DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall **DATE SURVEY COMPLETED: August 3, 2021**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.		
	An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from July 19, 2021 through August 3, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 78. The survey sample totaled 44 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**		
	This requirement was not met as evidenced by: Cross Refer to the CMS 2567 – L survey completed August 3, 2021: F582, F600, F609, F610, F657, F684, F688, F689, F692, F695, F756, F757, F801, F812, F842, F880, F883 and F943.	Cross Refer to the CMS 2567 – L survey completed August 3, 2021: F582, F600, F609, F610, F657, F684, F688, F689, F692, F695, F756, F757, F801, F812, F842, F880, F883 and F943.	10/01/21
	A waiver by Order of the Department of Health		

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	and Social Services documented that, "Pursuant to the authority established in Governor John Carney's Declaration of a State of Emergency…the Division of Public Health, on behalf of the Department of Health and Social Services, the waivers of the regulatory requirements for Skilled and Intermediate Care Facilities…that went into effect April 9, 2020 and September 16, 2020… Skilled Care and Intermediate Care Facilities…Waiver was rescinded as of July 13, 2021."		
	Specific Requirements for Tuberculosis		
3201.6.9.2	**The facility shall have on file the results of tuberculin testing performed on all newly placed residents.**		
3201.6.9.2.3	This requirement was not met as evidenced by: Based on interview and review of the facility's documentation, it was determined that for one (R38) out of five residents reviewed for immunization requirements, the facility failed to ensure that R38's medical record included evidence of tuberculosis test results. Findings include: 8/3/21 - Review of R38's electronic immunization record in PCC (Point Click Care) revealed that the facility lacked evidence that a tuberculosis (TB) test was performed on R38 upon admission. 8/3/21 2:00PM - Interview with E1 (NHA) and E2 (DON) confirmed that the facility lacked evidence that R38 received TB testing upon admission. **Minimum requirements for pre-employment tuberculosis (TB) testing require all employees**	1. R38 is deceased. 2. Infection Preventionist or designee will review records for all residents and staff to determine other residents or staff who may have a TB test missing. 3. Root Cause analysis has identified additional training and staff turnover of Infection Preventionist as the root cause. TB Testing Procedure (attached State POC 3201.6.9.2) has been revised to include "Infection Preventionist or designee will review all new resident admissions within 7 days to ensure TB status is completed," and also "Payroll Manager will be responsible to ensure that no new hires are permitted to work prior	10/1/21

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3201.6.9.2.4	**to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** While the requirement for a two-step test is waived, facilities must complete a one-step TB test upon employment. This requirement was not met by: Based on interview and review of the facility's documentation, it was determined that for two (E26 and E31) out of 15 employees reviewed for pre-employment personnel requirements, the facility failed to ensure that E26 and E31 met the minimum pre-employment requirement for tuberculosis screening. Findings include: The following facility documentation was reviewed: - E26 lacked evidence of one step baseline tuberculosis screening prior to starting employment on 5/29/21. - E31 lacked evidence of one step baseline tuberculosis screening prior to starting employment on 9/14/20. 7/27/21 at 12:30 PM – In an interview, E23 (HR) confirmed with the surveyor that the facility	to receipt of evidence that the employee has been screened for TB." Interview/Hiring Checklist (attached "Interviewing/Hiring Checklist") will include either Receipt of a negative Chest X-Ray and completed TB questionnaire; or negative lab results and completed TB questionnaire; or negative 1st step PPD results are received prior to 1st day worked in the facility. DON or designee will in-service Infection Preventionist, Admissions Director and hiring managers on changes to procedure and new hire checklist. E26 has completed the 2 step PPD and is negative. E31 has completed a negative TB questionnaire and will produce a chest Xray before October 1st. 4. Administrator or designee will review a sampling of 3 new hires and new admissions (if there are any) weekly until there are 3 consecutive weeks with 100% compliance. After that Administrator or designee will review a sampling of 3 new hires or admission (if there are any) monthly until there are 3 months with 100% compliance. Once 3 months are 100% compliant, the monitoring will conclude. Results will be reported to QAPI.	

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	lacked evidence of E26 and E31's 1st step baseline TB screen. 8/3/21 at 1:00 PM - Findings were discussed with E1 (NHA). Findings were reviewed with E1 and E2 during the exit conference on August 3, 2021 at approximately 5:30 PM.		
	Health and Safety **Regulatory Provisions Concerning Public Health** **Long Term Care Facilities and Services**		
16 Del. C. Chapter 11 § 1144	Influenza Immunizations (a) Nursing and assisted living facilities shall annually offer, beginning no later than October 1 and extending through March 1 of a calendar year, onsite vaccinations for influenza vaccine to all employees with direct contact with patients at no cost and contingent upon availability of the vaccine. (b) The facility shall keep on record a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted or declined such vaccination. (c) Employment will not be contingent on influenza immunization. This requirement was not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to provide evidence that the facility offered the annual influenza vaccines to five (E25, E28, E34, E36 and E38) out of 15 employees reviewed for annual influenza		10/1/21

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	vaccination. Findings include: 8/2/21 at 3:25 PM – In an email correspondence, the surveyor requested evidence of annual influenza vaccination or refusal for the sampled employees including E25 (Activity Aide), E28 (CNA), E34 (LPN), E36 (Housekeeper) and E38 (CNA). Review of documentation provided by the facility revealed that E25, E28, E34, E36 and E38 lacked evidence of the annual influenza vaccination or refusal documentation from October 1, 2020 through March 1, 2021. 8/3/21 at 1:00 PM –Findings were discussed with E1 (NHA). Findings were reviewed with E1 and E2 during the exit conference on August 3, 2021 at approximately 5:30 PM.	1. No residents were affected. A review of resident records reveals that here no cases of influenza in the facility. 2. No residents were affected. A review of resident records reveals that here no cases of influenza in the facility. 3. Root Cause Analysis for missing documentation of Influenza vaccination has been identified as additional training and changeover in the Infection Preventionist position. The Influenza Vaccine for Staff Policy (attached State POC 16 Del C. Chapter) was revised by the DON to include "Infection Preventionist will review staff immunization records monthly to track progress and timing of vaccines and report results to DON." DON or	

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		designee will in-service Infection Preventionist to changes to the policy. 4. Monitoring will begin once flu season starts on October 1, 2021. A sampling of 3 employees flu vaccines will be reviewed weekly by DON for completion until 3 weeks are found to be 100% compliant. Then, a sampling of 3 employee flu vaccines will be reviewed monthly by DON for completion until 3 months are found to be 100% compliant. Once there has been 3 months of 100% compliance, monitoring will be completed. Results of monitoring will be reported to QAPI.	

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	085047	A. BUILDING ______ B. WING ______	C 08/03/2021

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning July 19, 2021 through August 3, 2021 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 78. For the Emergency Preparedness survey, all contracts, operations plan, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from July 19, 2021 through August 3, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 78. The survey sample totaled 44 residents. Abbreviations/definitions used in this report are as follows: ADL (activities of daily living) - activities including dressing, eating, bathing, and caring for oneself; ADON - Assistant Director of Nursing; BIMS - (Brief Interview for Mental Status) - test to measure thinking ability with scores ranging from 00 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment; CNA - Certified Nurse's Aide; contracture - a permanent shortening of muscle,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/01/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 tendon or skin, as a result of disuse, injury or disease; COPD (Chronic Obstructive Pulmonary Disease) - condition involving constriction of the airways and difficulty or discomfort in breathing; COTA - Certified Occupational Therapy Assistant; DON - Director of Nursing; Glucometer - medical device that helps to measure glucose or sugar levels in the blood; (HgbA1c) - laboratory test for diabetes management; LPM - liters per minute; LPN - Licensed Practical Nurse; Lumbar spine - region of the lower spine; MAR - Medication Administration Record; MDS (Minimum Data Set) Assessment - assessment tool used in long term care facilities; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Oxygen (O2); oxygen concentrator - a type of medical device used for delivering oxygen to individuals with breathing-related disorders; oxygen saturation - the amount of oxygen in the blood stream; PCV13 (pneumococcal conjugate vaccine) - Pneumonia vaccine; PNP - Psychiatric Nurse Practitioner; POA (Power of Attorney) - someone appointed to make decisions on your behalf; POC (Point of Care) - electronic charting; PPSV23 (pneumococcal polysaccharide vaccine) - Pneumonia vaccine; Range of motion (ROM) - the measurement of the amount of movement around a joint in the body; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator;	F 000		

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F 000	Continued From page 2 Splint - device provided to people who need protection and support for painful, swollen or weak joints and their surrounding structures. Splints ensure that your wrist and hands are positioned correctly; TAR - Treatment Administration Record; Thoracic spine - region of the spine between the neck and abdomen; Transverse process - a bony protrusion from the back of a vertebrae bone in the spine and there is one on each side of every vertebrae of the thoracic and lumbar spine; Vertebrae - each of the series of small bones forming the backbone.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews and review of other facility documentation it was determined that the facility failed to ensure that all residents were free from sexual abuse when one (1)	F 600	1. Resident R42 has advanced dementia and has received 1 on 1 supervision since 10/31/19 and has no further instances of abuse.	10/1/21

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F 600	Continued From page 3 resident (R42) out of 44 sampled residents sexually abused two residents over a two month period. R42 was a resident with a known history of inappropriate sexual behaviors towards female residents and the facility failed to prevent further sexual abuse until after the 10/31/19 incident with R281 when the police became involved and 1:1 staff supervision was implemented. During the survey, R42 was non ambulatory. Findings include: The facility's policy titled Resident Abuse Policy/Procedure, last reviewed by E1 (NHA) on 6/23/21 stated: "...4. Identification. a. For the purposes of this procedure abuse, neglect or mistreatment may be suspected in, but not limited to, the following situations...II. Physical Abuse: Intentionally and unnecessarily inflicting pain, injury, or degradation to a resident. This includes, but is not limited to hit...or sexually molest any resident...". The following was reviewed in R42's clinical record, other clinical records and in other facility documents reviewed: 11/7/16 - R42 admitted to the facility. 5/3/19 - The quarterly MDS assessment documented a BIMS score of 4 indicating severe cognitive impairment, no behavioral symptoms, was independent with walking, was independent with locomotion on the unit and required supervision off the unit. 5/28/19 at 3 PM - An Incident Report was completed in which it was reported to the charge nurse that R42 put his hand on the breast of a	F 600	2. Resident was placed on 1 on 1 supervision since 10/31/19 and no other residents have been affected. 3. Resident Abuse Policy and Procedure has been revised (attached F600-1) Incidents regarding resident to resident abuse will be reviewed by clinical team; a care plan review will be conducted and appropriate interventions will be escalated according to the nature of the resident to resident abuse. Staff Development Director or designee will in-service all staff regarding these changes. 4. DON or designee will review all reports of resident to resident abuse weekly until there are 3 consecutive weeks with 100% compliance to ensure that the clinical team reviewed the incident and that the care plan was revised and updated to prevent future occurrences. After that, DON or designee will review all reports of resident to resident abuse monthly until there are 3 consecutive months with 100% compliance to ensure that the clinical team reviewed the incident and that the care plan was revised and updated to prevent future occurrences. After 3 months with 100% compliance, the monitoring will be concluded. Results to be reported to QAPI.	

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F 600	Continued From page 4 female resident; the incident was witnessed by a family member as well as the Staff Coordinator (E46). The facility's corrective action was to have R42 attend a Safety Program from after breakfast to 4 PM and from 4 PM to 8 PM to have close supervision. 6/16/19 3:15 PM - An Incident Note documented "At 1100 a.m. Resident was at the safety program when he approached another female resident who was lying in the recliner and attempted twice to put his hand in the brief. Safety Program aid were passing out snacks when they noticed him. The staff was able to redirect R42 successfully." 6/17/19 7:44 AM - A Nurse's Note documented that E10 (PNP) ordered to increase an anti-depression medication. 6/28/19 3:40 PM - A Nurse's Note documented to discontinue the Safety Program. Although the Safety Program was discontinued, there was lack of evidence of new interventions to prevent further sexual abuse by R42. 8/3/19 1:48 PM - A Nurse's Note documented that E47 (Housekeeper) saw R42 touching a female resident, R280 in the breast area and that a nurse immediately separated the resident (R42). A call was placed to R42's POA (Power of Attorney) and E2 (DON) was notified. In addition, the Psychiatric Nurse Practitioner (E10) was notified to evaluate the resident during her next visit. 8/7/19 - The facility's Incident Report stated the corrective actions included to approach R42 in a calm manner and to redirect as necessary, discuss behavior and why it was not acceptable,	F 600		

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F 600	Continued From page 5 guide resident away from situation as necessary, redirect resident when he was being sexually inappropriate, and visual checks every hour. 10/31/19 2:58 PM - An Incident Note documented that it was reported to E10 (LPN) that R281 was touched in the private area by R42. R42 had already been separated when the incident was reported. E48 (CNA) was the assigned CNA who witnessed the incident. Call placed to POA and she was made aware. E2 (DON) also notified E10 (PNP) and E10 ordered to increase the anti-depressant medication. 10/31/19 - Review of the CNA documentation for visual checks every 30 minutes from 7 AM to through 11:30 PM lacked evidence that this intervention was carried out. 8/3/21 1:50 PM - An interview with E2 (DON) and E3 (ADON) was held and the above findings were reviewed. E2 stated that after the 10/31/2019 incident, R42 has been on continuous 1:1 staff supervision. 8/3/21 2:15 PM - An interview with E45 (Therapy Director) revealed that E42 was unable to independently stand or walk at this time. 8/3/21 at 5:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		10/1/21

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F 609	Continued From page 6 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the State of Delaware Division of Health Care Quality (DHCQ) Incident Report program, it was determined that for one (R42) out of four residents reviewed for abuse, the facility failed to ensure that an allegation of abuse was immediately reported. Findings include: Cross refer F600 The facility's policy entitled, "Resident Abuse Policy/Procedure - Investigating and Reporting",	F 609	1. Resident R42 has advanced dementia and has received 1 on 1 supervision since 10/31/19 and has no further instances of abuse. 2. Resident R42 was placed on 1 on 1 supervision since 10/31/19 and no other residents have been affected. DON has reviewed all open investigations and no other residents have been affected. 3. Resident Abuse Policy and Procedure has been revised on 7/28/21(attached F600-1) to include reporting "reasonable	

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F 609	Continued From page 7 last revised on 12/15/14, stated, " ... C. Administrator/Director of Nursing or designee will be responsible for overseeing incident report procedures and ensuring proper authorities are notified of above incidents." Review of R42's clinical record and facility documents revealed the following: 5/28/19 at 4:00 PM - The facility's incident report stated that R42 put his hand on another resident (R19) touching her breast. R42 was redirected by staff with no success. 5/30/19 - Review of the DHCQ's Incident Report Program revealed that R42's allegation of abuse was reported two days after the incident. 8/3/21 at 1:40 PM - During an interview with E2 (DON) and E3 (ADON), it was confirmed that the facility failed to report R42's allegation of abuse on 5/28/19 in a timely manner to the State Survey Agency. 8/3/21 at 5:25 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2.	F 609	suspicion of crime" to local law enforcement and DHCQ within 2 hours. Staff Development Director or designee will in-service all staff regarding these changes. 4. DON or designee will review all reports of resident to resident abuse weekly until there are 3 consecutive weeks with 100% compliance to ensure that reporting was made within the 2 hour time requirement if a crime was reasonably suspected. After that, DON or designee will review all reports of resident to resident abuse monthly until there are 3 consecutive months with 100% compliance to ensure that reporting was made within the 2 hour time requirement if a crime was reasonably suspected. After 3 months with 100% compliance, the monitoring will be concluded. Results to be reported to QAPI.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		10/1/21

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F 610	Continued From page 8 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation as indicated, it was determined that for two (R42 and R50) out of four sampled residents reviewed for allegation of abuse, neglect and/or mistreatment, the facility failed to have evidence that the allegations involving R42 and R50 were thoroughly investigated. Findings include: The facility's policy entitled, "Resident Abuse Policy/Procedure - Investigating and Reporting", last revised on 12/15/14, stated, " ...A. Facility will thoroughly investigate any incidents reported regarding the identification of incident as listed above ...B. The facility will investigate all incident reports based on information obtained from witness statements, caregiver statements, and interviews as available." 1. Cross refer F600 5/30/19 4:00 PM - The facility's incident report stated, " ...The incident was witnessed by a staff member, she wrote in her statement, that another family member [F2] who was visiting [R80] came into the fish bowl and said a man had his hands down a woman's shirt touching her breast, [E46]	F 610	1.1 Main witness F2 is deceased. 1.2 R50's onset of pain occurred acutely in the afternoon of 6/14/21, and she was seen walking normally without pain on 6/14/21 her onset of pain in the afternoon, therefore an interview of E8 who worked 6/13/21 was not necessary. E8's termination date is not relevant. 2.1 & 2.2 DON or designee will review active incidents of residents who may have experienced abuse or injuries with unknown origin to ensure statements are collected from all witnesses and a thorough investigation has been completed. 3. Root Cause was determined to be the need for additional training for staff on the "Internal Resident Incident Report Procedure". Internal Resident Incident Report Procedure (attached F610-1) has been revised by DON to include "Charge Nurse is responsible for collecting statements from witnesses to the incident that may include residents, staff or visitors," and "ADON or designee will review statements and incident reports to ensure that all witness statements are	

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F 610 Continued From page 9

went out to the front hall, she saw [R42] sitting next to [R19], [E46] tried to move [R42] away but he refused to move, so [E46] move [R19] away from this resident. Resident has diagnosis of dementia."

The facility lacked evidence of a thorough investigation when the facility's incident report lacked an individual statement from the main witness to the alleged incident on 5/28/19.

5/30/19 12:04 AM - The facility reported the alleged abuse incident and 5 day follow-up to the State Survey Agency, however, they did not include an individual statement from the main witness.

8/3/21 2:35 PM - During an interview with E3 (ADON), it was confirmed that an individual statement from the main witness was not obtained.

2. The following was reviewed in R50's clinical records, the facility's incident investigation documentation, and the hospital's discharge summary:

6/15/21 3:53 AM - The facility reported to the State Agency an injury of unknown origin, in which on 6/14/21 at approximately 2:45 PM, R50 experienced an onset of pain, but was unable to state where the pain was due to her dementia. R50 was bent over when she was walking. E14 (MD) was notified and a physician's order was obtained to send R50 to the hospital for evaluation.

6/18/21 - R50 returned to the facility after treatments for multiple broken bones, including

F 610

collected." Staff Development or designee will in-service all staff on changes to procedure. Resident Abuse Procedure was revised to include under the "Protection" section: "To protect residents from further harm, an employee suspected in a case of abuse neglect or mistreatment will
be suspended immediately pending a thorough
investigation." (attached F943 and F610 Resident Abuse Procedure with Immediately added 9-17-21.pdf)
4. DON or designee will review all incident reports related to abuse, neglect or mistreatment weekly to ensure that witness statements are collected from relevant witnesses until there are 3 consecutive weeks with 100% compliance. After that, DON or designee will review all incident reports related to abuse, neglect or mistreatment monthly to ensure that witness statements are collected from relevant witnesses until there are 3 consecutive months with 100% compliance. After 3 months with 100% compliance, the monitoring will be concluded. Results to be reported to QAPI.

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the right rib and the thoracic and lumbar transverse processes of the spine. In addition, R50 received treatment for a urinary tract infection during the hospitalization.

6/20/21 - The facility's 5 day follow-up documented that R50 experienced a fall on 6/10/21 where she was found on the floor in the common shower, but did not have any injury or any complaints of pain after the fall until 6/14/21 when R50 had a new onset of pain and she was bent over. The facility concluded that R50 may have had another fall between 6/10/21- 6/14/21 and got herself up without telling anyone as she was cognitively impaired.

6/20/21 - Review of the facility's investigation revealed written statements from CNAs who provided care to R50 and did not include written statements from other staff, including the licensed nurses.

7/28/21 2:15 PM - An interview with E3 (ADON) revealed that she only requested written statements from CNAs who provided care to R50, but had not received all the written responses back. E3 confirmed that no statements were requested from the licensed nursing staff who provided care to R50. E3 confirmed that she was still awaiting a written response from E8 (CNA) who provided care to R50 on 6/13/21 from 7 AM to 3 PM, one day before the new onset of pain experienced by R50.

The facility failed to have evidence of a thorough investigation of an allegation of injuries of unknown origin when R50 had a new onset of pain and was found to have significant injuries.

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F 610	Continued From page 11 8/3/21 12:30 PM - Above findings reviewed with E2 (DON). E2 verbalized that E8 (CNA) was no longer worked at the facility and that was the reason for the lack of statement. The Surveyor requested for E8's date of last employment, however, no follow-up was received from the facility. 8/3/21 5:25 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		10/1/21

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F 657	Continued From page 12 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for two (R73 and R25) out of 44 sampled residents for Care Plan Review, the facility failed to ensure that the care plan was prepared by an IDT (Interdisciplinary Team) that included the attending physician or his/her designee, the nurse's aide with responsibility for the resident and a staff member from nutrition/food services. Findings include: 1. Review of R73's clinical records revealed the following: 1/21/21 - The Admission MDS (Minimum Data Set) Assessment was completed. 2/3/21 2:37 PM - E17's (RNAC) Plan of Care Note documented, "...Son requested to speak with dietitian regarding resident's menu and food choices; dietitican made aware via email...". 2/4/21 - Review of the resident record lacked evidence that R73's attending physician or designee, the nurse's aid responsible for the resident and a staff member from nutrition/food services participated in the care planning process. 6/24/21 12:44 PM - Meeting via phone conference before MDS Assessment was completed. E17's (RNAC) Plan of Care Note documented, "...Son is requesting resident be scheduled for eye appointment for glaucoma and complaints of eye pain to the son...scheduler	F 657	1. R73 and R25 will have evidence that all members of the IDT team including physician, CNA and nutrition have participated in their most recent care plan. 2. All residents may be affected. 3. Care Plan Policy (attach F657-1) has been revised by DON to include the "The interdisciplinary team will contribute to the care plan and these members include physician or designee, a registered nurse, a nurse aide, a member of food and nutrition, resident and/or representative and therapy as necessary." Staff Development or designee will in-service RNACS on these changes to policy. 4. DON or Designee will review a sampling of 3 Care Plans weekly to ensure all members have input into the care plan until there are 3 consecutive weeks with 100% compliance. After this, DON or designee will review a sampling of 3 care plans monthly until there are 3 consecutive months with 100% compliance. Once 3 consecutive months are found to be complaint, the monitoring will conclude. Results will be reported to QAPI.	

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F 657	Continued From page 13	F 657		

notified via email... ".

6/24/21 - Review of the resident record lacked evidence that R73's attending physician or designee, the nurse's aid responsible for the resident and a staff member from nutrition/food services participated in the care planning process.

6/28/21 - The Quarterly MDS Assessment was completed.

7/19/21 11:32 AM - In an interview, R73 stated that she wanted her son and son's wife to come up to her room when they visit her again. When asked if resident visitation was brought up during the careplan meeting discussions with any of the members of the interdisciplinary team, the resident replied that she was never invited to a care plan meeting. R73 stated, "I don't know, I have not been to any meetings."

7/22/21 2:10 PM - In an interview, E17 confirmed that the facility lacked written evidence that the above IDT members participated in the care planning process.

8/3/21 2:32 PM - During an interview, E19 (CNA) stated, "...Way before the pandemic started, the nurse's aids used to get invited to participate in meetings to talk about the residents condition. For now, I think they stopped asking."

2. Review of R25's clinical records revealed the following:

2/25/21- The Quarterly MDS Assessment was completed.

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F 657	Continued From page 14 2/25/21 - Review of the resident record lacked evidence that R25's attending physician or designee, the nurse's aid responsible for the resident and a staff member from nutrition/food services participated in the care planning process. 5/17/21 - The Annual MDS Assessment was completed. 7/21/21 10:17 AM - In a telephone interview with a family member during the survey screening process, F1 (Family Member) stated that the nurse's aid, staff from food and nutrition services and the attending physician did not attend the care plan meetings. In addition, F1 had to "pull a CNA to join the care plan meeting." 7/22/21 2:10 PM - In an interview, E17 (RNAC) confirmed that the facility lacked written evidence that the above IDT members participated in the care planning process. 8/3/21 2:26 PM - During an interview, E18 (CNA) stated that she knows her residents well and she always updates the nurses with any changes in resident status or any known preferences. E18 added, "Before they asked the nurse's aids to come to meetings, but it stopped. I go to the nurses more often than they come out to ask me questions about a resident." Findings were reviewed with E1 (NHA) and E2 (DON) on 8/3/2021 during the Exit Conference, beginning at 5:30 PM.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		10/1/21

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F 684	Continued From page 15 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of other documentation as necessary, it was determined that for one (R330) out of seven residents reviewed for accidents, the facility failed to ensure that hospital discharge orders regarding R330's range of motion (ROM) restrictions were followed after sustaining a broken hip. Findings include: Review of R330's clinical records revealed the following: 10/14/19 - R330 was sent to the emergency room after a fall and diagnosed with a broken hip which required surgery. 10/17/19 - R330 was discharged from the hospital with new orders for "posterior hip precautions (don't bend the hip past a 90-degree angle, such as bending at the waist; don't cross the legs; don't twist the operated hip inwards -keep knees and toes pointed upwards)." 10/2019 - The MAR/TAR showed no evidence that R330's ROM restrictions orders were followed. 11/2019 - The MAR/TAR showed no evidence	F 684	1. R330 is no longer a resident of Gilpin Hall. 2. All residents who return from the hospital with Physician Orders may be affected by this practice. 3. DON has revised the 24 Hour Chart Check Procedure (attached F684-1) to include "Residents returning from the hospital or new admissions will have a thorough review of medications and physician orders to ensure all orders are addressed correctly." Staff Development will in-service Nurses on changes to the 24 Hour Chart Check Procedure. 4. DON or Designee will review a sampling of 3 Physician Orders daily until there are 3 consecutive days with 100% compliance. After that DON or designee will review a sampling of 3 physician orders weekly until there are 3 consecutive weeks with 100% compliance. Once 3 consecutive weeks are 100% compliant, the monitoring will conclude. Results will be reported to QAPI.	

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F 684	Continued From page 16 that R330's ROM restriction orders were followed. 8/2/21 - Record review revealed the physical therapy (PT) "PT Evaluation & Plan of Treatment" record, dated 10/18/19 through 11/16/19, lacked evidence that the ROM restrictions for R330 were followed during therapy sessions. 8/2/21 - Interview with the Physical Therapy Director, E45, confirmed that R330s physical therapist did not document the restrictions in the physical therapy plan of treatment record for certification period: 10/18/19 through 11/16/19. 8/3/21 5:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		10/1/21

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F 688	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to ensure that a resident with limited range of motion (ROM) received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (R38) out of three (3) residents investigated for ROM. Findings include: Review of R38's clinical record revealed: 9/10/20 - R38 was admitted to the facility with left hand and wrist contractures. 11/19/20 - A signed Physician's Order located in R38's medical records stated, "...1) RNP Restorative NP [Nursing Program] left wrist/hand orthotic device (black splint) on daily in AM - skin check before and after donning [putting on splint]/doffing [removing splint]. 2) FMP [Functional Maintenance Program] - green splint on when in bed...". 12/8/20 (Last Revision Date) - A care plan was developed for limited physical mobility related to muscle weakness and left hand/wrist contractures. Interventions included a splint to the left hand/wrist as ordered and referrals to Physical and Occupational Therapy as ordered. 4/30/21 - A quarterly MDS assessment indicated R38 was cognitively intact for daily decision making and had an upper extremity ROM limitation on one side of the body. 7/1/21 through 7/31/21 - A review of R38's Active Physician's Orders included an original order	F 688	1. R38 is no longer a resident of Gilpin Hall. 2. All residents who have physician orders for splints will be reviewed by DON or designee to ensure that orders are followed correctly for splint use. 3. DON has revised the 24 Hour Chart Check Procedure (attached F684-1) to include "Residents returning from the hospital or new admissions will have a thorough review of medications and physician orders to ensure all orders are addressed correctly." Staff Development will in-service Nurses on changes to the 24 Hour Chart Check Procedure. 4. DON or Designee will review a sampling of 3 Physician Orders daily until there are 3 consecutive days with 100% compliance. After that DON or designee will review a sampling of 3 physician orders weekly until there are 3 consecutive weeks with 100% compliance. Once 3 consecutive weeks are 100% compliant, the monitoring will conclude. Results will be reportedhttps://web.qiesnet.org/AspenWeb/epoc/facility/poc/topBack?execution=e1s26&_eventId=back to QAPI.	

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dated 6/7/21 which stated, "...Rehab (rehabilitation): Occupational Therapy Eval (evaluation) and Treat as Indicated...".

There was no current order for the use of a left hand and/or wrist splint in the facility's Electronic Medical Records System, the source for all of the current Physician's Orders to be recorded.

7/1/21 through 7/20/21 - CNA documentation indicated that the black splint was removed at bedtime and a green splint was applied at night. There was lack of evidence that the green splint was removed in the AM [morning] and a black splint was applied as ordered for this same period of time.

7/21/21 11:52 AM to 7/23/21 9:46 AM - The following observations were made of R38:
- 7/21/21 11:52 AM: R38's left hand/wrist was without a splint. The Surveyor asked R38 "Do you wear a splint to the left hand and/or wrist?" R38 was unable to tell the Surveyor when the splint was worn. The Surveyor observed a green splint on top of the table in R38's room and R38 stated she wore the splint at night when she was sleeping.
- 7/22/21 10:33 AM: R38 was in bed and her left hand and/or wrist lacked a splint.
- 7/23/21 9:46 AM: R38 was observed sitting up in chair with a tan left wrist splint.

7/23/21 10:50 AM - A telephone interview with E12 (COTA) revealed that the tan left hand splint was discontinued in October 2020 and E12 confirmed that it should not have been applied to R38.

7/23/21 11:05 AM - A joint observation with E12

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(COTA) was conducted in which R38 was observed with a tan hand splint. E12 confirmed that R38 was wearing a splint that was discontinued in October 2020 and stated that she should be wearing a neutral thumb resting hand splint which was black in color. E12 proceeded to attempt to locate the black splint in R38's room, however, it could not be found.

7/26/21 12:14 PM - An interview with R38 confirmed that she puts on and takes off the tan splint as the facility does not put on the required splint.

There was lack of evidence of an order for R38 to self apply the tan left hand/wrist splint, despite the fact that the facility was aware that the tan splint was being worn by R38.

7/26/21 12:35 PM - The Surveyor informed E3 (ADON) that R38 uses the tan splint since she has not been provided the appropriate splint during the day hours.

7/27/21 10:03 AM - An interview with E3 revealed that the facility was unable to locate the black splint, thus, an order was placed to obtain the ordered splint.

8/3/21 12:10 PM - An interview with E2 (DON) confirmed the above findings and stated that the facility failed to transcribe the 11/19/20 orders for the left hand/wrist splint into the facility's EMR system, resulting in failure to implement and provide the services to apply and remove the black splint.

8/3/21 5:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2).

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined that the facility failed to ensure that the resident environment remained as free of accident hazards as possible. Findings include: The facility's policy titled Oxygen Use with the last review date of 8/25/20, stated, "...Steps in Procedure....2. Plug in O2 Concentrator or set up O2 tank in a storage container for safety...". 7/20/21 11:00 AM - A random observation of R68's room revealed an oxygen tank located at the right side of the head of the bed and not secured in a storage container. A joint observation immediately with E5 (RN Supervisor) confirmed that the oxygen tank was not secured and E5 proceeded to remove the tank out of R68's room and placed it in a storage container. 8/3/21 5:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 689	1. Oxygen tank in R68's room was removed from the room and placed in the designated storage area during the survey on 7/21/21. 2. All rooms have been searched for oxygen tanks to ensure that all tanks were secure or removed. 3. DON has revised the Oxygen Use Procedure (attached F880-3) to include "Empty Oxygen tanks should be placed in a storage container." Staff Development Director will in-service nursing staff on revisions to the procedure to ensure that empty oxygen containers are placed into a storage container. 4. DON or designee will review a sampling of 3 resident rooms daily for residents who use oxygen to ensure that oxygen cylinders are secured properly until there are 3 consecutive days with 100% compliance. After that DON or designee will review a sampling of 3 resident rooms weekly for residents who use oxygen to ensure that oxygen cylinders are secured properly until there are 3 consecutive weeks with 100% compliance. Once 3 consecutive weeks are found to be	10/1/21

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F 689	Continued From page 21	F 689	compliant, the monitoring will conclude. Results will be submitted to QAPI.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to offer a therapeutic diet for one (R38) out of two sampled residents reviewed for nutrition. Findings include: Review of R38's clinical record revealed: 3/31/21 - A Physician's Order was written for a mechanical soft sandwich at lunch daily in	F 692	1. R38 has expired. 2. Dietician and/or designee will review physician orders for all residents to identify orders relating to meal preferences for clarity. 3. Root Cause was identified that staff did not document resident refusal of a sandwich for that day. Dietary Manager has revised Policy C203 Physician Delegated Diet and Nutrition Orders	10/1/21

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F 692	Continued From page 22 addition to the lunch meal. 7/20/21 1:02 PM - An observation of R38's lunch revealed that the meal ticket stated, "mechanical soft sandwich daily @ [at] lunch in addition to meal per resident preference." Observation of R38's lunch tray lacked evidence of a sandwich. 7/20/21 1:30 PM - An interview with E11 (Dietary Aide) confirmed that she did not put a sandwich on R38's lunch tray and E11 proceeded to prepare a peanut butter and jelly (PBJ) sandwich for R38. 7/20/21 1:45 PM - A repeat observation of R38's lunch meal tray revealed a PBJ sandwich wrapped in plastic and R38 stated that "I am going to have this (sandwich) later.". 8/3/21 5:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 692	(attached exhibit F692-#1). The revision includes specific instructions that dietary staff will follow the written Physician Order exactly as written. Dietary Staff will be in-serviced regarding carrying out specific Physician Orders and changes to Policy C203 Physician Delegated Diet and Nutrition Orders. 4. Dietary Manager or designee will conduct a random audit of 3 resident meals daily for compliance with Physician Orders. Once 3 consecutive days are found to be compliant, Dietary Manager will conduct a random audit of 3 resident meals weekly until there are 3 consecutive weeks found to be compliant. Once 3 consecutive weeks are found to be compliant, Dietary Manager will conduct a random audit of 3 resident meals monthly until there are 3 consecutive months found to be compliant. Once 3 consecutive months are found to be compliant, monitoring will be concluded.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 695	1.1 R68 physician order for oxygen has	10/1/21

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F 695	Continued From page 23 review, it was determined that for two (R66 and R68) out of two sampled residents reviewed for respiratory care services, the facility failed to provide appropriate respiratory care as per the physician's orders. In addition, for R68, the facility failed to ensure the oxygen concentrator filter was maintained for cleanliness and the facility failed to ensure R66's oxygen tubing and the humidifier were changed weekly. Findings include: 1. Review of R68's clinical records revealed the following: 11/15/18 - R68 was admitted to the facility with diagnoses including COPD. 12/6/19 (revision date) - Review of the care plan for oxygen therapy related to COPD was initiated on 11/30/18 which included approaches to administer oxygen as ordered and to monitor and report signs and symptoms of respiratory distress to the attending physician. 12/1/20 - A Physician's Order was obtained by the facility for oxygen at 2 liters per minute (LPM) via nasal cannula (NC; a tube placed into nostrils to deliver oxygen) as needed for shortness of breath (SOB; difficulty breathing) and to titrate (adjust) to maintain an oxygen saturation of 92%. 7/1/21 through 7/18/21 - Review of the facility's electronic Medication Administration and Treatment Administration Records revealed that R68's oxygen saturation ranged between 93% to 100%. 7/19/21 11 AM - A random observation of R68's room revealed R68 in bed in no acute distress	F 695	been reviewed and her oxygen has been adjusted in accordance with the physician order. Filter has been cleaned during the survey on 7/20/21. 1.2 R66 physician order for oxygen use has been reviewed and her oxygen has been adjusted in accordance with the physician order. Oxygen tubing was changed and dated. 2. DON or designee will review orders for oxygen use for all residents with physician orders for oxygen for clarity. 3. Root cause was identified as staff requires additional training and auditing secondary to challenging and changing requirements related to the global pandemic. DON has revised the 24 Hour Chart Check Procedure (attached F684-1) to include "residents... will have a thorough review of medications and physician orders to ensure all orders are addressed correctly." Oxygen Use Procedure (attached F880-3) has been revised to include "Oxygen tubing must be changed weekly or if soiled. Tubing must be dated when changed. Humidifier bottles on concentrators must be dated when changed. Weekly tubing changed will also be documented in MAR." Staff Development will in-service Nurses on changes to the 24 Hour Chart Check Procedure and the Oxygen Use Procedure. 4. DON or Designee will review a sampling of 3 Physician Orders and observe Oxygen tubing daily for dates until there are 3 consecutive days with 100% compliance. After that DON or designee will review a sampling of 3	

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F 695	Continued From page 24 and R68 denied being short of breath. R68 had the oxygen via NC infusing at 3 LPM. The Surveyor asked R68 "Do you know how many liters of oxygen you are ordered?" and R68 replied "No." A joint observation with E5 (RN Supervisor) confirmed that R68 did not have an order to administer oxygen at 3 LPM and proceeded to decrease the liters to 2 and E5 stated she would review R68's oxygen order. In addition, E5 confirmed that the oxygen concentrator filter was dusty and that it would be addressed. Although R68 was observed on 7/19/21 at 11 AM with oxygen being administered at 3 LPM (incorrect amount of oxygen), record review lacked evidence of a respiratory assessment, including an oxygen saturation level prior to initiating the oxygen, as well as the liters of oxygen being administered and a post administration respiratory assessment, including a repeat oxygen saturation level. 7/20/21 10:59 AM - A repeat observation of R68's room revealed R68 in bed with no SOB and without oxygen. The oxygen concentrator filter remained dusty. A joint observation with E5 (RN Supervisor) revealed that it was unclear if it was the responsibility of nursing staff to ensure the filter was kept clean or not, however, E5 stated that she will address the issue. 7/21/21 9:45 AM - A subsequent observation of R68's room revealed R68 sitting up in a chair with no SOB and no oxygen. The Surveyor observed the oxygen concentrator filter was clean without debris or dust. 7/29/21 10 AM - An interview with E3 (ADON)	F 695	physician orders and observe Oxygen tubing daily for dates weekly until there are 3 consecutive weeks with 100% compliance. Once 3 consecutive weeks are 100% compliant, the monitoring will conclude. Results will be reported to QAPI.	

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F 695	Continued From page 25	F 695		

Continued From page 25
confirmed that R68's current order for oxygen was to be administered as needed for SOB and to titrate to 2 LPM via nasal cannula. In addition, prior to administering oxygen, staff must obtain oxygen saturation level and complete a respiratory assessment. Upon starting the oxygen, the staff must obtain a repeat oxygen saturation and document the outcome of this intervention.

8/3/21 12:10 PM - An interview with E2 (DON) confirmed the above findings.

2. Review of R66's clinical records revealed the following:

a. 12/27/18 - R66 was admitted to the facility with dependence on supplemental O2 (oxygen).

11/24/20 - R66 had an active physician's order to change the oxygen tubing and canister weekly.

7/20/21 9:00 AM - R66 was observed in the 2nd floor dining room with oxygen (tank) in use via nasal cannula (NC) at 3 liters per minute (LPM)). No date was observed on the tubing.

7/21/21 9:35 AM - R66 was observed in her room with oxygen (tank) in use via nasal cannula at 2.5 LPM. No date was observed on the tubing.

7/22/21 11:00 AM - R66 was observed resting in bed with oxygen (concentrator) in use via NC at 4 LPM. No date was observed on the tubing or humidifier bottle.

7/22/21 12:15 PM - In an interview, E21 (LPN Charge Nurse) confirmed that the nasal oxygen tubing that R66 was using was not dated and

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F 695	Continued From page 26 further stated that the NC tubing should be changed weekly and dated by the 11-7 shift. b. 7/22/21 11:10 AM - Review of R66's July 2021 MAR (Medication Administration Record) revealed that the licensed nursing staff have been signing off R66's order for O2 at 4 LPM via nasal cannula (NC) every shift for hypoxemia (low level of oxygen in the blood) from July 1 - 22, 2021. 7/22/21 12:15 PM - R66 was observed in the hallway with O2 in use at 2 LPM via NC. 7/22/21 12:20 PM - Further review of R66's records revealed that R66 had an active physician's order, dated 1/7/21, for oxygen at 4 LPM via NC every shift for hypoxemia. 7/22/21 12:25 PM - In an interview, E21 (LPN Charge Nurse) stated that R66 was care planned for oxygen therapy that included oxygen via NC as ordered. E21 further stated that R66 should be getting O2 at 2 LPM and to maintain PO2 (oxygen saturation) level above 92%. 7/22/21 12:40 PM - In a follow up interview, E21 confirmed that R66's oxygen therapy flow rate order of 4 LPM was clarified after the surveyor inquiry and discontinued immediately. A new physician's order, dated 7/22/21, stated O2 at 2 LPM via NC continuously, may titrate to maintain PO2 greater than 92% for hypoxemia. The facility failed to ensure that R66 was provided respiratory care consistent with her physician's order and comprehensive person - centered care plan. Findings were reviewed with E1 (NHA) and E2	F 695		

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F 695	Continued From page 27 (DON) during the Exit Conference on 8/3/21 at approximately 5:30 PM.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not	F 756		10/1/21

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F 756	Continued From page 28 limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy and procedure, it was determined that the facility failed to develop policies and procedures (P & P) for the monthly Medication Regimen Review (MRR) that included the time frames for different steps in the MRR process. In addition, the facility failed to ensure that the April 2021 MRR by the Consultant Pharmacist was obtained timely for one (69) out of five sampled residents for unnecessary medication review. Findings include: 1. Review of the facility's policy and procedure titled Consultant Pharmacist Reports, IIIA1: Medication Regimen Review, with an effective date of 12/20/20, failed to include the time frames for different steps in the MRR process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. 7/30/21 12:45 PM - An interview with E2 (DON) revealed that the above P & P was from the new Consultant Pharmacist and confirmed that the P & P lacked the time frames for different steps in the MRR process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. 2. Review of R69's clinical record revealed the following: There was lack of evidence that the monthly	F 756	1. R69 has since had an MRR completed in August 2021. 2. All residents have had an MRR completed in August 2021 by consultant pharmacist. 3. DON or designee has revised the Medication Regimen Review Policy (attached F756-1) to include that MRR will be reviewed at least monthly, and that reports will be provided "within 7 days of the review" to the facility, and that recommendations will be addressed "within 30 days of the review." Facility has also changed Pharmacy Consultants during the survey. Staff Development or designee will in-service Nurses on changes to the procedure. 4. DON or designee will review a sampling 3 MRR reports monthly for timeliness in accordance with MRR Procedure until there are 3 consecutive months with 100% compliance. Once 3 consecutive months are found to be 100% compliant the monitoring will conclude. Results will be reported to QAPI.	

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F 756	Continued From page 29 review was conducted by the Consultant Pharmacist for April 2021. 7/30/21 12:50 PM - An interview with E2 (DON) revealed that while requesting the June 2021 MRR from the Consultant Pharmacist during the survey on 7/21/21, E2 identified that the facility did not receive the April 2021 MRR and requested the same. Subsequently, the April 2021 MRR was provided to the facility during the survey. E2 confirmed that the facility failed to ensure the April 2021 MRR was obtained timely and E2 stated that the facility has contracted with a different Consultant Pharmacy organization as a result of this issue. 8/3/21 5:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		10/1/21

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F 757	Continued From page 30 consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to ensure one (R40) out of five residents reviewed for unnecessary medications received adequate monitoring for insulin. Findings include: 11/26/20 - Review of electronic MAR/TAR Physician orders for R40 stated that a Hgba1c level was to be drawn every three months. 7/2021 - Review of MAR/TAR physician orders for R40 under "Medications" documented R40 was ordered to be given insulin daily at 8 PM. 8/2/21 1:50 PM - Interview with E21 (LPN) Supervisor confirmed one Hgba1c level was drawn for R40 on 4/6/21. 8/3/21 at 5:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 757	1. R40 has had her Hgba1c level completed on 8/31/21. 2. DON or designee will review all resident who receive insulin will have their labs reviewed to verify that ordered labs have been completed. 3. DON has revised the Medication Monitoring and Management Procedure (attached F757-1) to include "Medical Records Coordinator will verify that routine labs are completed as ordered." Staff Development Director will in-service Medical Records Coordinator on changes to the procedure. 4. DON or designee will a sampling of 3 ordered labs weekly until there are 3 consecutive weeks with 100% compliance. After this, DON or designee will review a sampling of 3 ordered labs monthly until there are 3 consecutive months with 100% compliance. When 3 consecutive months are found to be 100% compliant, the monitoring will conclude. Results will be sent to QAPI.	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry	F 801		10/1/21

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F 801	Continued From page 31 out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.	F 801		

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F 801	Continued From page 32 §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to provide qualified dietary managerial staff to oversee food safety practices during all times of the kitchen operation. Findings include: During the initial kitchen tour on 7/19/21 from 8:00 AM to 9:45 AM, it was revealed that there were no individuals on premise with current	F 801	1. All residents may have been affected. 2. All residents may have been affected. 3. 6 Dietary employees have previously been ServeSafe Certified, many for over 10 years, however, 5 of those 6 certifications expired and facility, despite our best efforts, was unable to bring in a proctor which was required, to recertify and proctor testing for these employees	

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F 801	Continued From page 33 Certified Food Protection Manager training. Finding was reviewed and confirmed with E1 (NHA) on 7/21/2021 at approximately 11:30 AM.	F 801	due to COVID restrictions. Proctors were unavailable to enter the facility to administer ServSafe certification testing. Since the survey, Dietary Manager has himself become a proctor, and all 6 of the Dietary Employees are now ServSafe certified. Certifications attached (attachment F801-1). 4. ServeSafe certification is valid for 5 years, so no monitoring is necessary at this time. Dietary Manager will schedule Serve Safe certification test before the 3 year certification expires for these employees. Dietary Manager will check Serve Safe Certification status on annual evaluation.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		10/1/21

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F 812	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observations and interview it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: The following findings were made during the observation of the initial kitchen tour on 7/19/21 from 8:00 AM to 9:45 AM: - A spoon was left in the hand washing sink next to the dish washing station; - Non-Cleanable surfaces such as paper were used as shelving in the walk-in refrigerator. The usage of non-cleanable material traps moisture and microbes; - Observed expired yogurt in the walk-in refrigerator; - There were unlabeled foods (pork and eggs) left uncovered in the reach in refrigerator; - Observed dead insect parts lodged in the fume hood. Findings were reviewed and confirmed with E49 (Food Service Director) on 7/19/21 at approximately 10:00 AM. Findings were reviewed with E1 (NHA) on 7/19/21 at approximately 11:45 AM.	F 812	1. -Spoon has been removed from sink. -Non-cleanable surface has been removed from walk in refrigerator. -expired yogurt has been removed and discarded. -unlabeled food has been labelled. -the single wing of one fly was removed from the intake make up air vent which brings air from the rooftop to make up for air exhausted from the vent hood. 2. All resident may be affected. 3. Dietary Manager has created a Kitchen Audit Procedure and checklist (attached F812-1 and F812-2) to require an audit of the kitchen for the silverware in sinks, non-cleanable surfaces in the walk in refrigerator, proper review of expiration dates and proper labelling of food products. All dietary employees will be trained on the Kitchen Audit Procedure. 4. Dietary Manager or designee will conduct audits in the kitchen using the Kitchen Audit Checklist (attached F812-1) daily until there are 3 consecutive days with 100% compliance. Next, Dietary Manager or designee will conduct audits in the kitchen using the Kitchen Audit Checklist weekly until there are 3 consecutive weeks with 100% compliance. Next Dietary Manager or designee will conduct audits in the kitchen using the Kitchen Audit Checklist until there are 3 consecutive months with 100% compliance. After this monitoring will be concluded. Results will be reported to QAPI via Abaqis.	

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F 842	Continued From page 35	F 842		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		10/1/21

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F 842	Continued From page 36 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and interview, it was determined that the facility failed to ensure, in accordance with accepted professional standards and practices that medical records for three (R19, R38, and R330) out of 44 sampled residents were complete and accurately documented. Findings include: 1. Review of R19's clinical records revealed the	F 842	1.1 R19 her splint order was updated during the survey. 1.2 R330 is no longer a resident of Gilpin Hall. 1.3 R38 is no longer a resident of Gilpin Hall. 2.1 DON or designee will review all residents to identify residents with splint orders and ensure they are up to date.	

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F 842	Continued From page 37 following: 8/15/17 (revised 2/24/21) - A care plan with interventions that included (initiated 12/2/20) RNA (Restorative Nursing Assistant) for right upper extremity orthotic device for 4 hours only. Should be applied when resident is positioned on her back, left side or out of bed only. Must be removed when positioned on her right side. 7/28/21 at 11:00 AM - Review of the July 2021 TAR (Treatment Administration Record) revealed that licensed nursing staff were documenting that they applied splints on R19's right upper extremity at 10:00 AM and removed at 6:00 PM. In addition, licensed nursing staff documented that they applied the orthotic device on R19's right upper extremity for 4 hours daily on the 7-3 shift. 7/28/21 at 11:15 AM - During an interview, E22 (RN) confirmed that she signs off the rehab (rehabilitation) splint orders for R19 in the TAR. When asked what type of splint was applied on R19 as she has two different splint orders, E22 stated she did not know which one was the new order as there was only one splint currently in use and she will need to clarify with OT (Occupational Therapy). 7/28/21 at 1:20 PM - Review of the Rehab referral note for the Restorative Nursing Program, dated 10/16/20, indicated instructions for the splint to the right upper extremity and right hand for up to 4 hours daily. The splint on the right upper extremity was to be used only when lying on the back, out of bed to the wheelchair or in the left side lying position. 7/28/21 at 1:25 PM - In an interview, E12 (COTA)	F 842	2.2 DON or designee will review the CNA flow sheets for residents who have sustained a fall within the previous week to identify other residents who may be affected. 2.3 DON or designee will review the CNA flow sheets for meal consumption for all residents within the previous week to identify other residents who may have undocumented meals. 3. Root Cause was identified to be the need for additional training and auditing of staff related to 24 Hour Chart Check Procedure, Meal Intake Monitoring Procedure and CNA Documentation Procedure. DON has revised 24 Hour Chart Check Procedure (attached F684-1) to include "residents.... will have a thorough review of medication and physician orders to ensure all orders are addressed correctly." DON has revised the CNA Documentation Policy (attached F842-1)to include "CNA must complete documentation before they leave each shift." DON has revised Meal Intake Monitoring Procedure (attached F842-2) to include "Nursing Supervisor must verify the completion of meal intake record at least one hour prior to the end of shift." Staff Development Director will in-service Nursing staff on changes to these procedures. 4. DON or designee will review a sampling of resident orders, CNA flow sheets and meal intake monitoring records for 3 residents daily until there are 3 consecutive days with 100% compliance. After this, DON or designee will review a sampling of resident orders, CNA flow	

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F 842	Continued From page 38 confirmed that the order to apply the right hand splint for 8 hours was not updated and should have been discontinued when R19 started using the elbow/hand combination splint for 4 hours daily on 10/16/20. Findings were discussed with E1 (NHA) and E2 (DON) during the Exit Conference on 8/3/21 approximately at 5:30 PM. 2. Review of electronic CNA (certified nursing assistant) documentation for R330 was incomplete on several occasions: a. 6/2019 - The ADL task "q1 (every one hour) safety checks on 11 PM-7 AM shift due to falls" was not documented on: - 6/28/19 on 11 PM-7 AM shift - 6/29/19 on 11 PM-7AM shift - 6/30/19 on 11 PM-7 AM shift. b. 10/2019 - The ADL task "Bed and chair alarm; check function and placement qshift (every shift) (put alarm in recliner chair if resident prefers to sleep in the recliner chair)" was not documented on: - 10/25/19 on 11 PM-7 AM shift - 10/31/19 on 11 PM-7 AM shift. The ADL task "hipsters (padded shorts) on at all times, remove for skin checks and hygiene qshift due to fall" was not documented on: - 10/21/19 on 11 PM-7 AM shift - 10/25/19 on 11 PM-7 AM shift - 10/31/19 on 11 PM-7 AM shift. The ADL task "q30min (every 30 minute) visual safety checks qshift due to falls" was not documented for:	F 842	sheets and meal intake monitoring records for 3 residents weekly until there are 3 consecutive weeks with 100% compl ance. After this, DON or designee will review a sampl ng of resident orders, CNA flow sheets and meal intake monitoring records for 3 residents monthly until there are 3 consecutive months with 100% compliance. After this, monitoring will conclude. Results to be submitted to QAPI.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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- 10/21/19 on 11 PM-7 AM shift.

c. 11/2019 - The ADLs task "Hipsters on at all times, remove for skin checks and hygiene q shift due to fall" was not documented on:
- 11/9/19 on 3 PM-11 PM shift
- 11/10/19 on 11 PM-7 AM shift
- 11/15/19 on 11 PM-7 AM shift
- 11/16/19 from 7 AM-3 PM shift
- 11/17/19 on 7 AM-3 PM shift
- 11/20/19 on 11 PM-7 AM shift
- 11/23/19 on 11 PM-7 AM shift.

The ADL task "resident is to have walker at his side at all times" was not documented on:
- 11/4/19 on 7 AM-3 PM shift
- 11/9/19 on 3 PM-11 PM shift
- 11/10/19 on 11 PM-7 AM shift
- 11/15/19 on 11 PM-7 AM shift
- 11/16/19 on 7 AM-3 PM shift
- 11/17/19 on 7 AM-3 PM shift
- 11/20/19 on 11 PM-7 AM shift
- 11/23/19 on 11 PM-7 AM shift.

8/3/21 4:00 PM - Interview with E1 (NHA) and E2 (DON) confirmed that CNAs document the care they provide to residents electronically in POC and that documentation does not occur anywhere else (i.e., paper charts or flow books).

3. Review of 38's clinical record and the facility's policy revealed the following:

The facility's policy titled Weight Management, with a most recent reviewed date of 8/20/20 by E2 (DON) stated, "...Steps in Procedure...Nutritional/Weight Assessment...8. The resident's meal intake will be recorded for every meal...".

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F 842	Continued From page 40	F 842		

Cross refer F692

9/10/20 - R38 was admitted to the facility.

4/1/21 through 4/30/21 - A review of the facility's meal consumption record revealed lack of meal percentages consumed on the following dates and meal(s) for four (4) out of 90 meals:
- 4/11/21 dinner
- 4/15/21 lunch
- 4/19/21 and 4/20/21 lunch and dinner.

5/1/21 through 5/31/21- Review of the facility's meal consumption record revealed lack of meal percentages consumed on the following dates and meal(s) for five (5) out of 93 meals:
- 5/7/21 dinner
- 5/20/21 lunch
- 5/26/21 breakfast and lunch
- 5/30/21 lunch.

6/1/21 - R38 was admitted to the hospital for treatment of a urinary tract infection.

6/7/21 - R38 was readmitted to the facility from the hospital.

6/7/21 through 6/30/21 - Review of the facility's meal consumption record revealed lack of meal percentages consumed on the following dates and meal(s) for 13 out of 72 meals:
- 6/12/21 dinner
- 6/14/21 and 6/15/21 breakfast and lunch
- 6/18/21, 6/20/21, 6/22/21, 6/24/21, 6/27/21, 6/28/21. 6/29/21, and 6/30/21 dinner.

7/1/21 through 7/18/21 - Review of the facility's meal consumption record revealed lack of meal

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F 842	Continued From page 41 percentages consumed on the following dates for 5 dinners out of 54 meals: - 7/4/21, 7/5/21, 7/6/21, 7/7/21, and 7/10/21. 7/29/21 11 AM - Interviews with two (2) RN Supervisors, E5 and E6, were conducted. Both indicated that the assigned licensed nurses are responsible to enter meal consumptions before completing their shift. In addition, the RN Supervisor is supposed to check to ensure the residents are offered meals and to document the food consumption. Both stated by the time they check the facility's electric charting system, oftentimes, the assigned nurse have left for the shift. 8/3/21 12:10 PM - An interview with E2 (DON) revealed that the RN Supervisors are responsible to ensure meal consumptions are recorded in the facility's electric charting system. The above findings were reviewed with E2. Findings were discussed with E1 (NHA) and E2 (DON) during the Exit Conference on 8/3/21 at approximately 5:30 PM.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		10/1/21

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F 880	Continued From page 42 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 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	F 880		

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F 880	Continued From page 43 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, reviews of facility information and other resources as indicated, it was determined that the facility failed to ensure that proper infection control procedures were followed by nursing staff, including proper cleaning and disinfection of glucometers that are used to check residents' blood sugars, the lack of handwashing/sanitizing after contamination of clean gloved hands and storage/handling of oxygen tubing. Findings include: According to the Healthcare Professional Operator's Manual (2017) for the Evencare G3 glucometer, alcohol wipes were not included in the list of approved cleaning agents. 1. An observation on 8/3/21 at 7:54 AM during medication administration revealed that E43 (LPN) used two alcohol wipes simultaneously to clean and disinfect the glucometer before using it on R9. The facility practice of using alcohol wipes contradicts the manufacturer's instructions on	F 880	1.1 Manufacturer approved cleaning products for the glucometer have been ordered. 1.2 Manufacturer approved cleaning products for the glucometer have been ordered. 1.3 E4 received an in-service on Handwashing on 8/25/21. 1.4 Oxygen tubing has been changed for resident R9. 2.1 All residents that utilizes the glucometer machine may be affected. 2.2 All residents that utilizes the glucometer machine may be affected. 2.3 All residents that were tested on 8/3/21 may have been affected. 2.4 All residents using oxygen may be affected. 3.0 Root Cause analysis detail can be found in attachment (F880-1). Root Cause was identified as the need for additional training and auditing of Cleaning	

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F 880	Continued From page 44 cleaning and disinfecting the EVENCARE G3 glucometer between resident uses. 2. An observation on 8/2/21 at 12:10 PM, E15 (LPN), after R42 refused to have FSBS (finger stick blood sugar) performed, cleaned the glucometer using an alcohol pad. An interview immediately after the observation with E15 confirmed that she only uses alcohol pads to clean the glucometer between resident uses. 8/3/21 1:50 PM - An interview with E2 (DON) confirmed that the facility's practice was to use alcohol pads which contradicted the manufacturer's instructions. 3. An observation on 8/3/2021 at 9:57 AM revealed that after E4 (RN) washed her hands and applied cleaned gloves, E4 touched the front of her facemask to readjust it with her clean gloved hand, proceeded to R7's room opening R7's screen door and entered the room with her contaminated gloved hand and performed a COVID-19 nasal swab test on the resident. E4 failed to wash or sanitize her hands immediately after she touched the front of her facemask. The finding was immediately confirmed with E4. 4. 8/3/21 9:00 AM - Observed oxygen concentrator with uncovered oxygen tubing attached resting on a community table in the hallway on the third floor beside the exit for the patio/porch. 8/3/21 9:05 AM - Interview with E20 (LPN) stated they would find out which resident the concentrator belonged to. E20 took the concentrator with tubing attached away in the direction of the oxygen storage room.	F 880	Procedure, Handwashing Procedure and Oxygen Use Procedure. 3.1. Procedure for Cleaning of Non-Disposable Equipment was revised to include cleaning the glucometers after every use with the manufacturers approved cleaning wipes. 3.2. Procedure for Cleaning of Non-Disposable Equipment was revised to include cleaning the glucometers after every use with the manufacturers approved cleaning wipes. (attached F880-1) 3.3. Handwashing procedure was revised to include washing hands your hands specifically before after touching your face mask. (attached F880-2)(attached F880-4) 3.4. Oxygen Use Procedure was revised to include changing oxygen tubing at least weekly or if soiled, that tubing must be dated when changed and weekly tubing changes will be documented in the MAR. (attached F880-3) All Healthcare Professionals will be in-serviced by Staff Development or Designee on procedural changes to Cleaning of Non-Disposable Equipment (including glucometers) and will be required to perform a return demonstration of glucometer cleaning and disinfection at the time of training. Staff Development or Designee will also in-service all Nursing staff on Handwashing/Sanitizing including contamination of clean gloved hands and proper storage and handling of Oxygen tubing/nasal cannula (Oxygen Use Procedure) (Attachments have been	

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F 880	Continued From page 45 8/3/21 9:26 AM - Observed E44 (CNA) brought an oxygen concentrator with tubing out from the oxygen storage room. 8/3/21 9:27 AM - Observed E44 (CNA) state to E20 (LPN) that the oxygen concentrator belonged to R9. 8/3/21 9:27 AM - Interview with E20 (LPN) confirmed that the concentrator was the same concentrator previously identified. 8/3/21 9:28 AM - Observed E20 (LPN) take the concentrator with the tubing from E44 (CNA) and place the nasal cannula on R9. 8/3/21 9:30 AM - Interview with E20 (LPN) confirmed the oxygen tubing was not changed after it was removed from the hallway table. E20 stated that the tubing was placed inside of a bag inside the oxygen storage room, however, it was not witnessed. 8/3/21 5:30 PM - All findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 880	checked and are valid files and will be emailed for F880-1 Cleaning Procedures and for F582 as per ASPEN email notice). 4. PIP will be created for FTAG 880 Infection Control to include a root cause analysis (attached F880-5), and an audit of a sampling of 3 glucometer cleanings, 3 handwashing's, and 3 oxygen tubing observations daily on both the day and/or eve shifts until there are 3 consecutive days with 100% compliance. Next, an audit of a sampling of 3 glucometer cleanings, 3 handwashing's, and 3 oxygen tubing observations will be done weekly on both the day and/or eve shifts until there are 3 consecutive weeks with 100% compliance. Next, an audit of a sampling of 3 glucometer cleanings, 3 handwashing's, and 3 oxygen tubing observations will be done monthly on both the day and/or eve shifts until there are 3 consecutive months with 100% compliance. After this monitoring will conclude. (attached F880-5)	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		10/1/21

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F 883	Continued From page 46	F 883		

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits

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F 883	Continued From page 47 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that two (R32 and R38) out of five sampled residents reviewed for influenza and pneumococcal immunization received or were offered the PPSV23 pneumococcal vaccine. Findings include: 1. 10/1/18 - R32 was admitted to the facility. 8/2021 - Review of R32's admission consent documentation reflected that the resident/resident POA declined the vaccines stating "received previously 2-2-19", however, there was no indication which vaccine R32 received. 11/17/18 - R32's record indicated the resident received PCV13. The facility's records lacked evidence to support that R32 received or did not receive the PPSV23 vaccine. 2. 9/18/20 - R38 was admitted to the facility. 8/2021 - Review of R38's admission consent documentation reflected the resident/resident POA consented to receive PCV13 in addition to PPSV23. 12/6/18 - R38's record indicated the resident received PCV13.	F 883	1.1 R 32 consented to PPSV23 and received the vaccine 9/1/21. 1.2 R 38 is no longer a resident of facility. 2. All resident immunization records will be reviewed by Infection Preventionist or designee to determine if any other PPSV23 vaccines are missing. 3. Root cause was identified to be the need for a monthly audit of immunizations by the Infection Preventionist. The immunization of Residents: Pneumococcal and Influenza Policy (F883) was revised by the DON to include "Infection Preventionist will audit resident immunization records monthly to track progress and timing of vaccines and report results to DON." Also attached is a blank Influenza and Pneumococcal Immunization Informed Consent and Education form (F883-2 "Consent Decline Education.pdf Pneumococcal"). 4. A sampling of 3 resident pneumococcal vaccines will be reviewed weekly by DON for completion until 3 weeks are found to be 100% compliant. Then, a sampling of 3 resident pneumococcal vaccines will be reviewed monthly by DON for completion until 3 months are found to be 100% compliant. Once there has been 3 months of 100% compliance, monitoring will be completed. Results of monitoring	

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F 883	Continued From page 48 The facility's records lacked evidence to support that R38 received or did not receive the PPSV23 vaccine. 8/3/21 5:30 PM - All findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 883	will be reported to QAPI.	
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation as indicated, it was determined that the facility failed to ensure that required training on abuse, neglect, exploitation and misappropriation of resident property was completed for three (E7, E9 and E27) out of 17 randomly sampled staff members. Findings include:	F 943	1. E27, E7 and E9 have all been assigned Abuse Prohibition and Dementia training. 2. Staff Development Director or designee will conduct a review for all staff to ensure they have completed required Abuse Prohibition and Dementia training. 3. Root cause was identified as staff requires additional training and auditing	10/1/21

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F 943	Continued From page 49 The facility policy entitled " ...Resident Abuse Policy/Procedure", last reviewed in 11/2006, stated, "...Steps in Procedure 2. Training...2a.. All new employees will undergo initial orientation, during which time definitions of abuse and neglect and mistreatment are discussed and identified by Administrator or designee during orientation...". 1. Review of E27's personnel records revealed: 11/24/20 - The first day of assignment at the facility for E27 (CNA). 8/3/21 at 1:30 PM - During an interview with E1 (NHA), no further evidence of training was provided. 2. Review of E7's (CNA's) personnel and educational transcript records revealed the following: 9/5/17 - E7's initial date of hire. 1/20 through 7/27/21 - There was lack of evidence of abuse prohibition and dementia trainings in E7's educational transcript records. 7/27/21 1 PM - An interview with E4 (Staff Educator) confirmed the above findings. 3. Review of E9's (LPN's) personnel and educational transcript records revealed the following: 7/17/06- E9's initial date of hire. 1/20 through 7/27/21 - There was lack of evidence of abuse prohibition and dementia	F 943	secondary to challenging and changing requirements related to the global pandemic, combined with confusion surrounding education requirements from 1135 waiver. The Resident Abuse Procedure (attached F600-1) was reviewed and/or revised on the following dates since 11/2006: 8/7/08, 10/16/09, 1/21/13, 3/18/13, 3/14/14, 12/15/14, 4/25/16, 9/18/17, 6/20/18, 8/21/19, 7/21/20, 6/23/21, 7/28/21, and 8/27/21. Resident Abuse Procedure was revised to include under the "Protection" section: "To protect residents from further harm, an employee suspected in a case of abuse neglect or mistreatment will be suspended immediately pending a thorough investigation." (attached F943 and F610 Resident Abuse Procedure with Immediately added 9-17-21.pdf)New Employee Orientation and Training Procedure (attached F943-1)was revised on 8/27/21 to include "Staff Development Director and/or hiring manager will ensure that all new employees completed the required training within orientation period and annually as part of the annual evaluation." Staff Development Director will in-service all hiring managers on revisions to this procedure. 4. Administrator or designee will review a sampling of 3 employees weekly for completion of required training upon hire and annually until there is 100% compliance for 3 consecutive weeks. After that, Administrator or designee will review 3 employees monthly until there are 3 consecutive months with 100% compliance. After this, monitoring will	

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F 943	Continued From page 50 trainings in E9's educational transcripts records. 7/27/21 1 PM - An interview with E4 (Staff Educator) confirmed the above findings. 8/3/21 5:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 943	conclude. Results will be reported to QAPI via Abaqis. (attached F943-2)	