will identify other**	12/09/2021

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	2:45 P.M., Resident 46 was noted sitting by the window in her dark room looking outside. On 11/5/21 at 9:33 A.M., Resident 46 was noted to be sitting in her dark room with no activity going on in the room. On 11/8/21 2:48 P.M., Resident 46 was noted to be sitting in her dark room talking to herself in Spanish. A record review was completed for Resident 46 on 11/8/21 at 3:12 P.M. Diagnosis included but were not limited to, dementia with Lewy Bodies, diabetes mellitus with diabetic neuropathy, and chronic kidney disease. The Admission Minimum Data Set (MDS) assessment, dated 9/10/21, indicated the resident had moderate cognitive impairment. Resident 46's preferred language was Spanish and the resident needed or wanted an interpreter to communicate with a doctor or health care staff. There was no care plan initiated for a communication barrier. During an interview, on 11/9/21 at 1:47 P.M., CNA 23 indicated Resident 46 did not go to activities or meals because no one understood her when speaking Spanish. CNA 23 indicated Resident 46 was isolating herself to her room. During an interview, on 10/9/21 at 2:00 P.M., the Resident Service Director indicated Resident 46 didn't speak much English. She would watch Resident 46's body language to determine if she understood the English spoken to her. She indicated the resident would come out for a little while, but then retreated to her room. She		**situations having the potential to be affected by the same deficient practices as follows:** All current and new residents with cultural language preferences other than English have the potential to be affected by the alleged deficient practice. The Reflections Manager and/or Activities Director/ Designee will identify any residents that have a cultural language preferences and complete an Activity Preferences Interview UDA to ensure preferences are care planned on or before the date of compliance. Reflections Manager and/or Activities Director/ Designee will update care plans accordingly with identified types of assistance residents prefers to ensure cultural language preference to assist with effective communication and participation in social conversation on or before the date of compliance. The Executive Director will review the facility assessment and update accordingly on or before the date of compliance. **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** The Executive Director/ Designee will educate Reflections Manager	

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	indicated this was due to the language barrier. During an interview, on 11/10/21 at 1:38 P.M., the Director of Nursing (DON) indicated Resident 46 should have activities of choice that interested her and in her preferred language when possible. There were approximately 8-10 Spanish speaking employees who work across various shifts. A language line was also available to the staff. The DON indicated, "We know we have a problem there." There was no documentation to indicate the resident was receiving any translation services and none was observed throughout the survey. A policy was provided, on 11/10/21 at 3:25 P.M., entitled "Plan of Care Overview", by the Regional Nurse. The policy indicated, " ....1. General Care Planning (PoC) Goals and Guidelines d. The facility will: vi. Incorporate the resident's personal and cultural preferences in developing goals of care ...." 3.1-38(2)(E)		and/or Activities Director/ Designee on the policy: “Plan of Care Overview" on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows:** Reflections Manager and/or Activities Director/ Designee will monitor 5 residents 3x weekly x 4 weeks, then 3 residents weekly x 6 months, the ability of residents to effectively communicate and participate in activities utilizing, “Resident Activities Participation Record.” The Executive Director will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			

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	Based on observation, record review and interview the facility failed to implement an activities program that incorporated the resident's interests, hobbies and cultural preferences for 1 of 3 residents reviewed for activities. (Resident 46) Findings include: During an interview on 11/4/21 at 10:06 A.M., Resident 46, answered questions with a response of, "No English." Resident 46 was observed sitting in her room on 11/4/21 at 10:06 A.M. The room had no lights illuminated and no television or radio playing. At 2:45 P.M., Resident 46 was noted sitting by the window in her dark room watching outside. On 11/5/21 at 9:33 A.M., Resident 46 was noted to be sitting in her dark room with no activity going on in the room. On 11/8/21 2:48 P.M., Resident 46 was noted to be sitting in her dark room talking to herself in Spanish. A record review was completed for Resident 46 on 11/8/21 at 3:12 P.M. Diagnosis included but were not limited to, dementia with Lewy Bodies, diabetes mellitus with diabetic neuropathy, and chronic kidney disease. The Admission Minimum Data Set (MDS) assessment, dated 9/10/21, indicated the resident had moderate cognitive impairment. The Activity Preference Assessment, dated 9/3/21, indicated the resident had a current preference for games (slot games), crafts/arts/hobbies (drawing), and past preference	F 0679	**F 679** **Activities Meet Interest/Needs Each Resident** **CFR(s): 483.24(c)(1)** The Reflections Manager will interview resident #46 using "Activity Preference Review UDA" to identify the resident's interests, hobbies and cultural preferences to incorporate into their personal activities program. Resident #46 Care Plan will be updated to identify personal activity choices on or before the date of compliance. No harm occurred related to alleged deficient practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** All current and new Residents who have moderate cognitive impairment or language barrier have the potential to be affected by alleged deficient practice. The Director of Nursing will identify all residents that have a language barrier and/or moderate cognitive impairment. (BIMs 8-12) The Reflections Manager /Designee will then interview residents utilizing "Activity Preference Review UDA" to determine resident's preferences. Care plans will be updated to reflect current interests on or before the date of compliance. **The measures that will be put**	12/09/2021

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	of gardening. There was no care plan for activities. During an interview, on 11/9/21 at 1:47 P.M., CNA 23, indicated Resident 46 would not go to activities or meals because no one understood her when speaking Spanish. CNA 23 indicated Resident 46 was isolating herself to her room. During an interview, on 10/9/21 at 2:00 P.M., the Resident Service Director, indicated Resident 46 liked to look out the window. She indicated the resident would come out for a little while, but then retreated to her room. She indicated this is due to the language barrier. The Resident Service Director could not provide any documentation of activities Resident 46 has participated in since admission. During an interview, on 11/10/21 at 1:38 P.M., the Director of Nursing (DON) indicated Resident 46 should have activities of choice that interested her and in her preferred language when possible. There were approximately 8-10 Spanish speaking employees who worked across various shifts and language line was available to the staff. The DON indicated, "We know we have a problem there." There was no documentation to indicate the resident was receiving any structured 1:1 programming and none was observed throughout the survey. A policy was provided, on 11/9/21 at 3:55 P.M., entitled "Activities Program", by the Regional Nurse. The policy indicated, " ...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. 1. The		**into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** The Executive Director/ Designee will educate the Reflections Manager and Activities Director utilizing the policy: "Activities Program" on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows:** The Reflections Manager and/or Activities Director will monitor activities of 5 residents with moderate cognitive impairment and/or language barrier 3x weekly x4 weeks utilizing “Activities Monitoring Tool” to ensure residents are participating in activities indicated in their care plans. To ensure deficient practice does not recur monitoring will continue 3 residents weekly x 6 months. The Executive Director will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	

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	activity program is: c. Consists of individual and small and large group activities which are designed to meet the needs and interests of each resident ...." 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to provide proper positioning for 1 of 1 resident reviewed for hospice services. (Resident 25) Findings include: During observations, on 11/4/21 at 10:24 A.M., Resident 25 was observed sitting in her wheelchair in an activity with her head and body leaning to the right side with her eyes closed. At 11:09 A.M., Resident 25 was in the activity room leaning forward with head down and eyes closed. At 2:45 P.M., Resident 25 was noted to be in bed with eyes closed. Resident 25's neck/head had hyperflexion from the pillow. During observation on 11/5/21 at 9:24 A.M., Resident 25 was noted sitting in her wheelchair in an activity with her chin against her chest with her eyes closed and leaning to the right. At 12:16	F 0684	**F684** **Quality of Care** **CFR(s): 483.25** Resident # 25 positioning will be evaluated by therapy any recommendations will be shared with hospice services and implemented on or before the date of compliance. No harm occurred due to alleged deficient practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** 1. All current and new admits who are dependent on positioning have the potential to be affected by alleged deficient practice. An audit will be completed to identify residents who are dependent with	12/09/2021

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	P.M., Resident 25 was observed slumped to the right with her head down and her eyes closed, still sitting in the same location. During observation on 11/8/21 at 10:01 A.M., Resident 25 was in bible study with her head down, leaning to the right and sleeping. At 2:26 P.M., Resident 25 was sleeping in her wheelchair leaning to the right with her head on the right wheelchair arm rest. During observation on 11/10/21 12:05 P.M., Resident 25 was sitting in her wheelchair in her room. She was leaning towards the right with her head on the right wheelchair arm rest. A record review was completed on 11/8/21 at 9:43 A.M. Diagnosis included but were not limited to, COPD (chronic obstructive pulmonary disease), dementia with behavioral disturbance, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 8/24//21, indicated the resident had severe cognitive impairment, required extensive assistance with two persons for transfers and extensive assistance with one person for bed mobility. During an interview, on 11/9/21 at 2:12 P.M., the Resident Service Director, indicated if Resident 25 was slumped over in the wheelchair and sleeping, then she should be laid down in bed. Resident 25 neck/head was always hyperflexed. During an interview, 11/10/21 at 12:10 P.M., LPN 7 indicated that Resident 25 should not be left to sleep in her wheelchair and should be placed in bed if leaning or sleeping.		positioning utilizing MDS assessment, therapy will screen residents to identify any wheelchair positioning issues and will be correct as applicable. **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** 1. The Director of Nursing/ Designee will educate the nursing staff will be educated and proper body alignment while up in wheelchair and while in bed utilizing “positioning policy” on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows:** 1. The Director of Nursing/ Designee will monitor 3 residents 3x a week x 6 months for proper body alignment in wheelchair and in bed for residents dependent on proper body alignment. The Executive Director will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	

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	A policy was requested but none was provided. 3.1-38(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record review, the facility failed to verify weights when changes in weight occurred for 1 of 1 residents reviewed for nutrition. (Resident 77) Finding includes: A clinical record review was completed, on 11/10/21 at 10:49 AM, Resident 77's diagnoses included but not limited to: cerebral infarction, diabetes type II, schizophrenia, dementia with behavioral disturbances, Parkinson's disease, and	F 0692	**F692** **Nutrition/Hydration Status Maintenance** **CFR(s): 483.25(g)(1)-(3)** Resident #77 weight will be reviewed and addressed by Registered Dietician on or before the date of compliance. No harm occurred due to alleged deficient practice. **The facility will identify other**	12/09/2021

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	hypertension. A Quarterly MDS (Minimum Data Set) assessment, dated 10/1/2021, indicated a BIMS (Brief Interview of Mental Status - cognitive assessment) score of 14, indicating intact cognition. Resident 7 had documented weights of 210 on 9/1/2021, 220.1 on 10/6/2021 and 198 on 11/2/2021. The Dietary Progress Note, dated 10/25/2021, indicated the resident had an 18-pound (8.9%) weight increase in 90 days which was a significant weight gain. He had an increase in his insulin on 9/30/2021 with a likely reason for 10-pound gain in 30 days. He had good meal intake of 75-100% on a NAS (no added salt)/CCD regular texture diet. The dietary progress note, dated 11/8/2021, indicated he had a significant weight loss of -22 pounds (9.9 %) in 30 days. Good meal intakes of 75-100%. No difficulty with chewing or swallowing. On 11/10/21 at 02:01 PM., the Regional Nurse indicated if a change in weight occurred, they should obtain a re-weight and then consult with the dietitian. On 11/10/2021 at 3:25 P.M., the Regional Nurse provided a policy titled, "Resident Height and Weight", dated 5/19/2016 and revised 7/16/2021, and indicated the policy was the one currently used by the facility. The policy indicated " ...9) Reweight Parameters: a) A plus/minus of 5 pounds of weight in one week will result in: i) reweight within 24 hours (1) Validation with nurse for accurate weight (2) Notify IDT team/doctor/family, if indicated ...."		**situations having the potential to be affected by the same deficient practices as follows:** All current and new admitted residents have the potential to be affected by alleged deficient practice. All residents' weights will be audited on the weight QAPI Tool. They will be reviewed and reweighed as needed per policy. Notification to Registered Dietician (RD) will occur. Any recommendations by RD will addressed with the physician and family on or before the date of compliance. **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** The Director of Nursing/ Designee will educate nursing staff on the policy: "Resident Height and Weight" on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows** The Director of Nursing/Designee will monitor all residents' weights obtained M-F x1 month utilizing "Weight Monitoring Tool" to ensure re-weighs occur and are notified to RD and addressed accordingly. This will be an ongoing practice. The Director of Nursing will report all findings to the QA committee monthly. The QAPI committee	

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	3.1-46		will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure that all emergency equipment was available at the bedside for immediate use for 1 of 1 resident reviewed for tracheostomy care. (Resident 19) Finding includes: On 11/04/21 at 12:07 P.M., a suction machine was observed on the nightstand covered in clear plastic bag, tubing loose in the bag, and no catheters, ambu bag, extra trach or oxygen in the room. On 11/08/21 09:23 A.M., a suction machine was observed on the night stand covered in clear plastic bag tubing loose in the bag, with no catheters, ambu bag, extra trach or oxygen in the room. A clinical record review was completed on,	F 0695	**F 695** **Respiratory/Tracheostomy Care and Suctioning** **CFR(s): 483.25(i)** Emergency equipment was immediately brought to Resident #19 room. Resident #19 refused to allow all Emergency Equipment be placed in her room. Resident #19 Care plan was updated regarding refusal on or before the date of compliance. No harm occurred due to alleged deficient practice. Resident educated 12/9/21 and is now allowing emergency equipment in her room. **The facility will identify other situations having the potential to be affected by the same**	12/09/2021

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	11/9/2021 at 10:02 A.M., Resident 19's diagnoses included but were not limited to: chronic respiratory failure, hemiplegia and hemiparesis, dysphagia, anxiety, tracheostomy status and hyperlipidemia. An Annual MDS (Minimum Data Set) assessment, dated 8/6/2021, indicated Resident 19 had a BIMS (Brief Interview for Mental Status - cognitive assessment) score of 14, indicating intact cognition. A Physician Order, dated 2/09/2019, indicated "...Trach: Ambu bag, oxygen(e.g., E-cylinder), suction canister and catheters in room at all times...." During an interview, on 11/09/2021 at 9:15 P.M., the Regional Nurse indicated that if there was an order for an ambu bag and oxygen to be at bedside then it should have been in the room. 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)		**deficient practices as follows:** All current and new admissions with tracheostomies have the potential to be affected by the alleged deficient practice. The Director of Nursing will complete an audit using “Trach Audit Tool” to ensure all emergency supplies are at bedside for immediate use on or before the date of compliance. **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** The Director of Nursing will educate the nurses on tracheostomy emergency equipment and/or supplies per MD order needed at bed side on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows** The Director of Nursing will monitor all residents with tracheostomy to ensure all emergency equipment is present in the resident’s room 3x weekly x6 months utilizing “Tracheostomy Monitoring Tool.” The Director of Nursing will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing	

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			monitoring is required.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review, observation and interview, the facility failed to provide specialized services and support for a resident that required 1:1 supervision for 1 of 3 residents reviewed for dementia care. (Resident 83) Findings include: A record review was completed on 11/5/21 at 11:12 A.M. Diagnosis included but were not limited to, Alzheimer's disease, major depressive disorder and diabetes mellitus type 2. The Quarterly Minimum Data Set (MDS) assessment, dated 8/11//21, indicated the resident had severe cognitive impairment and required limited assistance to ambulate in corridor or room. A Nurse/'s Note, dated 10/20/21 at 6:15 P.M., indicated Resident 83 was found in another resident's room having a physical altercation. The residents were separated by staff. The intervention put in place was continuous 1:1 supervision. A Physician's Order was obtained on 10/20/21 for 1:1 observation every shift for behaviors. An IDT (interdisciplinary team) follow up Nurse's Note, dated 10/21/21 at 1:47 P.M., indicated	F 0744	**F 744** **Treatment/Service for Dementia** **CFR(s): 483.40(b)(3)** Resident #83 when identified specialized services and support were not in place, Resident #83 was immediately placed on 1:1 supervision to follow Physicians order. No harm occurred due to alleged deficient practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** Current Residents or New Admission requiring specialized services and support have the potential to be affected by alleged deficient practice. The Director of Nursing will identify residents requiring specialized service 1:1 supervision. The Executive Director and Director of Nursing will review schedule daily to ensure any resident requiring specialized services 1:1 supervision has a staff member scheduled and is	12/09/2021

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	Resident 83 entered another resident room, grabbed her and was pulling her hair. Resident 83 was placed on 1:1 observation until alternate placement can be found. A behavioral Care Plan, initiated on 5/5/21, indicated an intervention of "1:1" dated 10/21/21. During continuous observation, on 11/8/21, the following was observed: 9:43 A.M. Resident 83 was sitting in bible study activity next to the activity director. 9:49 A.M. Resident 83 was taken to his room by LPN 7 and left in the room alone to watch television. 10:05 A.M. Resident 83 came out of his room and entered room 409. 10:07 A.M. Resident 83 came out of room 409 with a pair of pants in his hand and went into the dining room unattended. 10:08 A.M. Resident 83 came out of the dining room and was walking around in the hallway unattended. 10:09 A.M. Resident 83 came out of his room and went into room 409 with a pair of pants in his hand. 10:11 A.M. Resident 83 came out of room 409 with a blanket and plastic hanger in hands and began walking the hallway unattended. 10:14 A.M. Resident 83 continued to be walking around the hallway unattended holding a hanger. 10:17 A.M. LPN 7 took the hanger away from the resident and escorted him to the dining room for community snack. 10:22 A.M.-10:32 AM Resident 83 was pacing in the hallway unattended. During an interview, on 11/8/21 at 3:52 P.M., CNA 24 indicated when 1:1 supervision was not available, the resident was checked on frequently.		accounted for each shift to ensure specialized services and support are met. **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** The Regional Nurse/Designee will educate the Executive Director, Scheduler, and Reflections Manager on Treatment/Service for Dementia on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows** The Executive Director/ Designee and Scheduler will monitor schedule daily x 7days to ensure staff member is scheduled and accounted for each shift to ensure specialized services and support are met. This will be an ongoing practice. The Executive Director will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	

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	During an interview, on 11/8/21 at 3:54 P.M. LPN 7 indicated she was always looking where Resident 83 was located. LPN 7 indicated Resident 83 should have had 1:1 supervision today and was not aware why that didn't happen. During an interview, on 10/11/21 at 10:31 A.M., the Regional Nurse indicated that Resident 83 didn't always have 1:1 observation available. If he was not having behaviors, staff should keep an eye on him by monitoring him. A policy was provided, on 11/10/21 at 3:25 P.M., entitled "Plan of Care Overview" by the Regional Nurse. The policy indicated, "The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices and preferences including but not limited to, goals related to their daily routines ...II. Care Plan Team b. Members of the care planning team will coordinate care to meet resident preferences and care needs utilizing a holistic approach to care ...." 3.1-37(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were kept in a locked cart when unattended; medication storage areas were clean and free from loose medications and had resident identifiers; and medications were labeled and dated when opened, for 3 of 3 medication carts reviewed and 1 of 3 treatment carts reviewed. (300 hall medication and treatment carts, 200 medication cart and 100 medication cart). Findings include: 1. During a random observation, on 11/8/2021 at 2:35 P.M., the medication cart for the 300 hall was observed with two medication cards with 30 diabetic pills each sitting on top of the medication cart. There was no licensed nursing staff at or near the medication cart.	F 0761	**F761** **Label/Store Drugs and Biologicals** **CFR(s): 483.45(g)(h)(1)(2)** Medications were secured and medication carts were immediately locked when identified unlocked carts and education was provided to the nurse/med tech. Solution was removed from the medication cart and Nurse was educated regarding medication storage. Medication carts were cleaned of loose medications upon identification. All medications that did not have resident identifiers were immediately removed from the cart and reordered. Medications that were not labeled and dated after	12/09/2021

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	During an interview on 11/8/2021 at 2:45 P.M., RN 27 indicated the medication cart should be locked at all times when not in sight of it and the medication cards should be locked up in the med cart. 2. During a medication storage observation on the 100 hall medication cart, on 11/9/2021 at 2:00 P.M., the following was observed: a bottle of Dakins (topical solution) stored with oral liquid medications: an opened bottle of Lactulose (laxative) with no date opened; an opened bottle of Milk of Magnesium with no date opened; an opened bottle of Chlorhexidene (topical antiseptic) with no date opened; an opened bottle of Robafan with no date opened; an opened bottle of glycol with no date opened and 11 loose pills in the drawers. During an interview, on 11/9/2021 at 2:27 P.M., Licensed Practical Nurse (LPN) 6 indicated the Dakins solutions should not be with oral medications, the medications should have had open dates and there should be no loose pills in the medication cart. 3. During a treatment observation, on 11/9/2021 at 2:24 P.M., the 300 hall treatment cart was unlocked and not in sight of the licensed nurse. During an interview, on 11/9/2021 at 2:36 P.M., LPN 6 indicated the treatment cart should have been locked. 4. On 11/9/2021 at 2:42 P.M., during a medication storage observation of hall 300 with QMA (Qualified Medication Aide) 4, the following was noted: a tube of Ambesol with no name and or label; 2 loose pills in drawer 3 and 2 unopened boxes and an opened package of 2 patches for a		opening were removed from the cart. All medications were reordered. No harm occurred with alleged deficient practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** All residents receiving medications and treatments have the potential to be affected by alleged deficient practice. An audit was conducted of all medication carts to ensure appropriate storage of medications. **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** The Director of Nursing will educate all nurses on appropriate procedure for labeling and storage of medication utilizing the Policies: “Storage of Medications”, “Medication Administration", and “Discontinued Medications". This will be completed on or before the date of compliance. **The facility will monitor the corrective actions to ensure the deficient practice will not recur as follows** The DON/Designee will complete an audit utilizing 3x weekly for 1 month then monthly x6 months of	

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	resident who had been discharged on 11/1/2021. During an interview, on 11/9/2021 at 2:51 P.M., QMA 4 indicated there should have been a label on the Ambesol, the loose pills should not be in the cart, and the medication for the discharged resident should have been taken out when discharged. On 11/10/2021 at 12:11 P.M., Regional Nurse 2 provided the policy titled, "Storage of Medications", undated, and indicated the policy was the one currently used by the facility. The policy indicated..."2... Medication rooms, carts, and medications are locked when not attended by persons with authorized access. 3. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. 4. Orally administered medication are kept separate from externally used medications and treatments such as suppositories, ointments, creams, vagina products, etc. 8. Medication storage areas are kept clean.... Expiration Dating (Beyond-use dating) 5. When the original seal of a manufactures container or via is initially broken, the container or vial will be dated. a). The nurse shall place a "date opened" sticker on the medication and enter the dated opened....." On 11/12/2021 at 9:45 A.M., Regional Nurse 2 provided the policy titled," Medication Administration", dated 4/20/2017, and indicated the policy was the one currently used by the facility. The policy indicated"...II Safety Precautions: c. Lock medication cart when not in the immediate vicinity of the cart. V. Return cart to medication room after completion of medication pass. b. Return discontinued and outdated drugs for credit. d. Return unused drugs to pharmacy. e. Pull medications as soon as possible from cart		the medication storage utilizing. "Medication Storage and Labeling" to ensure proper labeling and storage of medications. The DON/Designee will complete an audit 1x week for 2 month of the medication utilizing medication storage audit to ensure proper storage of medications. The Director of Nursing will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	

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	when resident is discharged...." On 11/12/2021 at 9:45 A.M., Regional Nurse 2 provided the policy titled, Discontinued Medications", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...When medications are discontinued by the prescriber or the resident is discharged and medications are not sent with the resident, the medications are stored in a secure and separate area from the active medications. 2. Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue(to avoid inadvertent administration). 3.1-25(j)(m)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	155496	A. BUILDING 00 B. WING	11/12/2021

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure foods in the refrigerator and freezer were labeled, dated, and monitored for "used by dates". (Main Kitchen) This had the potential to affect 84 of 85 residents who received meals from the kitchen. Findings include: 1. During the initial tour of the kitchen with the Registered Dietitian, on 11/4/2021 beginning at 9:45 A.M. and ending at 10:30 A.M., the following were observed: a. The refrigerator had a container of cheese slices with no label, an open container of yogurt dated with marker as 11/1/21 that had a "best used by" date of 10/31/2021. There were six more yogurt containers with a "best used by date" of 10/31/2021, two unopened gallons of milk dated 11/3/2021, a thickened dairy drink open without a date. On 11/4/2021 at 9:50 A.M., the (RD) Registered Dietitian indicated that the items should have been labeled and the expired items should not have been used. She removed all the items. b. There was an open box of pre-cooked chicken and a box of bacon without a date, a zip lock bag with lunch meat dated 10/29/21 to be used by 11/15/21. On 11/4/2021 at 10:05 A.M., the RD indicated that she believed the lunch meat had a 7 day expiration date not 18 days. The meat was removed.	F 0812	**F 812** **Food Procurement, Store/Prepare/Serve-Sanitary** **CFR(s): 483.60(i)(1)(2)** The items identified in the refrigerator and freezer that were not labeled, dated, and monitored for "used by dates" were immediately removed. No harm occurred with alleged deficient practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** All residents have the potential to be affected. An audit was conducted of the refrigerator and freezer to ensure all food was labeled, dated, and not overdue for usage. **The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur are as follows:** Registered Dietician will complete in-service with dietary staff members to ensure understanding and compliance with policies regarding" Food Storage and Retention Guide" and "Food Storage: Cold Foods" on and before the date of compliance. **The facility will monitor the corrective actions to ensure the**	12/09/2021

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	c. The freezer had a zip lock bag of chicken nuggets dated 6/11/21 and 6/24/21. On 11/4/2021 at 10:15 A.M., the RD indicated that product should not still be in the freezer and removed it. 2. During a second observation of the kitchen on 11/5/2021 beginning at 11:30 A.M., there were two open beverage cartons of Silk soy milk and Imperial thickened liquid drink in the refrigerator. On 11/5/2021 at 11:35 A.M., the District Manager indicated it should be labeled with an open date. A policy was provided by the District Manager, on 11/4/2021 at 11:39 A.M. titled, " ...Food Storage: Cold Foods", revised date 9/2017 and indicated the policy was the one currently being used by the facility. The policy indicated " ... 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. And policy titled, Food Storage and Retention Guide dated 2017. Ready to eat/prepared foods-food in a form that is edible without additional preparation to achieve food safety. Up to 7 days, day 1 is the day of preparation" .... 3.1-21(i)(l)		**deficient practice will not recur as follows** Registered Dietician/ Food Service Manger will monitor 3x weekly x1 month then monthly x6 months, refrigerator and freezers items utilizing, " Infection Prevention Rounds Checklist-Dietary Department" and then 2 x weekly x 1 month utilizing, " Infection Prevention Rounds Checklist-Dietary Department." The Registered Dietician will report all findings to the QA committee monthly. The QAPI committee will review systematic changes, effectiveness and continued compliance at least one time monthly and determine if ongoing monitoring is required.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §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.			

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

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	must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	A. Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 by not ensuring staff and visitors were wearing the appropriate personal protective equipment in designated Yellow isolation rooms of the facility during an outbreak of COVID-19. This deficient practice affected 14 of 14 residents reviewed for infection control. (Residents 81, 28, 61, 87, 4, 138, 66, 22, 69, 41 and 31) (Room 107 A, 108 A, and 215 A) B. Based on observations, interview, and record reviews, the facility failed to properly prevent or/contain COVID-19 by failing to ensure handwashing practices were monitored, linens were bagged and transported appropriately and ensuring appropriate infection control practices	F 0880	**Directed Plan of Correction** **F880 483.80 Infection Prevention & Control (a)(1)(2)(4)(e)(f) 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 infection.A Root Cause Analysis (RCA) was conducted by the Infection Preventionist (IP), who provides with input from the Medical Director, DON / IP,**	12/09/2021

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	were implemented related to not fanning an area for glucose testing for 1 of 1 residents reviewed for glucose testing. (Resident 60) Findings include: 1. During an interview, conducted with the Executive Director (ED), on 11/4/21 at 9:55 A.M., he indicated the facility had 3 COVID-19 positive staff members and no positive residents. During an initial tour of the facility, conducted on 11/4/21 between 10:00 A.M. and 10:30 A.M., the following observations were made: A Yellow colored stop sign was posted on the door of Room 204 that indicated the room was in droplet transmission based precautions (TBP) and a N95 mask, faceshield, gown and gloves were required to enter the room. A certified nursing assistant (CNA) was observed entering the room without donning a gown or gloves. A Yellow colored stop sign was posted on the door of Room 210 that indicated Yellow droplet TBP's were in place for the Resident's of the room. Resident 81 was observed sitting in the hallway on a rollator with a surgical mask looped around her ears but positioned underneath her chin. During an interview, conducted with Resident 81, at that time, she indicated they told her she was in quarantine but she thought it was "bull****". She then propelled herself into her room. CNA 17 was observed in the 200 hall. She walked over to the entrance of Room 210, wearing a N95 and faceshield, she donned a gown and gloves and then entered the room without washing her hands. She performed duties in the room and doffed without washing her hands before exiting		**Executive Director and Regional Director of Clinical Operations to determine the root cause resulting in the facility's Infection Control Citation: · The Nursing Leadership team failed to provide education to the facility nursing staff, on the policies and procedures for proper use of PPE and/or enter any isolation/quarantine/resident care areas, including the proper sequence of donning and doffing PPE in all isolation carts/areas where appropriate, to ensure the protection/safety of both staff and residents. · The Nursing Leadership failed to provide education to the facility nursing staff, on the policies and procedures for proper hand washing to ensure the protection/safety of both staff and residents.· The Nursing Leadership failed to provide education to the facility nursing staff on the policies and procedures of Infection Control Practices of Laundry/Linens to ensure the protection/safety of both staff and residents. · The Nursing Leadership failed to ensure nurses were educated on the correct procedure for obtaining a blood sample for a glucometer check.· The facility lacks routine rounding**	

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	the room. On 11/4/21 at 1:00 P.M., CNA 24 entered Room 204 to provide a lunch tray with a surgical mask, faceshield and no other PPE. Room 204 was designated to be a Yellow droplet isolation room. On 11/4/21 at 2:48 P.M., a medical professional, entered Room 110, a room designated by signage to be in Yellow droplet isolation precautions, wearing a white lab coat, mask and faceshield. He did not donn a gown or gloves prior to entering the resident's room. On 11/5/21 at 9:25 A.M., Resident 138 was observed walking in the hallway with a staff member, he dropped his surgical mask on the floor, picked it up and placed it on his face before continuing to walk to his destination with the staff member. On 11/5/2021 between 10:30 A.M. and 11:30 A.M., Resident 81 was observed in the 200 hall sitting on a rollator, wearing a purple coat with the hood up and propelling herself toward the front of the building. Resident 81 was interviewed at that time and asked if she was still in isolation precautions, she stated facility staff told her she was but she thinks they don't know what they are talking about. She was not wearing a mask at that time. She then turned around and propelled herself to her room. On 11/5/21 between 10:30 A.M. and 11:30 A.M., Qualified Medication Aide (QMA) 9 entered Room 210 B to administer medications. He was wearing a surgical mask and faceshield he did not donn a gown or gloves prior to entering the room. During an interview, that was conducted at that time, he indicated the Residents residing in Room		**and correction of infection control practices deficiencies. The solutions and systemic changes developed by the Division (Consultant IP), DON / IP and Regional Director of Clinical Operations include: · The Director of Nursing/IP or designee will education to the facility nursing staff, utilizing the policy and procedure: "Infection Prevention Program" for proper use of PPE and/or enter any isolation/quarantine/resident care areas, including the proper sequence of donning and doffing PPE- return demonstration for competency utilizing Relias skills checklist- "Personal Protective Equipment". This will be completed on or before the date of compliance. · The Director of Nursing/IP or designee will education to the facility staff, utilizing the policy and procedure: "Standard Precautions" for proper hand hygiene. A return demonstration for competency will be completed utilizing Relias skills checklist- Hand hygiene. This will be completed on or before the date of compliance. · The Director of Nursing/IP or designee will education to the facility staff, utilizing the policy**	

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	210 were not in isolation precautions as he was told in report that they were not in transmission based precautions. He acknowledged the Yellow sign on the door but repeated he was told they were not in Yellow droplet isolation precautions. On 11/5/2021 during an interview, conducted with the Director of Nurses (DON), at 5:00 P.M., she indicated the facility had a total of 7 Resident's and 7 staff members who had tested positive for COVID-19. On 11/5/21 at 5:00 P.M., the clinical record for Resident 81, who resided in Room 210 A, was reviewed. During an interview, conducted with the Regional nurse, at that time, she indicated Resident 81 had been placed in Yellow TBP related to a possible exposure she may have had with a positive staff person on 11/2/21. She was not vaccinated for COVID-19. She indicated she tested positive during outbreak testing on 11/5/2021 and was being placed in the RED ZONE. On 11/5/21 at 5:00 P.M., the clinical record for Resident 28, who resided in Room 215 A, was reviewed. During an interview, conducted with the Regional nurse, at that time, she indicated Resident 28 had tested negative and placed in Yellow TBP related to a possible exposure she may have had with a COVID-19 positive staff member on 11/2/21. She indicated she was not vaccinated for COVID-19. She indicated she tested positive during outbreak testing on 11/5/2021 and was being placed in the RED ZONE. On 11/5/21 at 5:00 P.M., the clinical record for Resident 61, who resided in Room 207 A, was reviewed. During an interview, conducted with the Regional nurse, at that time, she indicated Resident 61 was tested as part of outbreak testing		**and procedure: "Infection Control Practices for Laundry/Linens" to ensure proper handling of linen. This will be completed on or before the date of compliance.** **The Director of Nursing/IP or designee will education to the nurses, utilizing the policy and procedure: "Obtaining Finger Stick Blood Glucose" to ensure proper procedure is followed while performing a finger stick for blood glucose. This will be completed on or before the date of compliance.** **The clinical leadership team will monitor through daily clinical meeting the review of documented COVID 19 symptoms, ensuring the appropriate COVID 19 assessments are completed and TBP are implemented. This process is on-going.** **The DON / IP, Executive Director, Division (Consultant) IP and Regional Director of Clinical Operations reviewed the LTC Infection Control Self-Assessment. Changes were made to the assessment so it would now be an accurate reflection of the facility.** **Corrective Action:1. The Director of Nursing/ Infection Preventionist will conduct in-services for all staff employed by the facility. The in-services will consist of**	

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	on 11/2/21 but tested negative. She was not placed in TBP at that time because she was fully vaccinated. She indicated she tested positive during outbreak testing on 11/5/2021 and was being placed in the RED ZONE. On 11/5/21 at 5:00 P.M., the clinical record for Resident 87, who resided in Room 204 A, was reviewed. During an interview, conducted with the Regional nurse, at that time, she indicated Resident 87 had tested negative and was placed in Yellow TBP related to a possible exposure she may have had with a positive staff member on 11/2/21. She indicated she was not vaccinated for COVID-19. She indicated she tested positive during outbreak testing on 11/5/2021 and was being placed in the RED ZONE. On 11/5/21 at 5:00 P.M., the clinical record for Resident 4, who resided in Room 107 B, was reviewed. During an interview, conducted with the Regional nurse, at that time, she indicated Resident 4 had tested negative and was placed in Yellow TBP related to a possible exposure he may have had with a positive staff member on 11/2/21. She indicated she was not vaccinated for COVID-19. She indicated she tested positive during outbreak testing on 11/5/2021 and was being placed in the RED ZONE. On 11/5/21 at 5:00 P.M., the clinical record for the newly admitted resident, who resided in Room 108 A, was reviewed. During an interview, conducted with the Regional nurse, at that time, she indicated this resident had been tested as part of outbreak testing on 11/2/21 but not placed in TBP related to being fully vaccinated for COVID-19. She indicated she tested positive during outbreak testing on 11/5/2021 and was being placed in the RED ZONE.		**training on implementation of COVID 19 infection control policies and procedures.** **2. The facility will conduct in-services for staff involved are educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection.** **3. Ensure staff involved are educated, with return demonstration, for hand hygiene (hand washing and ABHS) and understand when to perform hand hygiene. Follow CDC guidance and facility policy. Ensure Hand Hygiene items, including soap and water or ABHS are available at all times.** **4. Ensure staff involved are educated on proper transportation or soiled and clean linen to prevent cross contamination during the transportation of linen. Staff are also educated on laundry policies related to soiled or contaminated linen. Follow CDC and facility policy.** **5. The Director of Nursing/ Designee will provide education Ensure staff involved**	

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	On 11/5/21 at 5:00 P.M., the clinical record for the newly admitted Resident, who resided in Room 107 A, was reviewed. During an interview, conducted with the Regional Nurse, at that time, she indicated this resident had been tested as part of outbreak testing on 11/2/21 but not placed in TBP related to being fully vaccinated for COVID-19. She indicated she tested positive during outbreak testing on 11/5/2021 and was being placed in the RED ZONE. On 11/5/21 at 5:00 P.M., the clinical record for the newly admitted Resident, who resided in Room 215 A, was reviewed. During an interview, conducted with the Regional Nurse, at that time, she indicated this resident had been tested as part of outbreak testing on 11/2/21 but not placed in TBP related to being fully vaccinated for COVID-19. She indicated she tested positive during outbreak testing on 11/5/2021 and was being placed in the RED ZONE. On 11/8/21 at 10:00 A.M., the clinical record for Resident 138 was reviewed. During an interview, with the Regional Nurse, she indicated Resident 138 was fully vaccinated for COVID-19. He had tested negative on 11/5/21 during outbreak testing but began exhibiting symptoms of a runny nose and congestion on 11/6/21. He tested positive for COVID-19 and was placed in the RED ZONE. On 11/8/21 at 10:00 A.M., the clinical record for Resident 66 was reviewed. During an interview, with the Regional Nurse, she indicated Resident 66 was fully vaccinated for COVID-19. He had tested negative on 11/5/21 during outbreak testing but began exhibiting symptoms of congestion on 11/7/21. He tested positive for COVID-19 and was placed in the RED ZONE.		**are educated on infection control practices regarding glucometer use.** **6. Training will be conducted by a clinician certified in infection control. Clinician will submit credentials to State Survey Agency, at request. 7. The facility will ensure adequate supplies of Alcohol base hand sanitizing stations are readily available to all staff and applicable to their duties and responsibilities. 8. The DON, IP, and/or designee will complete and document visual rounds of staff for compliance with infection control policy and procedures (including for in-service areas listed above). These rounds will be conducted weekly for six weeks and monthly thereafter. Any staff found through the monitoring process to have failed to follow facility policy and procedure will receive 1:1 Instruction from the DON and/or IP as appropriate. 9. The facility will conduct a root cause analysis (RCA) which will be done with assistance for the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated in the intervention plan. 10.**	

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	On 11/8/21 at 10:00 A.M., the clinical record for Resident 22, who resided in Room 112 B, was reviewed. During an interview, conducted with the Regional Nurse, at that time, she indicated this resident had been tested as part of outbreak testing on 11/2/21 and 11/5/21 and tested negative, she was not vaccinated and had been placed in TBP, but began exhibiting symptoms of headache and runny nose on 11/7/21 she tested positive for COVID-19 and placed in the RED ZONE. On 11/9/21 at 11:00 A.M., the clinical record for Resident 69, who resided in Room 111-A was reviewed. During an interview, conducted with the Regional Nurse, at that time, she indicated this Resident was fully vaccinated for COVID-19, she had been placed in TBP, tested negative on 11/2/21 and 11/5/21 but tested positive on 11/9/21 as part of outbreak testing. She was asymptomatic and had a PCR sent to the lab. On 11/9/21, at 11:00 A.M., the clinical record for Resident 41, who resided in Room 205 A was reviewed. Resident 41 was fully vaccinated for COVID-19. He had tested negative on 11/2/21 and 11/5/21 for outbreak testing but tested positive on 11/9/21 and was placed on the RED ZONE. On 11/9/21, at 11:00 A.M., the clinical record for Resident 31 who resided in Room 211 A was reviewed. Resident 31 had been placed in TBP on 11/2/21 after testing negative for COVID-19 for a possible exposure from a positive staff member. He tested negative on 11/5/21 but on 11/9/21 began exhibiting symptoms of increased mucous and cough and tested positive. During an interview, that was conducted with the		**Immediately implement an appropriate infection prevention and intervention plan, which includes the RCA, consistent with the requirements of 483.80 for the affected residents/halls identified in the deficiency.11. The Administrator and/or designee shall ensure all current employees are educated on the systems, policies and procedures required to be developed and implemented by this directed plan of correction (DPOC)12. The DPOC shall be completed by 12/9/21 The Director of Nursing or designee will complete the following audits / observations to ensure compliance:** **The DON, IP, or designated facility leadership will conduct full facility department rounds at a minimum of daily for 6 weeks and until compliance is maintained: to ensure staff are wearing PPE appropriately while in the facility and enforce corrective measures and education if deficiencies are observed.** **The DON, IP, or designated facility leadership will complete daily full facility department rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and ensure**	

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	155496	A. BUILDING 00 B. WING	11/12/2021

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	DON, on 11/8/21 at 10:30 A.M., she indicated that the staff had been educated with regard to personal protective equipment. She indicated the facility management staff had monitoring in place for mask wearing, donning and doffing and handwashing. She indicated visitors who enter the facility had to adhere to the same personal protective equipment protocols as staff. A Policy, titled "Infection Prevention Program", with a revision date of 3/5/21, was provided by the DON on 11/8/21 at 9:50 A.M., was reviewed on 11/10/21 at 2:00 P.M.. The policy indicated "...B. Surveillance of Infections i. There is on-going monitoring of infections for residents and employees and follow up documentation. ii. Prevention of spread of infections is accomplished by education and implementation for the use of hand hygiene, standard precautions, and transmission based precautions as appropriate, with treatment and follow up, and employee work restrictions for illness. C. Education: i: Staff and resident education focuses on risk of infection and practices to decrease risk including but not limited to hand hygiene compliance and cough/sneeze etiquette to break chain of infection. Education to staff on donning and doffing of personal protective equipment is a focus of the infection prevention program D. Policy & Procedure i: Policies, procedures and aseptic practices are followed by employees in performing procedures and in disinfection of equipment...." 2. During a random observation on 11/05/2021 at 10:40 A.M., in room 307 there were dirty bed pads on the floor with an aide standing by the bed. CNA (Certified Nursing Assistant) 10 picked up the dirty wet pads and walked down the hallway will the pads not bagged and placed them in the dirty room.		**proper and hygiene is being performed. This will occur for 6 weeks and until compliance is maintained.** **The DON/ Designee will monitor x3 nurses a week x 6 weeks, weekly x3 months, then monthly x3 months to ensure proper procedure for completing a blood glucose check utilizing "Obtaining Finger Stick Blood Glucose Checklist."** **The DON/ Designee will monitor x3 CNAs a week x 6 weeks, then 3 CNA's monthly x6 months to ensure proper procedure utilizing, "Infection Control Practices for Laundry/Linens Checklist"** **The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA, daily or more often as necessary for 6 weeks for no less than 6 months or until compliance is maintained. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified in as above. This will occur for 6 weeks and until compliance is maintained and for 6 months of citation. Quality Assurance and Performance Improvement (QAPI): The facility through the**	

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	During an interview on 11/5/2021 at 10:43 A. CNA (Certified Nursing Assistant) 10 indicated the pads should not be on the floor. 3. During a random observation on, 11/5/2021 at 10:55 A.M., a resident exited an isolation room wheeling down the hallway without a face mask on. During an interview, on 11/5/2021 at 10:56 A.M., CNA 10 indicated the resident should have had a mask on. 4. During a random observation, on 11/9/2021 at 7:10 A.M., CNA 12 was observed carrying unbagged dirty linens down the hall with gloves on. CNA 12 indicated he could not find any bags. CNA 12, without removing the gloves and washing his hands walked back to a resident in the hall way and started to push the resident towards the dining room. 5. During an observation on 11/9/2021 at 7:45 A.M., of Resident 60's glucose test, the following was observed: QMA (Qualified Medication Aide) 4 used an alcohol pad to wipe the residents finger. She then fanned the area with her open hand to dry the area. During an interview, on 11/9/2021 at 7:48 A.M., QMA 4 indicated she should not have fanned the area after cleaning it. 6. On 11/9/2021 at 8:10 A.M., QMA 4 was observed to put on an isolation gown and gloves and enter Resident 45's room. QMA 4 administered medications to Resident 45 in an isolation room. After administering the medications. QMA 4 removed her gown, gloves		**QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.**	

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	and face mask and placed them in the trash in the residents' room. She then exited the room and retrieved a new face mask from the PPE (personal protective equipment) bin outside of the residents room. QMA 4 did not wash her hands prior to leaving the residents room. During an interview, on 11/9/2021 at 8:15 A.M.,QMA 4 indicated she should have washed her hands prior to leaving the residents room. On 11/12/2021 at 9:45 A.M., Regional Nurse 2 provided the policy titled," Infection Control Practices for Laundry/Linens", dated 6/21/2021, and indicated the policy was the one currently used by the facility. The policy indicated"...III. Transportation of Linen. b. Soiled linen shall be transported in covered carts or closed bags; if transporting in closed bags, the bags should not touch the floor during transport...." On 11/12/2021 at 9:45 A.M., Regional Nurse 2 provided the policy titled," Standard Precautions", dated 4/1/2017, and indicated the policy was the one currently used by the facility. The policy indicated...II. When to perform Hand Hygiene. C. After contact with blood, body fluids or excretions, mucous membranes, non- intact skin, or wound dressings. ...F. For care between residents. G. After glove removal. On 11/9/2021 at 11:38 A.M., Regional Nurse 2 provided the policy titled, "Obtaining Finger Stick Blood Glucose", dated 4/20/2017, and indicated the policy was the one currently used by the facility. The policy indicated"...VI. Clean fingertip with alcohol preparation and allow to dry...." 3.1-18(b)			