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: Delaware Veterans Home

DATE SURVEY COMPLETED: October 12, 2020

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2 TITLE 16 Del.	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced COVID-19 Focused Infection Control and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection, which began on September 30, 2020 and ended on October 12, 2020. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census on the first day of the survey was 59. The survey sample totaled sixteen (16), which included fourteen (14) active record reviews and two (2) closed record reviews. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **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 is not met as evidenced by: Cross-refer to CMS 2567-L survey completed	1. The Facility failed to ensure fingerprinting and/or drug screening was completed or documentation that requirements were prior to the first day in the facility for consultants/contractors. Consultant E39 and contractors E40 and E41 all submitted necessary documentation 2. All consultants/contractors have potential to be affected by failing ensure fingerprinting and/or drug screening was completed or documentation that requirements were prior to the first day in the facility. Senior Fiscal Administrative Officer (SFAO) will complete an audit of all consultants/contractors hired since January 2020. 3. RCA – Absence of procedural plan for Human Resources (HR) to add contractor form requiring contractors to accomplish fingerprinting and/or drug screening to contractor package. Absence of standardized language on contractor form requiring contractors to accomplish fingerprinting and/or drug screening. Absence of procedural plan to coordinate and forward completed contractor package from	12/7/2020

Provider's Signature Carol Ehart Title ANHA Date 11/16/2020

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C., Chapter 11 Subchapter IV. § 1141	October 12, 2020: F563, F585, F607, F608, F609, F610, F656, F677, F679, F687, and F880. **Health and Safety Regulatory Provisions Concerning Public Health** **Long-Term Care Facilities and Services.** **Abuse, Neglect, Mistreatment, or Financial Exploitation of Residents or Patients.** **Criminal background checks.** **(a) *Purpose.* — The purpose of the criminal background check and drug screening requirements of this section and § 1142 of this title is the protection of the safety and well-being of residents of long-term care facilities licensed pursuant to this chapter. These sections shall be construed broadly to accomplish this purpose.** **(c) An employer may not employ an applicant for work in a facility before obtaining a criminal history. The criminal history of any person not employed directly by the facility must be provided to the facility upon the person's commencement of work.** **(d) The requirements of subsection (c) of this section may be suspended for 60 days if the employer wishes to employ the applicant on a conditional basis.** **(1) Before an employer may offer conditional employment, the employer must receive verification that the applicant has been fingerprinted by the SBI for purposes of the criminal history.** **This requirement was not met as evidenced by:** Based on review of facility documentation and	HR to DVH when complete. Need to reinstate DVH Credentials Committee, members including HR, SFAO, DOO & Trainers. Need to include in procedural requirement for Credentials Committee to review contractor package prior to contractor starting work within building Update to abuse policy to include not only employees, but volunteers, contractors or consultants. 4. The SFAO or designee will conduct audits of all newly hired consultants/contractors weekly x 4 weeks until 100% compliance is achieved. Audits will continue once weekly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

Provider's Signature Carol Blunt Title ANHA Date 11/16/2020

NAME OF FACILITY: Delaware Veterans Home **DATE SURVEY COMPLETED: October 12, 2020**

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	staff interviews, it was determined that the facility failed to ensure fingerprinting and/or drug screening was completed for three (E39, E40 and E41) out fourteen (14) sampled staff. Findings include: 1. E41(Consultant) 10/8/2020 1:30 PM - Review of the State Agency Personnel Audit Form completed by the facility revealed that E41's (Consultant) first day working in the facility was 1/6/2020. 10/9/2020 9:30 AM – Review of the State of Delaware fingerprint database revealed that E41's (Consultant) fingerprint clearance was not in the State database. 10/9/2020 10:00 AM – During an interview with E1 (NHA), it was confirmed that the facility did not have evidence that E41(Consultant) was fingerprinted. 10/9/2020 11:00 AM – During an interview, E41(Consultant) stated she was fingerprinted prior to starting work at the facility and provided the documents to a previous NHA (who is no longer employed by the facility). The facility lacked evidence of fingerprint clearance prior to E41's (Consultant) first day working in the facility. 2. E39 and E40 (Rehabilitation Contractors) 10/8/2020 1:30 PM - Review of the State Agency Personnel Audit Form completed by the facility revealed that the first day working in the		

Provider's Signature Carol Ehart Title LNHA Date 11/16/2020

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	facility was: 7/01/2020 for E39 (DoR), and 8/31/2020 for E40 (PTA). 10/9/2020 9:30 AM – Review of the State of Delaware background check database revealed that E39 (DoR) and E40's (PTA) fingerprint clearance and drug screening were completed prior to 2012 when the current State data base was implemented. 10/9/2020 10:00 AM – During an interview with E1 (NHA), it was confirmed that the facility did not have evidence that E39 (DoR) and E40's (PTA) had fingerprint clearance and drug screening prior to the first working in the facility. 10/9/2020 11:30 AM – During an interview, E39 (DoR) stated she could request this information from her employer. The facility did not obtain documentation that these requirements were met prior to these contract employees, E39 (DoR) and E40's (PTA), working at the facility. 10/12/2020 10:40 AM - During the exit conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).		

Provider's Signature Carol Blust Title NHA Date 11/16/2020

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	085051	A. BUILDING _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection, which began on September 30, 2020 and ended on October 12, 2020. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census on the first day of the survey was 59. The survey sample totaled seventeen (17), which included fourteen (14) active record reviews and three (3) closed record reviews. Abbreviations and Definitions used in this report are as follows: AD - Activites Director; ADL (Activities of daily living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; Asymptomatic - without symptoms; Autolysing - self-digestion, the destruction cells through the action of its own enzymes; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15: 13-15 - cognitively intact. 08-12 - moderately impaired. 00-07 - severe impairment; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation; Dystrophic - toenails that become misshapen, thickened, or a partially destroyed nail plate; CDC - Centers for Disease Control and	F 000		

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

Electronically Signed | 11/16/2020

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	F 000		

Prevention;
Cloth face covering - Textile (cloth) covers that non-direct care facility staff may wear and are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE;
CMS - Centers for Medicare & Medicaid Services;
CNA - Certified Nurse's Aide;
Cognitively intact - fully oriented and able to make appropriate decisions;
COVID-19 (Coronavirus) - 'CO' stands for 'corona,' 'VI' for 'virus', and 'D' for disease. Formerly this disease was referred to as "2019 novel coronavirus" or "2019-nCoV". There are many types of human coronaviruses, including some that commonly cause mild to severe upper respiratory tract illness;
DON - Director of Nursing;
DPH - The State Agency Division of Public Health;
Face masks - PPE and are often referred to as surgical or procedure masks; they are required to be worn by staff providing direct care to residents during the COVID-19 pandemic;
FM - Family Member;
HCP - Healthcare Provider;
Incurvated - curved, or bent inward;
LPN - Licensed Practical Nurse;
MD - Medical Doctor;
MDS - Minimum Data Set (standardized assessment forms used in nursing homes);
Morphology - identifying the form and structure of cells;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
Onychomycosis - fungus infection of the nail;
Peripheral artery disease - a common circulatory problem in which narrowed arteries reduce blood flow to the limbs (usually legs) and causes

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F 000	Continued From page 2 symptoms, like leg pain when walking and wounds; POA (Power of Attorney) - someone appointed to make decisions on your behalf; PPE (Personal Protective Equipment) - specialized clothing or equipment worn by an employee for protection against infectious materials, such as a mask, gloves, goggles and gowns; PUI - person under investigation for COVID-19 infection because of symptoms or awaiting test results; RN - Registered Nurse; RS - Regulatory Specialist; Source control - use of cloth face coverings or facemasks to cover a person's mouth and nose to prevent the spread of respiratory secretions when talking, sneezing, or coughing; SSA - Social Services Administrator; Subungual mycotic debris - accumulation of crumbling debris under a toenail, thickened and discolored nails; SW - Social Worker; TAR - Treatment administration record that nurses use to document care provided; UM - Unit Manager - manager of a nursing unit.	F 000		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to	F 563		12/7/20

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F 563	Continued From page 3 deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, interview, observations, review of facility records, and review of facility policy and procedure as indicated, it was determined that the facility failed to allow window visits and compassionate visits for two (R1 and R6) out of three sampled residents and their families. Findings include: 3/13/2020 - The CMS issued memorandum QSO-20-14-NH entitled "Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes" included "Facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation." https://www.cms.gov/files/document/qso-20-14-n	F 563	1. The Facility failed to allow window visits and compassionate visits. Activities Director is responsible for coordinating Window (or in person) Visitation and Nursing Supervisors are responsible for coordinating Compassionate Visitation. Two residents were identified R1 □ received Window Visitation on 9/13, 9/20 9/27; and Compassionate visits on 8/1, 10/2, 10/4, 10/11 (and more since). R6 □ received Window visits on: 9/11, 9/17, 9/24, 10/1 & Outdoor visits on: 10/8 (and more since). 2. All residents have potential to be	

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F 563	Continued From page 4 h-revised.pdf 6/5/2020 - The facility policy entitled "COVID-19 General Policy" included that the facility will follow recommendations from the CDC as well as the State Agency and to prohibit visitation (except on a case-by-case basis) during Level II interventions (initiated when the first COVID-19 case was confirmed in [the State])." 6/23/2020 - CMS document entitled "FAQs on Nursing Home Visitation" included that "While end-of-life situations were used as examples of compassionate care situations in previous CMS memoranda, the term 'compassionate care situations' does not exclusively refer to end-of-life situations ...CMS cannot define each situation that may constitute a compassionate care situation. We encourage facilities to consult with state leadership, families, and ombudsman, to help determine if a visit should be conducted for compassionate care ...To help with these visits, nursing homes may decide to create safe spaces within the facility, such as see-through separation walls or other such areas so that residents may physically see their family members (if outside visitation is not conducted)." https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf 9/17/2020 - The CMS issued memorandum QSO-20-39-NH entitled "Nursing Home Visitation - COVID-19" described compassionate visits, and guidelines for outdoor and indoor visitation:"...Facilities should accommodate and support indoor visitation, including visits for reasons beyond compassionate care situations ...the term 'compassionate care situations' does not exclusively refer to end-of-life situations.	F 563	affected by failing to allow window visits and compassionate visits. Activities Director will audit residents to ensure they were offered at least window visitation and visits were completed. Nursing Supervisor will audit that approved compassionate visitation requests meeting State/Federal guidance criteria at the time of the request to ensure they were completed. 3. RCA- Facility was exercising extreme caution, awaiting official guidance on window visits, and managing exposure to COVID-19 with conservative visitation measure to remain COVID-19 na¿ve. In person visitation was started with Stage One was approved 09/03/20. There was no designation of contingency activity staff replacements in the event of a section wide staff removal due to a COVID occurrence. Activity Director (AD) or designee will ask residents with a BIMS score over 8 or family member if the resident has a BIMS score of 8 or less, weekly if they would like visitation arranged. This will be documented in an Activities note and visitation will occur based on staff availability and according to standards put in place by State and Federal authorities throughout the State of Emergency. The AD will create a STAT Pack which will include all Essential Activities Department	

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F 563	Continued From page 5 Examples of other types of compassionate care situations include, but are not limited to...a resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration...a resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past)." Cross refer to F585, F656 and F679 1. Review of R1's record revealed the following: 6/10/15 - R1 was admitted to the facility. 8/12/2020 - A care plan meeting note included that "[E12] the nurse consultant responded to [FM4's (R1's family member)] request to have weekly in person meals with his father by explaining the constraints that were in place at this time which would not make that possible..." 10/2/2020 5:30 PM - During an interview, FM4 (R1's family member) expressed concern about the lack of visitation, neglect, weight loss, and resident rights. FM4 stated that these concerns were voiced and emailed to E1 (NHA) frequently since at least June 2020 without acceptable response from the facility. 10/9/2020 4:00 PM - During an interview, E1 (NHA) confirmed that she received emails with concerns from FM4 2. Review of R6's record revealed the following: 7/10/19 - R6 was admitted to the facility.	F 563	Functions and a checklist for completion of all tasks. The Director of Operations (DOO) will be the backup for the AD and act in his/her absence. Operational Support Staff(OSS) and Administrative Assistants (AA) will be the backup for Activities Line Staff in their absence. The Activity Director or designee will educate the DOO, OSS, AA staff using the STAT Pack on fulfilling the Essential Activity Department Functions and completing the associated checklist. The Nursing supervisor or designee will continue an ongoing audit the approved compassionate visitation requests meeting State/Federal guidance criteria at the time of the request to ensure they were completed. The audit will be completed at the morning clinical meeting. 4. Activities Director or designee will conduct audits of 15 random resident charts weekly x 4 weeks to ensure that at least window visitation is offered until 100% compliance is achieved. Audits will continue of 15 random resident charts monthly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. Nursing Supervisor or designee will conduct audit to ensure approved compassionate visitation requests were completed weekly x 4 weeks until 100% compliance is achieved. Audits will	

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F 563	Continued From page 6 10/6/2020 6:00 PM - During an interview, FM5 (R6's family member) revealed concerns about lack of visitation and that R6 was declining and losing weight. FM5 added that these concerns were voiced and emailed to E1 (NHA) since at least July 2020 without acceptable response from the facility. FM5 provided copies of emails sent to E1 on 7/30/2020 & 8/4/2020 expressing these concerns. 10/9/2020 4:00 PM - During an interview, E1 (NHA) confirmed that she received emails with concerns from FM5 (R6's family member). During an interview, when asked why window visits and compassionate visits were not started sooner since they were never prohibited by the regulations, E1 (NHA) replied that the facility was trying to keep the residents free of COVID-19 and was following the advice of the consultant (E12) and E1's supervisors. 3. 10/5/2020 - E38 (AD) sent a letter to families that the facility will be implementing outdoor visitation by appointment. 10/7/2020 4:00 PM - During an interview, E1 (NHA) confirmed that all activities, video, window and outside visits had been canceled, unless special approval was given. 10/12/2020 10:40 AM - During the exit conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 563	continue of all approved requests monthly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. Back up staff to ensure activities (including visits) addressed in absence of staff on audit F-679 Attached are the audits to the EPOC.	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585		12/7/20

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F 585	Continued From page 7 §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her	F 585		

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F 585	Continued From page 8 grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F 585		

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F 585	Continued From page 9 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, interview, observation, review of other facility documentation, and review of facility policies, it was determined that the facility failed to make prompt efforts to resolve grievances for three (R1, R6 and R8) out of four residents and/or their family members investigated for grievances. In addition, it was determined that the facility failed to implement a grievance policy that included procedures for filing resident grievances anonymously and posting of the current Grievance Official's name and contact information in prominent locations throughout the facility. Findings include: 12/27/06 - Facility policy entitled Resident Grievance Policy (last revised 1/18/19) included that: "A resident, their legal representative/responsible party, visitor, advocate, or staff member may file a verbal or written grievance without fear of threat or retaliation in any form. The facility Grievance Official is the Social Services Administrator ...Grievances will be filed on a Resident Concern/Compliment form. If the complaint is verbal, it is the responsibility of the staff member	F 585	1. The Facility failed to make prompt efforts to resolve grievances with a written decision provide to complainant, to implement a grievance policy that incudes procedures for filing resident grievances anonymously, and to post the current Grievance Official□s name and contact information in prominent locations thought out the facility. Nursing Home Administrator (NHA) had family meetings on the front porch with R1 family on 11/4 & R6□s family 10/27 to discuss concerns Residents R8 (Family member FM1) was discharged to home. Cross refer to 563 for visitation issues. 2. All residents have potential to be affected by the deficient grievance practices. Social Services or designee will meet with residents with BIM over 8 to ascertain if they have any outstanding grievances. NHA had family meetings on the front porch with all families invited to address	

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F 585	Continued From page 10 who received the complaint to properly complete the the facility Concern / Compliment form on behalf of the complainant. The facility will attempt to provide prompt and equitable resolution of any resident grievance." 1. Review of the above facility policy revealed the following required information was not included: - the right to file grievances anonymously; - the procedures for filing resident grievances anonymously; - the need to post in prominent locations throughout the facility: - the current Grievance Official's name and contact information with whom a grievance can be filed; - the right to and procedure to file grievances orally, in writing or anonymously. 10/5/2020 12:00 PM - During an observational interview and facility tour with E15 (SW), E15 confirmed there were no postings in the facility with the Grievance Official's name / information including the procedure on how to file grievances anonymously. 2. Review of R1's record revealed the following: 6/10/15 - R1 was admitted to the facility. 10/2/2020 5:30 PM - During an interview, FM4 (R1's family member) revealed concerns about lack of visitation, neglect, weight loss, and resident rights. FM4 explained that the concerns had been frequently voiced and emailed to E1 (NHA) since at least June 2020 without acceptable response from the facility. 10/5/2020 11:45 AM - During an interview, E3	F 585	any areas of concerns on 10/27, 10/28 and 11/4. There were no outstanding grievances brought to attention during those meetings. 3. RCA- No grievance boxes were available and resident accessible in prominent locations for residents to use anonymously. Aside from New Hire Orientation there is no documented evidence of continual staff education on the filing and submission of grievances. No evidence of continual resident education on the filing and submission of grievances. Absence of language within grievance policy to require the continual education of staff and residents on the procedures for filing resident grievances anonymously, documentation of acknowledging receipt of the grievance, the complainant to receive the decision and the timeframe in which grievances will be completed. Updated Grievance Policy to include procedures for filing resident grievances anonymously, documentation of acknowledging receipt of the grievance, the complainant to receive the decision and the timeframe in which grievances will be completed. Posted the current Grievance Officials (both of the Social Service staff members) names and contact information in prominent locations thought out the facility. Grievance boxes will be placed on each unit and the front lobby with blank	

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F 585	Continued From page 11 (DON) confirmed that the facility had no documented grievances or investigations for R1 related to lack of visitation, neglect, weight loss, or resident rights. 10/5/2020 12:00 PM - During an interview, E15 (SW) confirmed that E15 was the Grievance Officer and there were no documented grievances or investigations for R1 related to lack of visitation, neglect, weight loss, or resident rights after searching the previous Grievance Officer's paper and computer files. 10/9/2020 4:00 PM - During an interview, E1 (NHA) confirmed that she received emails with concerns from FM4 but did not initiate a grievance. E1 stated that the former Grievance Officer (E28) would have completed the grievance paperwork and investigation but was not sure if that was done. 3. Review of R6's record revealed the following: 7/10/19 - R6 was admitted to the facility. 9/29/20 7:19 AM - FM5 (R6's family member) submitted a complaint to the State that because of not being able to visit R6 since mid-March, he became weaker and depressed. FM5 requested window visits multiple times since April, and only recently had two window visits. Since these two window visits, she has seen an improvement in R6's demeanor. 10/5/2020 11:45 AM - During an interview, E3 (DON) confirmed that the facility had no documented grievances or investigations for R6 related to lack of visitation, decline or weight loss.	F 585	forms placed beside them. The Nursing Home Administrator (NHA) will educate the Activities Director (AD) Social Service staff members on grievance process. Activities Director (AD) will educate residents monthly at Resident Council on where they can obtain and submit grievances anonymously and who the Grievance Officials are and their contact information. The Trainer or designee will train staff on Grievance policy and add it to the annual mandated education. 4. Social Services or designee will conduct audits of all grievances weekly x 4 weeks adherence to grievance policy, timeframes and documentation, until 100% compliance is achieved. Audits will continue of grievances monthly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. Audits have been attached to the EPOC.	

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F 585	Continued From page 12 10/5/2020 12:00 PM - During an interview, E15 (SW) confirmed that she is the Grievance Officer and there are no documented grievances or investigations for R6 related to lack of visitation, decline or weight loss. E15 stated she search the previous Grievance Officer's paper and computer files. 10/6/2020 6:00 PM - During an interview with FM5 (R6's family member), it was revealed concerns about lack of visitation and that R6 was declining and losing weight were voiced to E1 (NHA) since at least July 2020 without acceptable response from the facility. In addition, emails with these concerns were sent to E1. 10/9/2020 4:00 PM - During an interview, E1 (NHA) confirmed that she received emails with concerns from FM5 but did not initiate a grievance. E1 stated that the former Grievance Officer (E28) would have completed the grievance paperwork and investigation but was not sure if that was done. 4. Review of R8's record revealed the following: 1/16/2020 - R8 was admitted to the facility. 4a. 5/21/2020 at 3:40 PM - Resident Concern/Compliment Form documented that R8 had a grievance that was verbally communicated to E15 (SW). R8's grievance was that he would like some of the restrictions in place for COVID-19 to be lifted so he and other residents can come off the wings where R8 resides and be able to see their families since the state is lifting some restrictions. The form documented that the facility's Grievance Officer, E28 (SSA) received the grievance on 5/22/2020 at 10:30 AM. Further	F 585		

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F 585	Continued From page 13 review of the form, which documented the handling of the grievance revealed the following Sections were left blank: "...Section B: Response, Person responding, Department, Date received, How did you respond/investigate/try to resolve the issue? Administrator Response, Person responding, Department, Date received, How did you respond/investigate/try to resolve the issue?..." The only documentation was for "... Grievance Official/Designee: Date Official/Designee spoke with complainant: 5/22/2020...Was grievance resolved in Section B? Yes (Checked)...". There was lack of evidence of the facility's efforts to promptly resolve R8's grievance. These failures included the lack of an investigation, lack of pertinent findings or conclusions regarding R8's concerns, lack of whether the grievance was confirmed or not confirmed, lack of any corrective action taken or to be taken by the facility as a result of the grievance, and lack of the date the written decision was issued. 10/7/2020 1:00 PM - An interview with E15 (SW) was conducted and revealed that upon receiving the grievance from R8 on 5/21/2020 at 3:40 PM, E15 completed the Resident Concern/Compliment Form and forwarded to E28 (SSA) as E28 was the facility's Grievance Officer. E15 reviewed the form and confirmed there was a lack of evidence how the facility responded, investigated, or tried to resolve the grievance. E15 stated that E28 was no longer was an employee of the facility. 10/8/20 2:25 PM - Findings reviewed with E1 (NHA).	F 585		

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F 585	Continued From page 14	F 585		

4b. 8/17/2020 9:37 AM - A Resident Concern/Compliment Form documented that R8's spouse (FM1) had expressed a grievance which was communicated to E15 (SW) by e-mail and included complaints about R8's COVID-19 testing being conducted without consent as well as restricted visitation. Further review of the form revealed the following: On 8/18/2020 the facility documented that they had investigated the grievance and alleged that consent was obtained prior to R8's testing. In response to the complaint related to visitor restriction, E2 (DON) documented that visitor restrictions were in place as directed by Division of Public Health (DPH) and the facility was working with DPH on a plan to allow visitations. The plan was for the facility to educate FM1 of the visitation plan.

There was lack of evidence of the facility's efforts to promptly resolve FM1's grievance beyond the two attempts to contact the complainant on 8/24/2020. There was also a lack of evidence that a written decision was issued to FM1.

10/7/2020 1:00 PM - An interview with E15 (SW) revealed that upon receiving the grievance from FM1 on 8/17/2020 at 9:37 AM, E15 completed the Resident Concern/Compliment Form and forwarded to E28 (SSA). E15 reviewed the form and confirmed there was a lack of evidence that the facility notified FM1 of the outcome of the grievance and a lack of a written decision from the grievance investigation. E15 stated that the Social Service Administrator was the Grievance Officer and that E28 no longer was an employee.

10/8/20 2:25 PM - Findings were reviewed with E1 (NHA) and the Surveyor requested any

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F 585	Continued From page 15 additional information and received none related to prompt resolution to FM1's grievance. 10/12/2020 10:40 AM - During the exit conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 585		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview, review of other facility documentation and review of the State Agency's documentation as indicated, it was determined that the facility failed to develop and implement written policies and procedures, which included the investigation of an allegation of sexual abuse. Findings include: Review of the facility's policy titled Resident Abuse Protection Program, with a revision date of 7/10/2019, stated, "...B. Sexual Abuse: is non-consensual sexual contact of any type with a resident including touching and non-touching acts of any kind.	F 607	1. The Facility failed to develop and implement written policies and procedures, which include the investigation of an allegation of sexual abuse. Investigations were completed for residents R11 and R3. Cross refer 608 and 610. 2. All residents who have allegations of sexual abuse have potential to be affected. No other allegations in the past 6 months, no action can be taken.	12/7/20

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F 607	Continued From page 16 Cross refer F608 and F610. 9/29/2020 12:59 PM - The facility filed an incident with the State Agency concering R3's allegation of sexual abuse. 10/7/2020 10:00 AM - An interview with E3 (DON) revealed that the facility did not have a written process for an allegation of sexual abuse and it was not the practice of the facility to send the resident to the hospital for a comprehensive evaluation. E2 verbalized that the facility did save the bed linen as evidence when R3 was initially physically examined by E7 (RN, UM). There was a lack of evidence that the facility developed a written process to address an investigation of an allegation of sexual abuse, including not tampering with evidence from the incident which may impede the facility's investigation and by other investigating authorities. 10/8/20 2:25 PM - An interview with E1 (NHA) confirmed that the facility did not have any written policy and procedure to address the investigation of an allegation of sexual abuse. 10/12/2020 10:40 AM - During the Exit Conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 607	3. RCA- Policy for Abuse was incomplete. Update Policy to include a process to address an investigation of an allegation of sexual abuse, including not tampering with evidence from the incident which may impeded the facility□s investigation and by other investigating authorities, and send the resident to the hospital for a comprehensive exam. The Trainer or designee will educate the staff on the updated abuse policy. The Nursing Home Administrator will educate Medical Director to adherence to abuse policy. 4. The Social Services staff or designee will audit sexual abuse allegations weekly x 4 weeks to ensure that the investigations are completed according to the updated policy until 100% compliance is achieved. Audits of allegations will continue monthly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. Audits have been attached to EPOC.	
F 608 SS=E	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes	F 608		12/7/20

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F 608	Continued From page 17 occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy and procedure, it was determined that the facility failed to develop and implement written policies and procedures that included requirements for the reporting of reasonable suspicion of a crime. Findings include: Review of the facility's policy and procedure titled Resident Abuse Protection Program, with a revision date of 7/10/2019, lacked evidence of requirements for the reporting of reasonable suspicion of a crime.	F 608	1. The Facility failed to develop and implement written policies and procedures, which include requirements for the reporting of reasonable suspicion of a crime when there is an allegation of sexual abuse. Reports were completed for residents R11 and R3. Cross Refer 607 & 610 2. All residents who have allegations of sexual abuse have potential to be	

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F 608	Continued From page 18 Cross refer F607 and F610. 10/8/20 2:25 PM - An interview with E1 (NHA) confirmed that the facility failed to develop and implement a policy and procedure for the reporting of suspicion of a crime. 10/12/2020 10:40 AM - During the exit conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 608	affected. No other allegations in the past 6 months, no action can be taken. 3. RCA- There was no policy for reporting of reasonable suspicion of a crime when there is an allegation of sexual abuse. Created a Policy on Reporting of Reasonable Suspicion of a Crime. The Trainer or designee will educate the staff on the new Reporting of Reasonable Suspicion of a Crime policy. 4. Cross refer audit 607 & 610 Audit attached to the EPOC.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		12/7/20

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F 609	Continued From page 19 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 and interview it was determined, that for two (R4 and R11) out of three residents sampled for abuse, the facility failed to identify and as a result failed to immediately report allegations of abuse. R4 was observed being willfully struck by another resident. Due to no result in injury, the facility failed to recognize the incident as physical abuse and did not report it to the State Agency. R11 reported two separate allegations of sexual abuse to staff between April and May of 2020; the allegations were not recognized as abuse until August 2020, resulting in a delay in reporting. Findings include: Review of the facility's policy and procedure titled Resident Abuse Protection Program, with a revision date of 7/10/2019, indicated the following: "Purpose C. Allegations of abuse, neglect, or mistreatment will be reported immediately within two hours of forming the suspicion. Definition:	F 609	1. The Facility failed to identify and as a result failed to immediately report allegations of abuse. Resident R4 is deceased, therefore no action can be taken. Investigations were completed for residents R11 2. All residents have potential to be affected by failing to identify and as a result failing to immediately report allegations of abuse. . Social Services will review all progress notes since Nov 1 to validate there not been any potential abuse. 3. RCA- Although there was no injury, the staff failed to recognize the emotional abuse of the resident based on the fear stated by R4 the day after the incident, as well as the complaints by R11 when they were first made. Update Abuse Policy to include the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

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F 609	Continued From page 20 A. Physical abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish. This includes but is not limited to hitting, kicking, pinching, scratching, shoving, slapping or pulling hair... B. Sexual Abuse: is non-consensual sexual contact of any type with a resident including touching and non-touching acts of any kind. This may include but is not limited to forced or unwanted touching , either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks....Sexual harassment and sexual coercion will also be considered such." 1. Review of R11's clinical record revealed; 3/6/2020 - A quarterly MDS assessment documented R11 as requiring supervision and set up assistance for bathing. 5/8/2020 - E17 (CNA) documented in the CNA notes, R11 "[refused bathing] was upset and agitated that a black aid washed [R11's] rectum yesterday and didn't feel that should happen." 5/14/2020 10:41 AM - E26 (SW) documented that E26 was informed by the floor nurse that R11 was upset this morning and told the nurse that R11 had been fondled. The unit manager and social worker met with R11 to investigate the issue more thoroughly. Review of facility documentation lacked evidence that R11's allegation of "fondling" was recognized as abuse and that it was immediately reported to the State Agency. 5/14/2020 2:39 PM - A progress note documented R11 stated, "some black nurse [E24 (CNA)] knows came in my room and scrubbed	F 609	definitions of Abuse per the Delaware Code. Trainer will educate staff on the update policy, including identification of abuse and the need to report it immediately. 4. The Social Services staff or designee will audit resident progress notes x 4 weeks to identify potential abuse until 100% compliance is achieved. Audits of resident progress notes will continue monthly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. Audit is attached to the EPOC.	

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F 609	Continued From page 21 my butt, I don't need for anyone to do that for me. [R11] related this last Friday, but has been bringing it up several times since then. Today though, [R11] asked if [E24] was working and stated that [E24] knows the Black nurse who fondled me.' Spoke to social worker and unit manager, they were made aware of [R11's] statement." 8/11/2020 - The facility filed the allegation of abuse with the State Agency that documented R11 told an employee that R11 "was fondled while in the shower" ... Investigation revealed this incident occurred in May 2020 when R11 initially made the comment of being "fondled" to E25 (Former Unit Manager) ... R11 stated that a CNA washed R11's buttocks on 5/14/2020 but the resident felt this could be done independently. There was no documentation that the initial allegation of "fondling" (sexual abuse) was reported to the State Agency when brought to the facility's attention in May 2020. 8/11/2020 - E27's (Security Guard) written statement included that R11 stated that "[R11] had been fondled by an unnamed CNA and that [R11] had reported the same to [E26 (SW)]." 8/12/2020 - The allegation of abuse submitted to the State Agency documented, "it was reported today by [E17 (CNA)] that [R11] was overheard on an unknown date between April and May 2020, stating to an unknown person something to the effect of [E22 (CNA)] and [E23 (CNA)] made fun of his manhood." 10/8/2020 at 3:58 PM - During an interview, E17 (CNA) confirmed that E17 did not recognize that R11's statements about the two incidents were	F 609		

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F 609	Continued From page 22	F 609		

allegations of abuse. E17 stated, "I overheard, but didn't see who [R11] was talking to." Pertaining to the incident when R11 made an allegation while refusing bathing, [E17] stated, "I wasn't sure, so I just told the nurse [does not recall who]. Then I told [R11] to talk to the nurse."

2. Review of R4's clinical record revealed the following;

4/7/2020 - A progress note documented, R4 stated "I don't feel safe living here with that guy. Referring to [R17], social services aware."

4/6/2020 - A facility incident report documented, "altercation" with R17.

4/6/2020- A witness statement attached to the incident involving R4 and R17 documented "call bell went off so I walked to see what [R4] wanted as I got closer, I heard [R4] hollering for help, pulled back curtain and saw [R17] over top [R4] throwing punches and [R4] defending themselves, had to pull [R17] off and ushered [R17] out of the room".

4/6/2020 - A witness statement attached to the incident involving R4 and R17 documented, R17 "went into [R4's] room and was over top of [R4], while [R4] was sleeping. [R4] had to protect himself from [R17] and turned on the [call bell] light."

4/22/2020 - A physician's progress note documented "recent event of fellow resident entering room during the night on or about 4/6/2020. Resident able to recall event. Resident reports fellow resident entered room of [R4] who was in bed at time of event. [R17 stood] beside

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F 609	Continued From page 23 bed of [R4] and attempted one time to strike [R4]. Per [R4] 'I put my arms up in front of me [R4 demonstrated placement of arms in an X formation] and [R17] hit my arm. Then two CNA's came and got [R17] out." 10/7/2020 - Review of the incident report for the resident-to-resident incident involving R4 and R17, found no evidence that is was reported to the State Agency. 10/8/2020 (untimed) - During an interview E3 (DON) confirmed the incident involving R4 and R17 was not reported to the State Agency. 10/9/2020 at 10:55 AM - During an interview, E16 (Q.A. Administrator) confirmed the incident was not reported to the State Agency. E16 stated, "based on our internal report there was no injury so that is why it wasn't submitted, and we didn't think it met the criteria, for reportable's under resident-to-resident abuse. So it was not sent." 10/12/2020 10:40 AM - During the exit conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 610		12/7/20

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F 610	Continued From page 24 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, review of other facility documentation and review of the State Agency's documentation as indicated, it was determined that the facility failed to prevent further potential abuse while the criminal investigation was in progress for one (R3) out of three sampled residents reviewed for allegations of abuse. Findings include: Review of the facility's policy and procedure titled Resident Abuse Protection Program, with a revision date of 7/10/2019, stated, "...B. Sexual Abuse: is non-consensual sexual contact of any type with a resident including touching and non-touching acts of any kind...F. Protection. a. It is imperative that residents are protected from harm when an allegation of abuse...is being investigated. b. The protective action will depend on the nature of the allegation and the accused person's role/scope at the facility. Protective action includes suspension of the individual(s) accused. c. The facility will keep the information as confidential as possible for the integrity of the investigation and resident privacy..." Cross refer F607 and F608. 9/29/2020 12:59 PM - According to the facility's	F 610	1. The Facility failed to prevent further potential abuse while the criminal investigation was in progress for an allegation of sexual abuse. Employee involved in allegation of sexual abuse for R3 was put back on administrative leave pending result of criminal investigation. . Cross Refer 607 & 608 2. All residents who have allegations of sexual abuse have potential to be affected. No other allegations in the past 6 months, no action can be taken. 3. RCA- Abuse policy does not include when to return the suspect to active duty. Update Abuse Policy to include when to return the suspect to active duty. The Trainer or designee will educate the staff on the updated abuse policy. 4. Cross refer audit 607 & 608	

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F 610	Continued From page 25 Incident Report submitted to the State Agency, the facility stated, "It was reported to me by [E7 (RN, UM)] at approximately 11:30 this morning that [R3] reported to [E8 (CNA)] that a black husky man came in to change [R3] and was fondling him last night." R3 was unable to report the name of the person or provide any specific details. A skin check was performed without findings of any new skin impairments. Medical Team, Family, and Milford Police Department notified and investigation initiated. 10/2/2020 - The facility's Incident Investigation documentation titled Internal Memorandum, completed by E6 (RS) stated, "...Subject: Allegation of Abuse of [R3] by C.N.A [E11]...Recommendation...Because no evidence was discovered to indicate any wrongdoing on the part (sic) [E11], this writer recommends that [R11] be returned to duty immediately...Signed by [E6]. Both [E1 (NHA)] and [E3 (DON)] documented that they agreed with the analysis and recommendation. Despite the fact that the facility reported the allegation of sexual abuse to law enforcement, the the facility recommended that return E11 (CNA) to his duty as a CNA. 10/5/2020 - According to the facility's 5 day follow-up Incident Report submitted to the State Agency by E3 (DON) stated, "Outcome of the investigation: After review of the statements from the involved parties, interview with [E11], video footage, nursing/CNA notes, and physical assessments, the facility is unable to substantiate sexual abuse...Care Plan Change Explanation: [R3's] care plan has been updated to be assigned to female CNA caregivers."	F 610	Audits are attached to the EPOC.	

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F 610	Continued From page 26 10/7/2020 10:00 AM - An interview with E3 (DON) revealed that upon completion of the facility's investigation of the allegation of sexual abuse, the accused CNA was allowed to return to work as a CNA and resumed providing care to the residents beginning on the night shift on 10/2/2020 and had worked on 10/3/2020, 10/4/2020, and 10/5/2020. The Surveyor verbalized that the criminal investigation remained open with the police and that the facility must protect R3 and other residents from further abuse until the investigation was completed. 10/7/2020 11:26 AM - An interview with E1 (NHA) was conducted and E1 was advised by the Surveyor that the criminal case remained open with the police and E1 immediately verbalized that she will remove E11(the accused CNA) from resident care pending the criminal investigation. The facility failed to protect R3 and other residents while the criminal investigation of the alleged sexual abuse was being conducted by law enforcement. 10/12/2020 10:40 AM - During the Exit Conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		12/7/20

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F 656	Continued From page 27 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to develop and implement a comprehensive person-centered	F 656	1. The facility failed to develop and implement a comprehensive person-centered care plan for weight loss	

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F 656	Continued From page 28 care plan for weight loss one (R1) out of 17 residents sampled. Findings include: 7/5/19 (implementation date) - The facility policy for Care Plan Development, Implementation and Timing included that "Care Plans will be reviewed and/or revised no less than once every 3 months between comprehensive assessments or with a significant change in resident status." Review of R1's clinical record revealed the following: 6/10/15 - R1 was admitted to the facility. 3/5/2020 to 9/22/2020 - Review of documented weights revealed a gradual decline totaling a weight loss of over 24%. 8/11/2020 - A Care Plan Conference note documented, "Resident has lost weight since the COVID-19 pandemic started." 8/18/2020 - A significant change MDS assessment documented that R1 had a weight loss of 5% or more in last month or 10% or more in last 6 months which would trigger the need for the facility to initiate a care plan for weight loss. 10/2/2020 4:00 PM - Review of R1's printed care plan provided by E3 (DON) lacked evidence of a weight loss problem, even though the interdisciplinary team had implemented interventions to address weight loss. 10/2/2020 4:50 PM - During an interview, E3 (DON) confirmed that the facility did not have a care plan related to R1's weight loss.	F 656	for one resident. R1 - Care plan for weight loss was updated by Dietician repeatedly and last on 8/11/20 per resident record. No other changes can be made at this time as resident is deceased. 2. All residents with documented weight loss have potential to be affected by failing to develop and implement a comprehensive person-centered care plan for weight loss. Residents with documented weight loss in the past quarter will be audited for a comprehensive person-centered care plan for weight loss. Care plans will be updated as needed. 3. RCA □ The survey team could not find a comprehensive care plan for weight loss on Resident R1. The current documentation system (American Data ECS) is cumbersome and the Survey team is unfamiliar with its navigation. The care plan was under the dietician□s care plan where weight loss/gains are addressed. The care plan was provided to Survey team, but it was not highlighted and not pointed out when asked on 10/2/20. The RN Assessment Coordinator (RNAC) who manages the care plan was not involved in providing information to the Survey Team. No attempts were made to follow up with providing all of the care plan revisions since 3/5/20, including discontinued items. Due to the difficulties with navigating and managing the ECS system, contract	

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F 656	Continued From page 29 10/12/2020 10:40 AM - During the exit conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 656	negotiations are almost complete to change the software to the more familiar and easier to navigate Point Click Care software. The RNAC will institute a weekly Risk meeting to review all residents who have weight loss and review their individualized care plan each week. The Nursing Home Administrator will educate the leadership team on effective Survey management. 4. The RNAC will audit residents with documented weight loss each week x 4 weeks to ensure a comprehensive person-centered care plan is developed and implemented for each until 100% compliance is achieved. Audits will continue monthly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to provide the necessary services to maintain the cleanliness for one (R4) out of four residents reviewed for activities of daily living, when R4 did not receive	F 677	1. The Facility failed to provide the necessary services to maintain the cleanliness of resident. R4 did receive multiple bed baths each week during June.	12/7/20

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F 677	Continued From page 30 scheduled showers. Findings include: Review of R4's clinical record revealed: 3/5/2020 - An order was written for R4 to receive no baths, may shower. Showers were scheduled three times a week on Monday, Wednesday, and Friday. 6/5/2020 - A quarterly MDS assessment documented R4 as dependent for bathing. June 2020 - Review of CNA documentation revealed that R4 received four showers total; 6/17, 6/24, 6/26 and 6/29. There were no documented reasons for the missed showers. During an interview on 10/6/2020 at 8:41 AM with FM3 (R4's family member), it was reported that R4 "was constantly missing showers, they would blame [R4] saying, [R4] took too long to eat and missed shower time. [R4] would show up to appointments looking dirty, with dirty nails and dry skin as if [R4] hadn't been bathed." During an interview on 10/9/2020 at 11:05 AM with E3 (DON), it was confirmed that R4 should have received three showers a week. E3 added that "If there's no documented refusals, I'm not sure why they weren't received." 10/12/2020 10:40 AM - During the exit conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 677	R4 is deceased; therefore no corrective action can be taken. 2. All residents have potential to be affected by failing to provide the necessary services to maintain the cleanliness. Nursing Supervisors or designee will complete initial audit of residents orders for bathing to ensure that they are clear and accurate. Nursing Supervisors will then audit a retroactive 7 day period of November 6th-November 12th, reviewing bathing documentation for missed scheduled bathing to ensure all bathing occurred per the order and missed bathing was documented with interventions attempted and reasons given for refusals. 3. RCA: Resident R4 had a procedure on 2/19/20 with an associated order not to get the site wet, no shower or baths. On 3/3/20 that order was discontinued and an order was placed for no baths, may shower. With both of these orders, the medical team intended that R4 not be immersed in a tub for a tub bath (as the full order states). The portion of the order no baths was extremely limiting, thereby confusing and Nursing did not clarify the order. The resident was actually bathed, receiving bed baths on 6/1, 6/5, 6/8, 6/10, 6/12, 6/15, 6/19, 6/22. There was no documentation as to why the showers were not given on the specified days. The RCA is that the written order and the documentation of omissions were not	

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F 677	Continued From page 31	F 677	clear. Nursing Supervisor will audit the bathing report for the past 24 hours for missed scheduled bathing to ensure all bathing occurred per the order and missed bathing was documented with interventions attempted and reasons given for refusals. The results will be reviewed at the morning clinical meeting. The Trainer or designee will educate nursing staff on reviewing orders for clarity and accuracy, expectations for bathing, including interventions for dealing with refusals and documentation of attempts and reasons for refusals. 4. Nursing Supervisor or designee will conduct audits of a sample of 15 resident charts weekly x 4 weeks to ensure that bathing occurred as schedule or omissions documented until 100% compliance is achieved. Audits of a sample of 15 resident charts will continue monthly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. Audits attached to EPOC.	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		12/7/20

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F 679	Continued From page 32 §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of clinical records and other facility documentation as indicated, it was determined that the facility failed to provide an ongoing program to support the residents in their choice of activities. Findings include: 10/7/2020 10:30 AM - During an interview, E1 (NHA) stated that two staff members COVID-19 tests came back positive this morning and that the State DPH's (Department of Public Health) physician instructed her to send all of the Activities Staff home for a 14 day quarantine. 10/7/20 2:17 PM - FM5 (R6's family member) received an email from E10 (SW) stating: "In accordance with the notification policy, I am contacting you to advise that two staff members have tested positive for the Covid virus. Two additional staff have test results pending. Due to an abundance of caution, all activities have been suspended for two weeks. As a result, video calls, window or outside visits have been canceled." 10/7/2020 4:00 PM - During an interview, E1 (NHA) confirmed that all activities, video, window	F 679	1. The Facility failed to provide an ongoing program to support the residents in their choice of activities. No specific residents were named related to the activities. 2. All residents have potential to be affected by failing ensure an ongoing program to support the residents in their choice of activities. All Activity staff members have returned and activities have been completed per normal routine. 3. RCA- There was no designation of contingency activity staff replacements in the event of a section wide staff removal due to a COVID occurrence. The Activity Director will create a STAT Pack which will include all Essential Activities Department Functions and a checklist for completion of all tasks. The Director of Operations (DOO) will be the backup for the AD and act in his/her	

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F 679	Continued From page 33 and outside visits had been canceled, unless special approval was given. When asked if the facility had an alternative plan to meet the activity needs of residents for the next 14 days, E1 replied "No. Because we do not have enough staff." 10/9/2020 9:00 AM - During an interview, E1 (NHA) said that E3 (DON) and E13 (ADON) will be instructing the CNAs to provide activities for the residents. 10/9/2020 11:00 AM - 12:00 PM - During a tour of the Red, Gold and Green nursing units, no resident was engaged with staff in activities. On all three units some residents were watching TV or sitting in wheelchairs in the halls. 10/9/2020 11:20 AM - During an interview, E34 (CNA) stated, "I have not been told to do activities with residents." 10/9/2020 11:30 AM - During an interview, E35 (CNA) stated, "I have not been told to do activities with residents, but since there are no activities staff here, I will pass out some puzzles to residents" 10/9/2020 11:50 AM - During an interview, E36 (CNA) stated "I have not been asked to do activities with residents." 10/7/2020 - 10/10/2020 - Analysis of the facility's nursing staffing hours per patient day (PPD) averaged 6.28 hours (range from 5.55 to 7.51 hours). Since the minimum State requirement is 3.28 hours, it would be expected that nursing staff could safely provide activities to residents.	F 679	absence. Operational Support Staff (OSS) and Administrative Assistants (AA) will be the backup for Activities Line Staff in their absence. The Activity Director or designee will educate the Director of Operations, OSS, Activity Assistant staff using the STAT Pack on fulfilling the Essential Activity Department Functions and completing the associated checklist when the Activity Director is absent or there are less than two Activity Staff in the building. 4. Director of Operations or designee will conduct audit of Activity staff absences/checklist completion daily x 4 weeks to ensure that Essential Activity Department Functions are completed until 100% compliance is achieved. Audits weekly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. Audits are attached to the EPOC.	

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F 679	Continued From page 34 The facility failed to develop an activity program to meet the needs of the residents. Instead, the facility cancelled all activities and family visits. 10/12/2020 10:40 AM - During the exit conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 679		
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation as indicated, it was determined for three (R3, R6, and R12) out of four sampled residents for foot care, the facility failed to arrange for podiatry care as ordered. Findings include: Review of the facility's policy and procedure titled Foot Care, with the revision date of 4/27/2017 stated that residents would be referred to podiatry clinic as needed. 10/2/2020 11:00 AM - During an interview, E30 (Staff Member wishing to remain anonymous)	F 687	1. The facility failed to obtain Podiatry Care as ordered. R12 received Podiatry Care services on 10/14/20. R6 received Podiatry Care services on 10/14/20. R3 received Podiatry Care services on 10/28/20 2. All residents have potential to be affected by failing to obtain Podiatry Care as ordered. Infection Preventionist (IP) will audit all residents with Podiatry Care orders will be audited for when they last	12/7/20

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F 687	Continued From page 35 stated that "Podiatry services have only been in-house once since 3/1/2020. Multiple staff have asked [E1 (NHA)] and [E13 (ADON)] numerous times to have a Podiatrist in to see the residents. [E13] said the Podiatrist did not want to come into the facility, but other staff have spoken to him and he denied saying this. [E1] does not want anyone to come into the facility because she is more afraid of COVID-19 than the care of our residents. Many residents have been requesting this service. They had no plan to bring in podiatry services until two days ago, so the Medical Team sent several residents out to office appointments. A resident is now experiencing pain and is at risk to fall due to the facility's failure to provide the services required for him to maintain his functional level and quality of life. Orders are still in place for residents to have in-house podiatry every 2-3 months, and these orders have not been followed. The pandemic has changed how we provide services, but it does not absolve the facility of providing services ordered or required for our residents to maintain their quality of life." 10/2/2020 1:00 PM - During an interview, E13 (ADON) stated that she was able to schedule an in-house podiatry clinic on 10/14/2020. E13 explained that since 2/26/2020, she had only been able to have one in-house podiatry clinic which was on 5/20/2020 (when 18 residents were seen). Prior to the COVID-19 pandemic, the in-house podiatry clinics were usually held once a month to ensure all residents needing services were seen at least every three months. E13 stated that there was a variety of miscommunications with the Podiatrist's staff that prevented scheduling in-house clinics (e.g., COVID-19 screening and testing). E13 added that in September 2020 two residents were sent to the	F 687	received services. All resident who did not receive Podiatry Care services as ordered were scheduled and seen prior to 10/28/20 with the exception of two who refused. Podiatry clinics will return to the last Wednesday of each month. 3. RCA □ When there was a difficulty in obtaining in-house services, orders were not put on hold, no back up plan initiated for all residents who still needed care. The IP will contact Podiatry office to ascertain if there will be any difficulties in providing services. If there are issues presented, then work arounds, such as evaluations by in-house medical staff to determine needs of individual residents, sending residents with issues beyond in-house staff scope or emergent issues to the office or holding orders for residents who do not have emergent issues until routine Podiatry Care can resume. Nursing Home Administrator (NHA) will educate the IP on the necessity to obtain Podiatry Services or back up plans as necessary for each individual resident. 4. The IP will contact Podiatry office to ascertain if there will be any difficulties in obtaining Podiatry Care services each week x 4 weeks until 100% compliance is achieved. Audits will continue monthly x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F 687	Continued From page 36 Podiatrist's office for treatment. 10/5/2020 11:25 AM - During an interview, E29 (Staff Member wishing to remain anonymous) voiced concerns about delay in care, "Since March 2020, [E1 (NHA) and E13 (ADON)] were notified many times by staff of the need for podiatry services. Only a few residents have had an appointment, and many residents still are in need of podiatry care." 10/9/2020 2:30 PM - During an interview, E13 (ADON) provided an email from the State Agency dated 5/8/2020 that advised: Because the facility is COVID-19 naive, in-house Podiatry Services could continue with the Podiatrist and his staff being screened for COVID-19 and wearing at a minimum "...masks and gloves. The podiatrist would have to determine if he and his assistant wear a gown and face shield based on the care that is being provided...The room and any equipment must be sanitized between each resident." 1. Review of R12's clinical record revealed the following: 9/12/19 - R12 was admitted to the facility. 1/8/2020 - Podiatry note included that R12 received podiatry care "...today for treatment of painful thick toenails...all toenails elongated which impedes proper ambulation in shoe gear ... peripheral artery disease and onychomycosis ... treatment consisted of aseptic debridement of all affected toenails down to nail bed... follow-up appointment in 2-3 months or as needed." 1/20/2020 - Physicians' order included to	F 687	Audits attached to EPOC.	

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F 687	Continued From page 37 schedule next podiatry appointment in three months from last appointment (which was on 1/8/2020). 9/15/2020 - Annual Care Plan meeting notes include that "POA [power of attorney] concerned about [R12] being seen by the podiatrist...[Unit Manager] to follow-up with ADON and administrator about this..." 10/7/2020 10:30 AM - An observation with E9 (LPN) of R12's toenails revealed they were yellowish-brown, opaque, thick and long. R12 did complain of some generalized, mild right foot discomfort which E9 further assessed. 10/8/2020 2:00 PM - During an interview, E13 (ADON) confirmed R12 has not had podiatry services since 1/8/2020. 2. Review of R6's clinical record revealed the following: 7/10/19 - R6 was admitted to the facility. 2/26/2020 - Podiatry note included that R6 received podiatry care "...today for treatment of painful thick toenails ... Patient complains of painful toe when wearing shoes and ambulating...all nails elongated which impedes proper ambulation in shoe gear. Positive abnormal toenail morphology depicting painful, autolysing brittle, dystrophic, yellowed, thickened, incurvated toenails with sub-ungual mycotic debris...peripheral artery disease and onychomycosis...treatment consisted of aseptic debridement of all affected toenails down to nail bed...I will follow-up appointment in 2-3 months or as needed."	F 687		

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F 687	Continued From page 38 3/14/2020 - Physicians' order included to schedule next podiatry appointment in three months from last appointment (which was on 2/26/2020). 10/5/2020 10:00 AM - An observation with E18 (RN) of R6's bilateral toenails revealed they were yellow, thick and very long. R6 denied any pain or discomfort of his feet or toenails. 10/8/2020 2:00 PM - During an interview, E13 (ADON) confirmed R6 has not had podiatry services since 1/22/2020. 3. Review of R3's clinical record revealed the following: 8/9/2019 - R3 was admitted to the facility. 1/8/2020 - A physician's order was written for routine podiatry care every 3 months. 1/20/2020 - R3 received routine podiatry care with a follow-up appointment in three months. There was a lack of evidence of additional podiatry care since 1/20/2020, approximately nine months ago. 10/2/2020 3:15 PM - An observation of R3's toenails revealed they were clean and slightly long. R3 denied any pain or discomfort of his feet, including his toenails. 10/6/2020 3:00 PM - An interview with E9 (LPN) confirmed that R11's most recent podiatry care was on 1/20/2020.	F 687		

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F 687	Continued From page 39 10/8/2020 4:00 PM - An interview with E14 (NP) revealed that routine podiatry care was ordered for an assessment and treat as needed. 10/12/2020 10:40 AM - During the exit conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 687		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, 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	F 880		12/7/20

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F 880	Continued From page 40 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of facility documentation it was	F 880	1. The facility failed to properly prevent COVID-19 by ensuring that residents wore	

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F 880	Continued From page 41 determined that the facility failed to properly prevent COVID-19 by ensuring that residents wore face masks / cloth face coverings and were social distancing according to State and Federal requirements. Findings include: 5/8/2020 - The CDC (Center for Disease Control)'s "Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19" included: "If residents leave their rooms, they should wear a cloth face covering or facemask (if tolerated), perform hand hygiene, limit movement in the facility, and perform social distancing." 6/9/2020 (original date 6/5/2020, no revisions) - The facility policy entitled "COVID-19 General Policy" included that the facility will follow recommendations from the CDC as well as the State Agency and that "Resident must wear a mask when out of room and when HCP [Healthcare Provider] is in the room." 1. Residents not wearing face masks / cloth face coverings: 9/30/2020 3:00 PM - 4:00 PM - During random observations on the Green, Gold and Red nursing units, no residents were wearing face masks / cloth face coverings. 9/30/2020 4:05 PM - During an interview E1 (NHA) and E6 (RS) were notified of the above finding. 10/1/2020 8:00 AM - During an interview with E1 (NHA) and E12 (CRN), E1 said that so many of the residents have dementia that the medical staff does not feel the residents need to wear	F 880	face masks/cloth face coverings according to State and Federal requirements with the following identified residents. All residents noted R11, R13, R14, R15, R16 are currently compliant with wearing face coverings. No specific residents were named related to sitting less than 6 ft. apart. 2. All residents have potential to be affected by failing to properly prevent COVID-19 by ensuring that residents wore face masks/cloth face coverings and were social distancing according to State and Federal requirements. Residents will be audited for mask compliance and social distancing. If non-compliance is noted, an Interdisciplinary Team meeting will be held to discuss and create individualized interventions to increase compliance. 3. RCA □ There was a lack of understanding of the guidance of Phase One. Information at Interdisciplinary Team meetings was not being adequately communicated to line staff. Ongoing education and surveillance of compliance of the residents was not completed to reinforce the need to have the residents wear face coverings and maintain social distancing. Residents will be audited ongoing for mask compliance and social distancing. If non-compliance is noted, an additional	

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F 880	Continued From page 42 masks. When asked if the facility staff have made efforts to encourage the residents to wear face masks / cloth face coverings when outside of their room and if residents were assessed why they are noncompliant, E12 said this probably has not been documented or care planned for individual residents. When asked if the facility had additional (to the 6/9/2020 "COVID-19 General Policy") COVID-19 policies/guidelines related to source control for residents, E12 stated to review the weekly COVID-19 meeting minutes. 10/5/2020 10:00 AM - During an interview, E18 (RN) stated nurses are supposed to document every shift that the residents are encouraged to wear a mask if outside their rooms. 10/7/2020 6:00 PM - During an interview, E32 (CNA) stated, "Everyone [all staff] is supposed to hand out masks to the residents and remind them to wear when out of their rooms. But, our [staff] effort to remind residents to wear masks has worn off over time." 10/9/2020 11:20 AM - During an interview, E34 (CNA) stated "We (CNAs) were told in a meeting several months ago that all residents' should wear a mask every time they are out of their room, but we do not have a place to chart it ...we have not had any more inservices of residents needing to wear masks." 10/9/2020 11:30 AM - During an interview, E35 (CNA) stated "I try to remind residents to wear a mask when they are out of their room, but some refuse ...we do not have a place to document if a resident refuses." 10/9/2020 - Five residents (R11, R13, R14, R15	F 880	Interdisciplinary Team meeting will be held to discuss and create individualized interventions to increase compliance. Trainer or designee will reeducate staff on need to have residents wear face coverings and maintain social distancing. Also, furniture was rearranged or removed if necessary, to encourage social distancing and discourage close contacts. Floor stickers were placed where applicable to delineate proper social distancing. 4. Nursing Supervisor or designee will conduct audits of 15 random residents for mask compliance and social distancing weekly x 4 weeks until 100% compliance is achieved. Audits will continue x 2 months until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. Audits attached to EPOC.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 43 and R16) were selected to review for use of a face masks / cloth face coverings when outside of their room. Review of all five residents' clinical record revealed the following: 6/18/2020 - 10/9/2020 - The TAR (treatment administration record) included: "Nursing Order: Resident will wear mask when outside of room, when receiving care of in close contact with other residents or caregivers as tolerated." 6/22/2020 - 10/9/2020 - The CNA assignment sheet included: "Resident will wear mask when outside of room, when receiving care of in close contact with other residents or caregivers as tolerated." a. Review of R11's clinical record revealed: 9/4/2020 - A quarterly MDS documented that R11 was cognitively intact (BIMS 15). 10/9/2020 11:00 AM - R11 was observed sitting in the unit's multipurpose room watching TV with several other residents. When asked if he usually wears a face masks / cloth face covering and if he had one, R11 said "No. It's in my room." b. Review of R13's clinical record revealed: 9/4/2020 - A quarterly MDS documented that R13 had impaired short term memory. 10/9/2020 11:10 AM- 11:20 AM - R13 was observed at the nurses' station talking on the phone to a family member. R13 self-propelled in his wheelchair prior to and after this phone conversation and was not wearing a face masks / cloth face covering. No staff were observed	F 880		

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	085051	A. BUILDING _____ B. WING _____	C 10/12/2020

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F 880	Continued From page 44 asking or encouraging the resident to wear a face masks / cloth face covering. 10/9/2020 11:15 AM - During an interview, E37 (RN) who was sitting at the same nurses' station near R13, stated "If I tell him to put a mask on, in five minutes he will just take it off. I usually just ask on my residents to put a mask on at the beginning of my shift." c. Review of R14's clinical record revealed: 9/18/2020 - A quarterly MDS documented that R14 was cognitively intact (BIMS 15). 10/9/2020 11:30 AM - R14 was observed in his electric wheelchair in the hall. When asked if he usually wears a face masks / cloth face covering and if he had one, R14 said "Yes. I wear it when I go out of this area. It's in my room." But, when he went into his room to look for it, he said, "I don't see it anywhere." d. Review of R15's clinical record revealed: 7/31/2020 - A quarterly MDS documented that R15 had moderate cognitive impairment (BIMS 11). 10/9/2020 11:05 AM - R15 was observed in a wheelchair in the hall. When asked if he usually wears a face masks / cloth face covering and if he had one, R15 said, "No." e. Review of R16's clinical record revealed: 7/3/2020 - A quarterly MDS assessment documented that R16 was severely cognitively impaired (BIMS 4).	F 880		

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F 880	Continued From page 45 10/9/2020 11:45 AM - R16 was observed walking into the unit's multipurpose room, sitting down and watching TV with several other residents. When asked if he usually wears a face masks / cloth face covering and if he had one, R16 laughed and pulled a surgical mask out of his shirt pocket but did not put it on. He then began talking to the surveyor about his daughter who had the same name as the surveyor. 10/9/2020 4:15 PM - During an interview, E33 (MD) was asked about the above five residents and if there was a medical reason any of them could not wear a face masks / cloth face covering. E33 stated none of them had a medical reason that wearing a mask would cause a respiratory problem, but identified the following resident issues that may contribute to noncompliance: - R11 had forgetfulness and mental illness. - R13 had poor memory and can be hostile. - R14 could be defiant but does wear a mask if he goes out for appointments. - R15 had poor attention span. - R16 has poor short-term memory. 10/9/2020 5:00 PM - During an interview with with E1 (NHA) and E3 (DON), E3 was asked to provide documentation that these five residents were assessed as to why they were noncompliant and if individualized interventions were implemented to encourage them to wear face masks/cloth face coverings when outside their room (such as providing cloth face coverings with military themes). This information was not provided. Residents seated less than six feet apart:	F 880		

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F 880	Continued From page 46 2. 10/4/2020 - During random dining observations of breakfast meals from 7:44 AM - 9:14 AM the following occurred: a. Gold unit - Four residents were seated at a rectangular table near the unit entryway, two of the residents were seated facing each other, two residents were seated side by side, less than elbows width apart and one resident at the far end of table. In the common area, one round table had two residents seated across from each other and two round tables with three residents seated together at the table each table. During an interview on 10/4/2020 9:14 AM with E 18 (RN), nurse assigned to gold unit, it was confirmed that the residents at the rectangular table appeared to be seated less than six feet apart. E18 then stated, "well, this is how they always sit." b. Red unit - In the common area, two estimated 4-foot round tables both had two residents seated across the table facing each other. During an interview on 10/4/2020 at 8:50 am with E21 (CNA) assigned to the red unit, it was confirmed that recommended social distancing guidelines were for residents to be seated six feet apart. c. Green unit - In the common area, two residents were seated side by side, less than elbow's width apart, at an estimated 6-foot long rectangular table. Several individual bedside tables were observed not being used along the walls. During an interview on 10/4/2020 at 8:15 AM with	F 880		

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F 880	Continued From page 47 E20 (CNA) assigned to the green unit, it was reported that "we try to seat residents far apart, but space is limited and most of these tables don't raise." During an interview on 10/4/2020 at 9:31 AM, E19 (RN, nursing supervisor) confirmed that during dining residents should be seated six feet apart and stated, "six feet apart and we just do a visual or instead of four at a table we may have three, we just use our [visual] judgement." 10/5/2020- During a second dining observations of breakfast meals from 8:00 AM to 9:05 AM the following occurred: Gold unit - Four residents were seated at the same rectangular table. Two residents were again seated across from each other 3.8 feet apart and two residents beside each other at an estimated 3.4 feet. One round table had two residents seated 4.4 feet away from each other. The second-round table had three residents seated at the table, the two residents at opposite ends were 4.9 feet across from each other, the center resident was 3.11 feet equally distanced from the resident to the right and the resident to the left. Red - All residents were seated individually, one resident to a table. Green - Two residents were seated at opposite ends, and opposite sides at a six-foot rectangular table, slightly less than six feet distance apart. During an interview on 10/5/2020 at 10:02 AM with E1 (NHA), it was confirmed that E19 (nursing supervisor), reported lack of social distancing during the 10/4/2020 dining observations to unit	F 880		

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F 880	Continued From page 48 managers and E1. E1 then stated, "they [staff] have been told and educated numerous times, we will educate them again." 10/12/2020 10:40 AM - During the exit conference, findings were reviewed with E1 (NHA), E2 (NHA), E3 (DON) and E6 (RS).	F 880		