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: Atlantic Shores Rehab. & Health Center **DATE SURVEY COMPLETED: September 30, 2021**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from September 22, 2021 to September 30, 2021. The facility census on the first day of the survey was 155. The survey sample totaled 54 residents. During this period, an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed September 30, 2021: F565, F568, F580, F583, F585, F637, F656, F657, R677, F684, F686, F689, F744, F755, F756 F758, F761, F812, F842, F880, F883, F921 and F925.		

Provider's Signature Wendy Ez Title NHA Date 10/22/21

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16 Del. C., Chapter 11, Subchapter VII **§ 1162**	**Minimum Staffing Levels for Residential Health Facilities** **Nursing Staffing:** **(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** **RN/LPN CNA*** **Day - 1 nurse per 15 res. 1 aide per 8 res.** **Evening 1:23 1:10** **Night 1:40 1:20** *** or RN, LPN, or NAIT serving as a CNA.** **(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.** **This requirement is not met as evidenced by:** A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it was determined that for two days out of 21	*see attached"	

Provider's Signature Wendy Cy Title WHA Date 10/22/21

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	days reviewed, the facility failed to provide a staffing level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of facility staffing worksheets, completed and signed by the Nursing Home Administrator revealed the following: 9/18/21 - PPD = 2.92 9/19/21 - PPD = 2.87 The facility failed to maintain the minimum PPD staffing requirement of 3.28. 9/24/21 11:40 AM – In an email, E1 (NHA) wrote that the facility realized "that the weekend dated (sic) of Sept (September) 18-19th PPD numbers are not in compliance. I am providing you with the projections we had for those dated (sic). We had call offs and attempted to cover them which the documentation does show. I'm fairly new NHA in Delaware and am hoping the Eagle Law will cover us." These findings were reviewed during the exit conference on 9/30/21 beginning at 5:04 PM with E1 (NHA), E2 (Interim DON) and E3 (CCC).		

Provider's Signature [signature] Title NHA Date 10/22/21

POC Annual Survey 9-30-21

FINDINGS	PLAN OF CORRECTION	COMPLETION
16 Del. C. , Chapter 11, Subchapter VII **1162** **Minimum Staffing Levels for Residential Health Facility**	1. All residents have the potential to be affected by the deficient practice. 2. Corrective Action has been taken to enhance staffing to ensure the deficient practice does not reoccur. This includes hiring two full time CNAs and three part time CNAs, and one PRN LPN. Contracts have been signed with additional staffing agencies. Education will be provided to staff in relation to how call off affect the facility. 3. **The facility determined that the root cause was call offs on the weekends.** 4. NHA or designee will audit staffing levels daily x 4 weeks then weekly until next quarter. All results will be report to QAPI.	November 15, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085037		C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning September 22, 2021 through September 30, 2021 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 155. For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from September 22, 2021 through September 30, 2021. The facility census the first day of the survey was 155. The survey sample was 54 (fifty-four). There were thirteen (13) additional residents in subsamples for food, pests and smoking. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited. Abbreviations/Definitions used in this report are as follows: ADLs (Activities of Daily Living) - tasks needed for daily living, e.g., dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; Antipsychotic - medication to treat psychosis and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/24/2021

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

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F 000	Continued From page 1 other mental/emotional conditions; BIMS - (Brief Interview for Mental Status) - test to measure thinking ability with scores ranging from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0-7: Severe impairment; Blanchable - skin loses redness/turns white when pressed with finger (better than non-blanchable); Bowel Impaction - when stool becomes lodged in the rectum and is difficult to pass, a complication of constipation; C (Celsius) - metric unit of temperature; CCC - Corporate Clinical Consultant; CNA - Certified Nurse's Aide; Dementia - overall term for diseases and conditions characterized by a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities; DON - Director of Nursing; e.g. - for example; eMAR - electronic medication administration record; Extensive Assistance - resident involved in activity, staff provide weight-bearing support; F (Farenheit) - American unit of temperature; FM - Family Member; Incontinence - loss of control of bladder and/or bowel function; Limited Assistance - resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance; LPN - Licensed Practical Nurse; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; Moderate Cognitive Impairment - decisions poor, cues / supervision required; NHA - Nursing Home Administrator;	F 000		

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F 000	Continued From page 2 NP - Nurse Practitioner; Offloading (heels) - positioning feet so heels do not touch surfaces, to prevent pressure on heels; PRN - as needed; Psychiatric - treatment of mental disorders; Psychotropic - medication capable of affecting the mind, emotions and behaviors; QA - Quality Assurance; RD - Registered Dietician; RN - Registered Nurse; Severe Cognitive Impairment - unable to make own decisions; Supervision - oversight, encouragement or cueing; SW - Social Worker; UM - Unit Manager; % - percent.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		11/15/21

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F 565	Continued From page 3 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that the facility failed to ensure that Resident Council grievances were promptly acted upon and that the facility response was communicated to the Council. Findings include: Cross-refer F804 The Resident Council meeting minutes for June, July, and August 2021 were reviewed for resident concerns. 6/22/21 - The Resident Council had concerns that laundry was taking more than three days to label and return laundry. 7/27/21 - The facility response to the laundry concern was that the facility was still working on a resolution to the issue. 7/27/21 2:00 PM - During the Resident Council	F 565	1. Resident council minutes for June, July and August were reviewed on October 20, 2021. The Grievances and follow ups were reviewed with the Resident Council. On October 20, 2021, at 1:00 PM impromptu meeting was held and residents R15, R31, R71, R75, R81, R124, R137 and R143 were in invited to discuss laundry, housekeeping, call bell response time, pests, unprofessional staff attitudes, food complaints and employee masking concerns. 2. On October 19, 2021, Activities Director approached Resident Council President about an impromptu meeting of the Resident Council to discuss any resident concerns or grievances. Also discussed the grievance process and opportunities how resolutions will be communicated.	

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F 565	Continued From page 4 meeting, concerns were raised that rooms were not being cleaned and paper items were not being restocked in resident rooms. R75 had concerns that staff were "unprofessional", call bells were not being answered and follow up's to requests was poor. A resident who wished to remain anonymous, stated staff were talking on their cell phones in resident rooms. Several residents also had concerns that they had pests (mice and bugs) in their rooms. 8/24/21 - Facility responses to the July Resident Council meeting concerns: - Laundry issue was due to limited laundry staff, because laundry staff were now helping housekeeping clean and stock resident rooms. - Staff education was ongoing concerning call bell responses and professionalism. - Pest resolution was ongoing and follow up from the facility listed the dates that pest control was in the facility. 8/24/21 2:00 PM - A Resident Council meeting was held where concerns were raised about call bell wait times, face masks not being worn properly, and not getting water at night. - No follow up to these concerns were noted in the resident minutes as of 9/22/21. 9/24/21 1:25 PM to 3:00 PM- During a Resident Council meeting held with residents (R15, R31, R71, R75, R81, R124, R137, R143) the attendees stated the facility did not always act on the Resident Council concerns. The food was often unpalatable, pests were seen in rooms, including mice and bugs. Laundry was often slow and misplaced items. There were concerns that staff members were unprofessional, did not answer call bells timely and often had a "bad	F 565	3. Education was provided by Nursing Home Administrator to facility administrative staff on grievance process, resolutions and how it should be communicated to residents/council members. 4. Education was provided to residents regarding who the grievance officer is and where they can get grievance forms along with how to make an anonymous grievance. During Resident Council meetings each month any complaint made will have a resident council concern form filled out and given to the manager of that department. The manager will follow up with that resident directly. During next month's meeting, previous months concerns will be reviewed by the Activities Director. A representative from each area i.e.: Nursing, Maintenance, Dietary, etc. will be present at Resident Council to ensure that residents are satisfied that the complaint has been settled. NHA or designee will audit responses monthly and report to QAPI x 3 months then quarterly or until 100 % compliance is achieved. Audit result will be submitted to QA committee. 5. Date of compliance November 15, 2021.	

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F 565	Continued From page 5 attitude." 9/27/21 4:00 PM - In an interview, R15 (Resident Council President) confirmed that the facility follow-up on Council concerns was inconsistent. R15 stated that he "still sees mice in his room, as well as black bugs in his shower." R15 stated that he spoke with E5 (Dietary Manager) about food concerns and that it would improve for a time, then in a month or so they (food concerns) would come up again. R15 also stated that staff members are still unprofessional and stated that especially at the change of shift, he could hear them yelling at each other and talking loudly about their personal business in the hall outside of his room. The facility failed to consistently communicate responses to Resident Council grievances. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 565		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly	F 568		11/15/21

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F 568	Continued From page 6 statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observation, it was determined that the facility failed to provide quarterly statements of personal funds accounts for one (R126) out of four residents reviewed for personal funds. Findings include: Review of R126's clinical record revealed: 5/17/19 - R126 was admitted to the facility. 9/7/21 - A quarterly MDS (Minimum Data Set) assessment stated that R126 had a BIMS (Brief Interview for Mental Status) score of 15 indicating she was cognitively intact. 9/23/21 1:45 PM - During an interview, R126 stated that she has not received any statements for her personal funds that the facility manages. She knows she can get money out, but she has no idea how much money is in her account. 9/29/21 1:35 PM - During an interview, E1 (NHA) stated that R126 must know how much money is in her account because she withdraws money. 9/29/21 4:00 PM - During an interview with E35 (Business Manager) and R126 in her room, B35 showed R126 her personal fund account statements. R126 denied ever receiving these statements and did not understand how she had so much money in her account. R126 said because she is now bed bound when she needs spending money, she asks the activity staff to get money for her out of her account. E35 explained to R126 the funds she now has (e.g., stimulus	F 568	1. Resident R126 received a copy of personal funds statement on 9/29/21. E35 was educated on the importance of resident receiving quarterly personal funds account. 2. A facility sweep identifying any resident with a BIMS (Brief Interview for Mental Status) of 13 or higher or a resident who requests money out of their personal funds account will receive their statement each quarter. Facility Business Office Manager will have resident sign a copy of the statement. All other resident statements will be mailed to their representative on file. 3. The facility determined that the root cause was staff not understanding which residents should receive their statements directly. Business office manager was educated on resident/representatives receiving quarterly statement of personal fund accounts. 4. NHA or designee will audit personal funds statements quarterly for signatures and mailing confirmation and will be submitted to QA for three quarters or until 100 % compliance is achieved. Audit result will be submitted to QA committee. 5. Date of compliance November 15, 2021.	

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F 568	Continued From page 7 checks received) and requested to contact her directly when she needs spending money. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 568		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		11/15/21

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F 580	Continued From page 8 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to immediately consult with the resident's physician for one (R126) out of six (6) residents reviewed for unnecessary medications. The facility failed to immediately consult R126's physician when she developed a nosebleed that required nursing intervention on 9/22/21 at 5:15 PM. R126 was on an anticoagulant (increases the risk of bleeding) drug that was decreased by half the dose after the physician was notified of the nosebleed by the surveyor. Findings include: The facility's policy titled Notification of Change (undated), provided by E3 (Corporate Clinical Consultant), included, "The charge nurse, unit manager or nursing supervisor will notify the physician when...there is a significant change in the resident's physical, mental or psychosocial	F 580	1. E 16 (NP) was verbally notified on 9/27/21 by ADON with no new orders of R126's nosebleed E13 Nurse was verbally educated on policy for physician notification of change in condition on 9/28/21. 2. Medical record documentation will be reviewed of residents on anticoagulant therapy to identify possible significant changes in condition related to bleeding that occurred in the last two weeks. Any identified findings during the review will be notified to NP or Physician for follow up. 3. The facility determined that the root cause was due to the staff's lack of knowledge related to change in condition and notification of change although issue	

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F 580	Continued From page 9 status...the licensed nurse will record in the resident's medical record any changes in the resident's condition and the notification of the physician, family member and/or responsible party." Review of R126's clinical record revealed: 5/17/19 - R126 was admitted to the facility. 5/17/19 (last revised 7/3/19) - A care plan was initiated that R126 has a potential for alteration in hematological (bleeding) status related to anticoagulant side effects and included interventions to monitor for side effects. 5/17/19 through 9/29/21 - A review of MDS assessments revealed that R126 had been receiving an anticoagulant medication (med) since 9/17/19. 8/31/21 - Physicians' orders (after R126's most recent readmission to the facility) included to give: - An anticoagulant med by mouth two times a day. - A low dose Aspirin (can increase risk of bleeding) once a day. 8/31/21 - An order notification was documented in the EMR warning of a potential severe level interaction that stated the use of [the anticoagulant med] with Aspirin may increase the risk of bleeding. 9/22/21 5:15 PM - When the Surveyor entered R126's room she was observed in bed having an active nosebleed of bright red blood and holding bloody tissues on her nostrils. E13 (LPN) was	F 580	may be resolved. Staff Development/Designee will in service licensed staff regarding change in condition and physician notification policy. 4. Audits of residents on anticoagulant therapy will be conducted by ADON/Designee to ensure that changes in condition are communicated to medical provider. Audits will be done weekly x 4 then monthly or until a 100% compliance is achieved, Audit result will be submitted to QA committee. 5. Date of Compliance November 15, 2021	

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	085037		C 09/30/2021

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F 580	Continued From page 10 notified of the nosebleed then entered the room to assess and assist R126. When asked, R126 stated she does take anticoagulants. 9/23/21 8:45 AM - During an interview with the nurse assigned to R126 for day shift, E57 (RN) stated that she was not informed of R126's nosebleed. 9/23/21 1:45 PM - During an interview, R126 stated that last night's nosebleed stopped after being assisted by E13. In addition, she stated that she has had other nosebleeds, but not recently. 9/29/21 8:30 AM - During an interview and observation, E19 (interim ADON) confirmed that there was no documentation in the EMR that R126 had a nosebleed on 9/22/21 or that the physician was notified. E19 reviewed and confirmed that the "Doctor's Book" did not have a message regarding the nosebleed. 9/29/21 9:10 AM - During an interview, E16 (NP) and E17 (Physician) confirmed they were not notified of the nosebleed and that they would have wanted to be notified because R126 was on anticoagulants. E16 checked and confirmed that the on-call medical group was not notified. 9/29/21 1:00 PM - During an interview, E15 (NP) confirmed she was not notified of the nosebleed and that she spoke with E18 (Medical Director) who was also not notified. 9/29/21 - Physicians' orders included to decrease the anticoagulant dose in half and to stop the Aspirin.	F 580		

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F 580	Continued From page 11 The facility failed to follow the standard of care to notify the physician and to document in the medical record R126's nosebleed. When on anticoagulants, evidence of bleeding, such as nosebleeds, blood in the urine, and red or tarry (black tar like) stools, warrant a call to the physician. (CapPharmacology) These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		11/15/21

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F 583	Continued From page 12 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that for one (rehabilitation- rehab) out of four units, the facility failed to secure the residents Protected Health Information (PHI). Findings include: 9/24/21 11:36 AM - A list of resident names, care issues, and diagnoses was observed on the top of an unattended medicine cart during a random observation in the rehab unit. An interview with E4 (RN) confirmed that she was aware that residents' PHI should not be left out in view. E4 then turned the information face down so it could not be viewed. 9/28/21 3:04 PM - A list of resident names, care issues, and diagnoses was observed on the top of an unattended medicine cart during another random observation on the rehab unit. An interview with E4 (RN) again confirmed that she was aware that residents' PHI should not be left out in view. E4 then turned the information face down so it could not be viewed. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 583	1. E4 educated on maintaining resident privacy and confidentiality of records. Facility observation will be conducted by DON/designee by October 27, 2021 to ensure staff are observing privacy and confidentiality of records. 2. The root cause of the incident was due to the staff's lack of understanding on ensuring PHI is secured. 3. Licensed Nurses will be in-serviced by Staff Development/Designee regarding the importance of maintaining that the resident's PHI is secured. Nursing Management staff will routinely monitor that staff's practices are consistent with procedure to maintain resident's privacy and confidentiality of records. 4. Audits will be conducted by Unit Managers/Designee through observation to ensure staffs are consistent with ensuring PHI is secured. Audits will be completed weekly x 4 weeks, then monthly x 2 or when 100% compliance is achieved. Audit result will be submitted to	

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F 583	Continued From page 13	F 583	QA committee. 5. Date of compliance November 15, 2021.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as 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	F 585		11/15/21

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F 585	Continued From page 14 (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (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	F 585		

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F 585	Continued From page 15 summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed 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 interview and review of other facility documentation, it was determined that, for two (R33 and R56) out of three residents sampled for personal property, the facility failed to have initiate a grievance when lost laundry items were not located. Additionally, the facility's grievance policy did not include a process for anonymous reporting. Findings include: 1. The facility policy entitled Grievance and Concerns / Complaint (revised 9/15/21) included the process for submitting a grievance or complaint. " ... Grievance forms are available on each nursing unit, the Reception Desk and each Social Services office ... Should a staff member overhear, or be the recipient of a complaint voiced by a resident, his/her representative, or	F 585	1. R33 and R8 grievances were completed for lost laundry items. Family member of R8 and R33 were contacted to review lost clothing items to assure replacement. E31 and E36 was educated on grievance form location and how to complete a grievance anonymously. 2. Social Services or designee will conduct visits with residents to assess if any issues arise related to lost clothing. 3. The facility determined that the root cause was due to staff not knowing who grievance officer was and resident's and resident families not knowing how to file a grievance. Staff will be in-serviced regarding grievances. Residents will be	

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F 585	Continued From page 16 other interested family member ... the staff member should encourage and assist ... to file a written concern with the facility ... If the resident is incapable of obtaining and completing a form ... the staff member should immediately notify social service representative ... assist with the completion of the form if the social service representative is not available ...". The policy did not include the process for filing a grievance anonymously. 9/24/21 3:01 PM - During an interview with E31 (SW), when asked where residents would get grievance forms and the location of the drop box, E31 did not know, she would ask the person who handled grievances. 9/24/21 3:25 PM - During a follow-up interview, E31 said the resident would get the form from us and we would put it in. When asked how a resident could do a grievance anonymously, E31 did not know the answer and stated that she would find out. 9/24/21 3:34 PM - During an interview, E31 said the forms are at the nursing stations and E31 did not identify how a grievance could be submitted anonymously, other than sliding it under the social services door. 2. 9/22/21 6:00 PM - 6:45 PM - During an interview, FM1 (Family Member of R8) expressed concern over the loss of numerous clothing items (20 pairs of underwear, three pairs of sneakers, four pairs of slippers and all of her pants and tops) along with three comforters. FM1 explained that this occurred just prior to COVID hitting, around March of 2020. FM1 added that R8's name was on all of her items and that FM1 went	F 585	reminded at each resident council how to file a grievance. Each nurse's station will have a mailbox and information regarding who grievance officer is and how to file a grievance anonymously. Residents and family members will be notified via letter regarding grievance procedure. 4. Grievance officer to look in mailboxes Monday, Wednesday, and Friday for grievances. NHA or designee will review completed grievances forms for any lost items/clothing. Audits will be completed weekly x 4 then monthly or until 100 % compliance is achieved for any identified issues and resolution. Audit result will be submitted to QA committee. 5. Date of Compliance November 15, 2021.	

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F 585	Continued From page 17 to the laundry room several times to look for the items. FM1 stated she was told by staff that R8 threw items in the trash or toilet. FM1 added that she discussed the issue with E45 (former NHA) and met with him. March 2020 - September 2021 - Review of all grievances provided by Social Services involving lost personal items found no grievance about R8's lost items. 9/28/21 approximately 4:05 PM - During an interview with E3 (CCC and former DON) to discuss the lost items, E3 stated, "I seem to remember the 20 pairs of underwear." 9/29/21 4:45 PM - During an interview, E30 (SW) stated a former SW took care of grievances at that time. E30 indicated she would look into it when the Surveyor stated that R8's grievance was not in the pile of grievances provided to the Surveyors. 9/30/21 10:29 AM - During an interview, E1 (NHA) stated that she was doing the grievance now. The Surveyor informed E1 that E3 was aware of the issue. 3. 9/23/21 12:31 PM - During an interview, R33 complained that six of her nightgowns that she had when she was on Station 2 have been missing for several months (she said that she was moved to a room on Station 1 a couple of weeks ago). R33 added that she told several CNAs (on Station 2 who then told the laundry staff) and the laundry staff visited her and told her they were looking for them. March 2020 - September 2021 - Review of all	F 585		

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F 585	Continued From page 18 grievances provided by social services involving lost personal items found no grievance about R33's lost items. 9/29/21 11:30 AM - During a follow-up interview, R33 stated that the facility did not find any of her nightgowns. 9/29/21 12:45 PM - During an interview, E36 (Housekeeping Manager) stated she had talked with R33 several times and tried to find her nightgowns. E36 stated most of the time residents' personal clothing is lost because the nursing staff do not make sure items are labeled with the residents' names. When asked if she did a grievance, E36 said no since the social workers are the ones who do them. 9/30/21 10:29 AM - During an interview, E1 (NHA) stated that she was doing the grievance now for R33's lost nightgowns. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 585		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than	F 637		11/15/21

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F 637	Continued From page 19 one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that, for one (R56) out of four residents sampled for dementia, the facility failed to identify a significant change of condition on the 7/22/21 quarterly MDS assessment. Findings include: 1/15/21 - R56 was admitted to the facility with dementia. 4/24/21 - The quarterly MDS assessment revealed R56's BIMS score was 12 (moderate cognitive impairment), was understood and could understand others, had behaviors four to six days a week, was frequently incontinent of urine, occasionally incontinent of bowel and denied having pain. 7/22/21 - The quarterly MDS assessment showed that R56 had severe cognitive impairment (score 3), was less able to understand others and less able to be understood, had no behaviors, was now always incontinent of urine and frequently incontinent of bowel. The facility failed to identify the change (decline) in three or more areas, and, thus, did not complete a significant change assessment. 9/29/21 10:32 - During an interview the Surveyor reviewed the findings with E27 (RNAC) who said she would look into it. 9/30/21 8:40 AM - During an interview, E33	F 637	1. R56□s MDS was modified on 10/1/2021 to reflect a comprehensive assessment after a significant change. E27 and E33 (RNAC) was educated on 10/1/2021 regarding appropriate assessments as per the RAI manual. 2. Facility sweep will be conducted to review quarterly assessments for the last 30 days. Declines will be reviewed and any assessments that need to be modified as indicated as per RAI manual will be completed. 3. The root cause was due to the staff □s understanding at the time of the assessment, criteria that it did not meet the definition of a significant decline in MDS coding. Corporate Consultant/Designee will educate facility RNAC related to assessments warranting a Significant Change in Condition assessment. 4. A weekly audit of due quarterly assessments for residents will be conducted by Corporate Consultant/Designee to determine if the quarterly assessment indicated a decline in ADL□s and or continence. An audit will be conducted weekly x 4 weeks until a 100% compliance is achieved. Following will be monthly for the next quarter. Audit	

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F 637	Continued From page 20 (RNAC) stated R56's change was not acute, it was disease progression. The Surveyor explained that there were declines in many areas indicating a decline and that a significant change MDS assessment would prompt a close review of care interventions R56 needed. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 637	results will be presented to QA committee. 5. Date of Compliance November 15, 2021	
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 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	F 656		11/15/21

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ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

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F 656	Continued From page 21 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 record review, it was determined that for one (R102) out of four residents sampled for pressure ulcers, the facility failed to develop a comprehensive care plan that included turning, repositioning, and offloading heels to prevent pressure injuries. Findings include: 8/18/21 - A physician order was written to turn and reposition R102 and to encourage offloading of heels while in bed. 8/19/21 - A nursing admission note by E4 (RN) revealed "mushy heels" and no other skin issues. 8/20/21- An admission nursing progress note revealed a pink blanchable buttock. 8/25/21 1:30 PM - A skin/wound note by E41 (CNP wound care) documented, "No open wounds on today's skin assessment; please keep patient's skin clean and dry, apply barrier cream as necessary to prevent skin breakdown, and	F 656	1. R102's Comprehensive care plan for pressure ulcers has been updated on 9/28/2021. 2. All residents at risk for pressure ulcers will be reviewed to assure that care plan will be updated with specific intervention to prevent pressure injuries. 3. A root cause analysis was conducted and determined that the omission was due to lack of follow up review for the new admissions. Staff Development/Designee will educate Licensed staff and RNAC's regarding the importance of developing a comprehensive plan of care for new admissions to prevent pressure injuries. 4. Audit by the ADON/Designee will be conducted for new admissions/readmissions to ensure	

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F 656	Continued From page 22 avoid pressure to any bony prominence (bony area on body that increases pressure on skin) by adhering to turn protocols and floating heels (positioning feet so heels do not touch surfaces, to prevent pressure) as applicable." 8/25/21 - R102's care plan to prevent pressure injuries failed to include turning and repositioning and encouraging offloading of heels. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 656	comprehensive care plan is in place to prevent pressure injuries. Audits will be done weekly x 4 then monthly or until 100% compliance is achieved. Audit results will be submitted to the QA committee. 5. Date of Compliance November 15, 2021	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		11/15/21

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F 657	Continued From page 23 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that, for two (R8 and R102) out of eight residents investigated for ADLs and respiratory care, the facility failed to revise their care plans to reflect the residents' current condition. Findings include: 1. Review of R8's clinical record revealed: 10/2/15 - A care plan for ADLs (revised 6/17/21) included the intervention for nursing staff to provide care as needed related to deficits to ensure ADL needs are being met. 9/13/21 - An annual MDS assessment documented R8 as having severe cognitive impairment and R8 needed physical assistance with bathing and limited assistance with both personal hygiene and toilet use. September 2021 - Review of CNA documentation revealed the tasks were not updated to reflect the level of assistance needed. Bathing/shower was listed as supervision and both personal hygiene and toileting were listed as independent. September 23, 24, 27, 28 and 29, 2021 - Observations showed that R8 received assistance with bathing prior to breakfast which were later recorded on the CNA documentation as providing extensive assistance each day.	F 657	1. R8 ADL and R102 Respiratory care plan/tasks were revised on 9/28/21. 2. Resident Care plans/tasks on ADL and respiratory status will be reviewed to assure that care plans are consistent with resident's current status. 3. The root cause was determined that the omission was due to lack of timely follow up in care plan revision related to ADL and respiratory care. Licensed Nursing staff, RNAC and therapy will be in-serviced by Staff Development/Designee regarding timely care plan revision related to ADL and respiratory care. 4. Audits will be completed by Rehab Director/Designee for residents scheduled for quarterly assessment to ensure level of ADL assistance is current for the residents. Audits will be completed Weekly x 4, monthly x 2 or until 100 % compliance is achieved. Audit on respiratory care plans with be completed by ADON/Designee to ensure care plan reflects resident's current status. Audit will be completed weekly x 4, monthly x 2 or until 100% compliance is achieved. Audit results will be reported to QA committee.	

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F 657	Continued From page 24 9/30/21 8:20 AM - During an interview with E55 (MDS), the discrepancy of the CNA tasks for bathing, hygiene and toileting compared to the MDS assesment was discussed. The Surveyor explained that a floating or agency aide would not know the degree of help that R8 needed. E55 confirmed that the degree of assistance included on the tasks were not reflective of R8's MDS assessment. 2. The following were revealed in R102's clinical record: 8/25/21 - R102's care plan did not include the use of oxygen. 8/31/21 9:29 PM - A skilled nursing note revealed that R102 was on oxygen. 9/2/21 6:18 PM - A care plan meeting note did not address the addition of oxygen. 9/2/21 10:06 PM - A skilled nursing note documented R102 was on oxygen at 2 liters. 9/27/21 3:53 PM - An interview with E20 (UM) confirmed that R102's care plan was not updated when oxygen was started. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (Corporate Clinical Consultant).	F 657	5. Date of Compliance November 15, 2021.	
F 677 SS=E	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	F 677		11/15/21

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F 677	Continued From page 25 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that, for three (R50, R56,and R59) out of five residents reviewed for activities of daily living, the facility failed to provide incontinence care, hand hygiene and hair brushing for residents unable to do so on their own. Findings include: 1. The following was reviewed in R59's clinical record: 4/23/20 - R59 was admitted to the facility with a left below the knee amputation. 7/23/21 - A quarterly MDS assessment documented that R59 was cognitively intact, required extensive assist for his care, and was incontinent of urine. 9/22/21 8:40 AM - During an interview, R59 reported that on the night shift he rang his call bell and told the CNA that responded to his call bell that he was wet, and that his shirt, his pad and the bed were all wet. R59 stated that the CNA changed his incontinence brief, but did not change his clothing or the bed linen. R59 lifted up his blankets for the surveyor to see and R59's bed was soaked from one side to the other beneath the resident. 9/27/21 8:21 AM - During an interview, R59 stated that he was wet through to his bed last night. R59's bed was unmade, the mattress was airing out, and appeared to be wet. During an interview, E40 (CNA) confirmed that R59's bed	F 677	1. R59's incontinent care task was reviewed. CNA involved will be educated regarding incontinence care and documentation. R59's skin was assessed with no skin alteration identified. CNA involved for R56 was educated regarding compliance with plan of care related to incontinent care. R50's hair was brushed and free of any tangles. A therapy referral will be requested to review R50s level of assistance with personal hygiene. Plan of care will be updated as applicable. 2. Current resident's POC documentation for the last 7 days will be reviewed for compliance with incontinence care and personal hygiene. Any issues identified will be addressed with staff involved and education will be provided. 3. Root cause was determined to be due to the CNA's delay with providing incontinent care and personal hygiene was and the lack of consistent documentation that care was provided. Staff Development/Designee will in-service CNAs on the importance of providing incontinence care and personal hygiene and to document the care provided in Point of Care (POC) 4. Audit will include a random observation of incontinent care and personal hygiene (nails, hair) of 10	

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F 677	Continued From page 26 was soaked this morning. R59's roommate, R100 stated that the last time an aide was in to change R59 was about 2 or 3 o'clock this morning. R100 is cognitively intact. 9/29/21 12:23 PM During an interview, E40 (CNA) reported that she had looked at R59's bladder incontinence record and her conclusion was that the resident did not get care for the 11 PM to 7 AM shift. E40 stated that the days she has been R59's aide, 9/27-9/29/21, R59 has been wet all the way through to the bed every day. E40 stated that even if R59 is a "heavy wetter", R59 should not have been that wet if the last rounds for incontinence care were provided. A review of R59's urinary incontinence record revealed that 10 entries were blank and lacked evidence that incontinence care was provided on the following dates and shifts: -Day shift 9/5, 9/11, and 9/13/21. -Evening shift 9/16/21. -Night shift 9/11, 9/15, 9/16, 9/19, 9/20, and 9/21/21. The facility lacked evidence that R59's need for urinary incontinence care was completed on the aforementioned dates. Cross Refer F637 and F686 2. Review of R56's clinical record revealed: 1/15/21 - R56 was admitted to the facility with dementia. 1/21/21 - A care plan for being at risk for	F 677	residents for each unit. by the Unit Manager/Designee. Audits will be done weekly x 4 then monthly or until 100% compliance is achieved of care provided and POC documentation. Audit results will be submitted to the QA committee. 5. Date of Compliance November 15, 2021.	

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F 677	Continued From page 27 pressure ulcers (a sore area of skin that develops when blood supply to it is cut off due to pressure from laying or sitting in the same position) included the intervention to perform incontinence care every two to three hours and as needed. 7/22/21 - R56's quarterly MDS assessment identified that R56 had severe cognitive impairment and was always incontinent of urine. 9/22/21 - 9/24/21 - Observations revealed the facility failed to provide incontinence care every two to three hours according to R56's care plan and failed to provide hand hygiene before meals. - 9/22/21 8:05 AM - 1:45 PM: R56 was seated in a wheelchair in the hallway at Station 3's nursing station. R56 ate breakfast and lunch in the same location. At 1:45 PM when the Surveyor left the area, R56 had not received incontinence care or hand hygiene since being up in the wheelchair from before breakfast. - 9/23/21 8:30 AM - 1:00 PM: R56 ate breakfast and lunch while in the hallway by Station 3's nursing station in her wheelchair. When the Surveyor left the area at 1:00 PM, R56 had not received incontinence care or hand hygiene. - 9/24/21 7:50 AM - 12:05 PM: While seated in her wheelchair in the hallway by the Station 3 nursing station, R56 ate breakfast and lunch and remained there without incontinence care until E7 (RN, UM) asked the aide to take her to the bathroom and use the sit to stand [lift]. 9/28/21 10:32 AM - During an interview with E3 (Corporate Clinical Consultant), the Surveyor provided a written list of identified concerns,	F 677		

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F 677	Continued From page 28 including the aforementioned observations. 9/29/21 9:35 AM - During an interview, E3 returned the written list with the observations marked with a yellow highlighter, but offered no explanation. 3. Review of R50's clinical record revealed: 3/22/21 - R50 was readmitted to the facility after having a stroke that left her without the ability to use her right arm/hand and difficulty speaking. 6/5/12 A care plan for ADL deficit due to late effects of a stroke (last reviewed 8/23/21) included that R50 required total assistance with personal hygiene care (including washing hair) and required one staff participation with showering. The goal was for R50 to complete all personal care tasks (excluding showering and hair care) with no more than set up assistance. September 2021 - Review of CNA documentation tasks, however, included that R50 was independent with personal hygiene, which was not reflective of R50's ability to brush her hair. 9/23/21 8:59 AM - During an observation, R50's hair was part way down her back below her shoulders and in a pony tail using a rubberband. R50's hair below the rubberband was tangled and matted. 9/24/21 10:10 AM - R50 was observed sitting in her wheelchair in the activity room awaiting her turn to receive nail care from CNA students. R50's hair remained the same, tangled and matted.	F 677		

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F 677	Continued From page 29 9/28/21 9:48 AM - While seated in her doorway, R50's hair remained tangled and matted below the pony tail. When asked if staff ever brushed her hair, she replied, "No." When asked if she could brush any part of her hair, she said, "No." When asked if she would want to have her hair brushed, R50 said, "Yes." 9/29/21 9:50 AM - During an interview with E27 (MDS Coordinator), CNA tasks and lack of interventions addressing R50's hair brushing were reviewed. E27 said she would take care of it. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R65) out of one resident reviewed for constipation the facility failed to implement the bowel protocol. R65 had no assessment or interventions for not having a bowel movement in eight days. Findings include:	F 684	1. R65's has been discharged from facility. 2. Current resident's bowel documentation record was reviewed to assure that necessary intervention per bowel protocol was initiated.	11/15/21

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F 684	Continued From page 30 The undated facility bowel protocol states: "If no bowel movement (BM) for three days, give Milk of Magnesia [laxative], if no results follow with Bisacodyl [laxative] tablets or suppository, if no BM after Bisacodyl, follow with Fleet's enema. If no results after enema, notify the provider." 7/28/21 - R65 was admitted for rehabilitation. A record review of physician orders for R65 revealed: 7/28/21 1:13 PM - A Physician's order was written for Milk of Magnesia thirty milliliters for no BM for three days. 7/28/21 1:13 PM - A Physician's order was written for Bisacodyl tablets or suppository every twenty four hours if Milk of Magnesia was not effective. 7/29/21 1:13 PM - A Physician's order was written for a Fleet's enema every day if Bisacodyl not effective and call MD if no results. September 2021 review of CNA documentation noted no documented bowel movement for eight days, from 9/17/21-9/24/21. 9/24/21 8:48 AM - During a random observation of R65 during breakfast, R65 was holding a basin and breakfast was on the table at the bedside, uneaten. R65 stated, "I'm sick to my stomach and can't eat." On interview, R65 stated to the Surveyor that she had only one BM since her admission to the facility. 9/24/21 9:57 AM - In an interview with E20 (UM) and E65, E20 was unable to explain why R65 had not had a BM for eight days. E20 stated that a	F 684	3. It was determined that the root cause was due to system alerts not triggering appropriately. A work order was requested, and this is issue was resolved on 10/8/21. Staff Development/Designee will in-service nursing staff regarding documentation of bowel movements and following bowel protocol per physician orders. 4. Audit by the ADON/Designee will be conducted to ensure bowel movements are documented appropriately and bowel protocol followed per physician orders. Audits will be done weekly x 4 weeks, then monthly or until 100 % compliance is achieved. Audit results will be submitted to the QA committee. 5. Date of Compliance November 15, 2021.	

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F 684	Continued From page 31 report was run every day that identified the residents who had not had a BM for three days and R65 was not identified on this report. E20 then asked R65 when she last had a BM and R65 was unable to state when she last moved her bowels. E20 listened to R65's bowel sounds and confirmed they were present. E20 stated that she will call the provider about the findings. 9/24/21 10:15 AM - During an interview, E22 (LPN) stated that R65 had a BM "a few days ago." E22 was unable to confirm with the CNA that R65 had a bowel movement. E20 went to report the findings to the provider. 9/24/21 10:30 AM - During an interview, E20 (UM) stated that she spoke to the doctor and x-rays were ordered to determine R65's bowel status. 9/24/21 1:25 PM - During an interview, E20 (UM) stated that the results of the x-rays were negative for bowel impaction. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON), and E3 (CCC).	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		11/15/21

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F 686	Continued From page 32 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that, for one (R56) out of five residents investigated for pressure ulcers, the facility failed to ensure measures to prevent pressure ulcers (sore area of skin that develops when blood supply to it is cut off due to pressure from sitting or laying too long) were implemented. Findings include: Cross Refer F677, Example 2 Review of R56's clinical record revealed: 1/15/21 - R56 was admitted to the facility with dementia. 1/21/21 - A care plan for being at risk for the development of pressure ulcers included the intervention to turn and reposition every two hours. 7/22/21 - The quarterly MDS assessment documented R56 needed extensive assistance in turning/sitting up in bed and was always incontinent of urine (unable to control urine from leaving the bladder). 9/22/21 8:05 AM - 1:45 PM - R56 was in her wheelchair in the hallway by Station 3's nursing station. R56 occasionally attempted to stand, without her buttocks lifting off of the wheelchair cushion. Every time R56 tried to stand, she was	F 686	1. R56's skin was assessed. No alteration in skin integrity was identified. Staff involved was educated on providing incontinent care and re-positioning while in chair to prevent pressure ulcers 2. Residents that require incontinent care and re-positioning in chair will be reviewed to assure that care is provided in order to prevent pressure ulcers. 3. Root cause was determined to be due to the staff's lack of understanding of the appropriate timing for providing incontinent care and assistance with turning and repositioning of the resident. Staff Development/Designee will in-service nursing staff regarding providing incontinent care and assistance with turning and repositioning in order to prevent pressure injury. 4. Audits through observation of 10 residents from each unit by the Unit Manager/Designee will be conducted to ensure staff is providing timely assistance with turning and repositioning and incontinent care audits will be completed weekly x 4 then monthly or until 100 % compliance is achieved. Audit results will be submitted to the QA committee.	

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F 686	Continued From page 33 directed to "Sit down." 9/23/21 8:30 AM - 1:00 PM - While in her wheelchair from breakfast until after lunch, R56 periodically tried to stand, without lifting her buttocks off of the wheelchair cushion. Due to her severe cognitive impairment, when staff asked what she needed, R56 was not able to state what she wanted and R56 was told to "Sit down." 9/24/21 7:50 AM - 12:15 PM - R56 attempted to stand multiple times from her wheelchair, but could not lift her buttocks off of the wheelchair cushion. At 12:15 PM, E7 (RN, UM) asked the aide to take R56 to the bathroom and to use the sit to stand lift since R56 was weak and did not walk. 9/28/21 10:32 AM - During an interview with E3 (CCC) to review concerns about R56, the Surveyor presented E3 with a written list, including the prolonged hours in the wheelchair and lack of incontinence care. 9/29/21 9:35 AM - E3 returned the written list with the observations highlighted in yellow and offered no explanation. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 686	5. Date of Compliance November 15, 2021	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		11/15/21

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F 689	Continued From page 34 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of other facility and State Agency documentation, it was determined that, for two (R73 and R79) out of three current residents investigated for accident hazards the facility failed to adequately monitor R73 to prevent elopement and failed to implement fall precaution interventions for R79. Findings include: 1. Review of R73's clinical record revealed: 2/2/21 - R73 was admitted to the facility with dementia from alcohol abuse and had a history of brain surgery. R73 threatened to leave the facility, but his family talked him into staying. 2/2/21 - Physicians' orders included a wanderguard bracelet which should activate an alarm when R73 got close to sensors located at exit doors in the facility. 2/3/21 - A care plan for elopement risk was initiated and included the use of the wanderguard. 5/10/21 - The quarterly MDS assessment identified that R73 had moderate cognitive impairment (decisions poor, cues / supervision required) with a score of 8 (moderate score range 8-12). 7/26/21 - A Psychology note documented some verbal aggression and sometimes seeking to exit	F 689	1. R73 is now located in a locked unit. Front door locking mechanism was inspected. R79's plan of care was reviewed and interventions applicable for the resident are now in place. 2. Current residents' elopement risk and fall risk will be reviewed to assure that appropriate interventions are implemented. will be reviewed for wandering risk. Resident triggering 3. Root cause R 73 -Resident left the facility due to a desire to buy alcoholic beverages. The root cause of R79 was determined to be staff ensuring that all resident interventions were in place during room change and reviewed periodically. Staff Development/Designee will in-service facility staff on assuring that residents who are on elopement and fall risk have appropriate interventions in place. 4. Residents who are at risk for elopement and fall risk will be completed by the Unit Manager/Designee to ensure interventions are in place based on plan of care. Audits will be done weekly x 4	

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F 689	Continued From page 35 (the facility). 8/2/21 - A Psychology note documented that R73 was preoccupied with leaving, and needed redirection and distraction from his obsessive thoughts. 8/10/21 - The quarterly MDS assessment documented that R73 was able to walk and had severe cognitive impairment with a score of 6 (severe score range 0-7). 8/17/21 - Review of facility information reported to the State Agency included that when [R73] was not in his room or on the unit, a search was conducted. [R73] was last seen in his room approximately 30 minutes prior when being given his medications. [R73] was located outside of the facility by the nurse and was safely returned inside the facility. A full body assessment was completed with no abnormalities. Vital signs stable. Resident was offered dinner in his room with no complaints. [R73] was placed on 15 minute checks at this time and the NP and sister were notified. The facility's conclusion was that the rug might have slid in/under the door when a visitor's scooter entered the building which deactivated the wanderguard alarm. 8/19/21 - A psychology note documented that [R73] was sorry he eloped to a liquor store. R73 was now in the locked unit. 8/20/21 - 9/15/21 - Review of the State Agency investigation found that R73 left the facility out the front door at 5:48 PM, crossed the four-lane highway and went to the store to buy beer. Shortly after 5:15 PM, several employees held the front door open for a visitor on a scooter who was	F 689	weeks, then monthly or until 100 % compliance is achieved. Audit results will be submitted to the QA committee. 5. Date of Compliance November 15, 2021.	

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F 689	Continued From page 36 having difficulty getting into the building. E45 (former NHA) identified that when the front door remained open for an extended period of time, the wanderguard alarm would not go off. Facility video of the front door showed the door was open a little after the visitor on the scooter entered the facility's front door. No one saw R73 leave the facility. R73 was found across the street and was driven back to the facility at approximately 6:30 PM with a bag containing three beers. The wanderguard alarm activated when R73 passed the wanderguard sensors upon his return. 9/27/21 7:40 AM - During an interview, E46 (Front Desk) stated that the facility updates the residents on the elopement list "every three to four days." E46 added that residents usually have on a wanderguard that triggers the alarm and the door to lock. 9/28/21 9:26 AM - During an interview, the Surveyor asked E3 (CCC) for R73's elopement investigation packet with statements, root cause analysis and anything done since the elopement. The information received did not include interventions/changes put in place after the elopement. 9/28/21 approximately 10:25 AM - During an interview while E48 (Maintenance) was at the keypad inside the front door which was uncovered with wires visible, when asked if he was fixing the door so that the wanderguard alarm would ring if the door remained open for an extended time, E48 acknowledged that the inside keypad was broken and that the wanderguard sensors were separate. There was no response about the deactivation of the wanderguard alarm when the front door remained open.	F 689		

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F 689	Continued From page 37 9/30/21 6:20 PM - During an interview, E47 (Front Desk) acknowledged that there is a posting at the front desk with pictures of residents on the elopement list. 2. The following was reviewed in R79's clinical record: 11/4/2018 - R79 was admitted to the facility with dementia. 11/5/2018 - R79's fall care plan was initiated and current interventions as of 9/2021 included: -Dycem (a rubber mat that prevents sliding) to wheelchair. -Hipsters (a brief with hip protection pads to cushion the hips in the event of a fall and to reduce the risk of hip fracture) on at all times. -Non-skip strips next to bed. -Non-slip socks, slippers or shoes at all times. 6/18/2021 - R79's Fall risk assessment documented that R79 was at high risk for falling. 8/10/2021 - A quarterly MDS assessment documented that R79 was moderately cognitively impaired and required assistance for transfers. 9/28/2021 1:00 PM - During an observation and interview with E40 (CNA) and R79, R79, E40 confirmed the aforementioned care plan interventions were not in place. R79 stated that she never had Dycem in her wheel chair, hipsters, or non-skid strips next to her bed. R79	F 689		

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F 689	Continued From page 38 was noted not to have hipsters on. R79 reported that she had non-slip socks, but the surveyor and E40 noted R79's bare feet and her non-slip socks were tucked into her wheelchair. E40 stated that she would have to look in the electronic medical record to see if the interventions were in the task documentation of R79's chart. 9/29/2021 - During an interview at approximately 9:30 AM, E40 (CNA) reported that she went to the therapy department right away after the observation and interview on 9/28/2021 and secured Dycem for R79's wheelchair. 9/30/2021 2:35 PM - During an observation, non-skid strips were noted to be in place on the floor next to R79's bed. The facility failed to implement R79's care planned fall risk interventions. These findings were reviewed during the exit conference on 9/30/2021, beginning at 5:04 PM, with E1 (NHA), E2(Interim DON) and E3 (CCC).	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that, for two (R56 and R77) out of four residents investigated for dementia, the facility failed to ensure the	F 744	1. R56's care plan was reviewed to include specific symptoms related to hallucinations and delusions with measurable goal. R77's care plan goals	11/15/21

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F 744	Continued From page 39 comprehensive care plans included resident symptoms, interventions to ensure consistent staff response and had measurable goals. Findings include: Cross Refer, F758, Example 1 1. Review of R56's clinical record revealed: 1/15/21 - R56 was admitted to the facility with dementia and psychosis (loss of touch with reality). Care plans were initiated for different aspects of R56's dementia: - 1/28/21: bowel incontinence with the goal to be continent during the daytime with an intervention to take R56 to the toilet at the same time each day (no time frame specified). - 2/26/21: paranoia related to accusatory statements for staff providing ADL care. The goal to have fewer episodes of paranoia was not measurable. - 3/2/21: antipsychotic medication related to psychosis. R56 had been taking the medication since admission on 1/15/21. 4/1/21 - A Psychiatric NP note included that R56 had paranoid delusions (false beliefs) and dementia with behaviors. 4/24/21 and 7/22/21 - A quarterly MDS assessments documented R56 had both delusions and hallucinations. 5/10/21 - A Psychiatric NP note documented R56 was diagnosed with major depression with psychotic features and paranoid delusions. 9/2421 10:30 AM - During a random observation,	F 744	were revised to be measurable. 2. Resident with behavioral issues related to aggression, hallucinations, delusions will be reviewed to ensure that care plan addresses symptoms and that goals will be measurable specific in the plan of care. 3. Root cause was determined to be staff's lack of understanding of care plan revision to include specific behaviors and measurable goals. Regional Consultant (RCC)/Designee will in-service IDT team responsible for plan of care to ensure care plan components related to behaviors are individualized and measurable goals are in place. 4. Random Audits of care plan related to behavior symptoms (hallucinations, delusions, aggressions) will be conducted by ADON/Designee to ensure that behaviors are addressed on care plan with measurable goals. Audits will be completed weekly x 4 then monthly or until 100 % compliance is achieved. Audit results will be submitted to the QA committee. 5. Date of Compliance November 15, 2021.	

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F 744	Continued From page 40 E56 was seated in the hallway near the nursing station and was talking to someone not visible to the Surveyor (hallucination). 9/27/21 - During an observation, E2 (RN, UM) was heard talking to E18 (Physician) in the presence of the Surveyor. E7 described in detail, R56's delusions that involved the CIA (Central Intelligence Agency) entering her room by the stairwell in her closet and killing her dog. The facility failed to include the resident's specific hallucinations and delusions in her comprehensive care plan, along with staff interventions for a consistent response. 9/29/21 at approximately 9:20 AM - During an interview, E3 (CCC) stated that the care plans would be updated. 2. Review of R77's clinical record revealed: 11/2/20 - R77 was admitted to the facility with dementia associated with alcoholism. 1/5/21 - A care plan for aggression was initiated (revised 8/16/21) with a goal to decrease behaviors, which was not measurable. All interventions were from January, 2021. Progress Notes documented R77's behaviors about calling and/or going home: - 2/11/21: impulsive behaviors regarding calling wife. - 2/14/21: up most of night pacing asking when was his wife was coming to get him. - 2/14/21: in the daytime, called 911 to go home. - 2/15/21: non-stop calling wife to beg her to get him.	F 744		

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F 744	Continued From page 41 - 2/23/21: called home several times. - 2/25/21: called home frequently. - 4/24/21: calling home nonstop. 6/4/21 - A care plan for using Seroquel (an antipsychotic medication) related to verbal aggression included the goal that verbal and physical aggression would decrease. The goal was not measurable. R77's care plans for aggression for Seroquel use were not revised or individualized to include R77's frequent calls to his wife at home and how staff should respond for consistency. 9/29/21 at approximately 9:20 AM - During an interview, E3 (CCC) stated that the care plans would be updated. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		11/15/21

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F 755	Continued From page 42 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that for two (Beach Cove Unit, South Cart and Bay Terrace, Back Hall Cart) out of four medication carts inspected, the facility failed to accurately reconcile the transfer of controlled drugs from one shift to another. Findings include: 8/21/21 (date of last revision) -The facility policy for "Controlled Substances" stated, in reference to shift change controlled substance count, that "Controlled Substances will be counted shift to shift between the oncoming nurse and the off going nurse...The oncoming nurse with the off going nurse will verify that each individual medication card, liquid bottle/vials, boxes are counted, and the total documented accurately on the Narcotic Count Sign in Sheet ...Any discrepancies will be reported to the Unit	F 755	1. Beach Cove (South Cart) was reviewed, and initials corrected. Nurses on that unit will be educated. Bay Terrace controlled drug count will be reviewed and corrected as applicable. 2. Facility wide review of controlled drug count sheet will be conducted to review accuracy and completion of signatures and count from the last 14 days. Any discrepancy will be investigated, and signatures corrected as applicable. 3. The root cause was determined to be due to the licensed nurse not paying close attention to the appropriate shift to indicate their initials. It was also determined that staff are not following	

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F 755	Continued From page 43 manager /Supervisor /ADON /DON immediately for investigation to determine the cause and identify any responsible parties ...". 1. 9/28/21 4:00 PM - During a narcotic count of Beach Cove Unit's South Cart with E32 (RN), it was discovered that the "Controlled Meds Count Record" sign in sheet was incorrectly signed by the oncoming nurse and the off going nurse for the past three shifts. In addition, while E32 was observed signing his initials to indicate the count was correct in the block for the nurse reporting on the 11-7 night shift (but he was reporting on the 3 -11 evening shift), he stated that he just needed to initial one spot before this form was checked. When asked to explain where he should have initialed when he verified the count was correct with the 7 - 3 day shift nurse, he scribbled over the entire block to cover his initials and said, "This sheet is completed wrong." 9/28/21 4:30 PM - During an interview and review of the form, E19 (ADON) confirmed that the "Controlled Meds Count Record" sign in sheet was incorrectly signed by the oncoming nurse and the off going nurse for the past three shifts, and that she would call each nurse to have them correct the sheet and to verify that the count was correct. 9/29/21 12:30 PM - During an interview, E19 (ADON) stated that she had to restart a new "Controlled Meds Count Record" sign in sheet and was still waiting for some of the nurses to resign the new sheet. 2. September 2021 - Review of Bay Terrace's Back Hall medication cart's controlled drug count record revealed incomplete entries including no	F 755	facility policy with controlled substance shift to shift count off. Staff Development/Designee will in-service Licensed staff regarding the controlled substance policy. Focus of the in-service will be on shift to shift counting and appropriate initials required after verification of count is completed. In-service will also include accuracy of count information is completed. 4. Unit Manager/Designee will check the controlled drug count sheet for accuracy and completeness of signature during shift count. Audits will be completed weekly x4 then monthly or until 100 % compliance is achieved of signatures on controlled drug count sheets. Audit results will be submitted to the QA committee. . 5.. Date of Compliance November 15, 2021.	

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F 755	Continued From page 44 nurse initials, items completed/disposed of, items received from the pharmacy and/or the total number of items in the drawer to verify that the count was correct: - Day to evening shift: September, 6, 11, 21 and 28. - Evening to night shift: September 1, 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, 15, 16, 17, 18, 20, 21, 22, 24*, 25 and 26. *The 9/24/21 entry recorded there were no (zero) items in the locked drawer when 14 were present on the evening to night count. - Night to day shift: September 22. 9/29/21 at approximately 10:35 AM - During an interview, the Surveyor showed E7 (RN, UM) and E3 (Corporate Clinical Consultant) the controlled drug count record from the back hall with incomplete entries, including nurse initials and missing amounts of controlled medication. E7 added that some of the staff may have worked a double and would verify with the schedules and get back to the Surveyor. 9/30/21 6:00 PM - No additional information was provided by the end of the exit conference. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 755		
F 756 SS=F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		11/15/21

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F 756	Continued From page 45 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that, for four (R3, R8, R56 and R77) out of five residents reviewed for unnecessary medications, the facility failed to ensure irregularities identified by the pharmacist were	F 756	1. Policy was reviewed and revised to include time frames for the different steps in the process, steps the pharmacist must take when an irregularity requiring urgent action to protect the resident identified,	

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F 756	Continued From page 46 reviewed by the physician. Additionally, the Facility's Drug Regimen Review policy did not contain the necessary requirements. Findings include: 1. Review of the facility policy entitled Drug Regimen Review (last reviewed 6/15/21) revealed the policy failed to include: - Time frames for the different steps in the process (time frame for pharmacist to inform the facility of irregularities and time frame for the physician to review the irregularities). - Steps the pharmacist must take when an irregularity requiring urgent action to protect the resident was identified. - If there was to be no change in the medication when the pharmacist made a recommendation, the attending physician should document the rationale in the resident's medical record. 9/28/21 9:22 AM - During an interview, E3 (CCC) was informed about the missing requirements in the policy and stated that the policy would be reviewed. 2. Review of R8's clinical record revealed: 12/2/15 - R8 was admitted to the facility with dementia. September 2020 - August 2021 - Drug regimen review reports revealed the following: - January 2021: original unable to be located, reprinted with no irregularities. - March 2021: no physician response to evaluate Seroquel with a psychosis diagnosis. - April 2021: no physician response to Seroquel with dementia diagnosis and the need to be evaluated.	F 756	physician's response and rationale in the medical records. a. R3 – drug regimen review that was missing from the last quarter has been submitted to the physician for review. b. R8's drug regimen review that was missing from the last quarter has been submitted to the physician for review. c. R56's drug regimen review that was missing from the last quarter has been submitted to the physician for review. d. R77's drug regimen review that was missing from the last quarter has been submitted to the physician for review. 2. Pharmacy Drug Regimen Review for the last month will be reviewed to ensure that irregularities identified by the pharmacist were reviewed by the physician. 3. Root cause was determined that a thorough review based on the regulatory requirement was not considered when the policy was recently reviewed, and nursing staff's understanding of the regulatory requirement related to DRR. It was also determined that in some cases, reviewed were completed and an appropriate order was in place, but the signed document cannot be retrieved. Pharmacy Consultant/Designee will educate the nursing management team regarding the Drug Regimen Review process and timely follow up required by physician	

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F 756	Continued From page 47 - May 2021: no irregularity; no physician response. 9/27/21 9:24 AM - During an interview, E3 provided copies of the drug regimen reviews and added that these were all that could be located. 3. Review of R56's clinical record revealed: 1/15/21 - R56 was admitted to the facility with dementia. January 2021 - August 2021 - Drug regimen reports revealed the May 2021 was missing. 9/27/21 9:24 AM - During an interview, E3 provided copies of the drug regimen reviews and added that these were all that could be located. 4. Review of R77's clinical record revealed: 11/3/2020 - R77 was admitted to he facility with dementia. December 2020 - August 2021 - Drug regimen reports revealed the following Pharmacist recommendations: - January 2021: missing, no evidence the review was completed. - April 2021: no physician response to evaluate the diagnosis of Seroquel [antipsychotic] with major depressive disorder with psychotic symptoms. - May 2021: missing, no evidence the review was completed. 9/27/21 9:24 AM - During an interview, E3 provided copies of the drug regimen reviews and added that these were all that could be located.	F 756	4. Monthly audit by DON/Designee will be conducted to ensure drug regimen review recommendations were reviewed, rationale for response stated and signed off by the physician x 3 months until a 100% compliance is achieved. Policy revision will be submitted to QA committee yearly. Audit results will be submitted to the QA committee. 5. Date of Compliance November 15, 2021.	

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F 756	Continued From page 48	F 756		
	These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).			
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		11/15/21

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F 758	Continued From page 49 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that, for four (R8, R56, R73 and R77) out of six residents reviewed for unnecessary psychotropic medications and/or for elopement, the facility failed to monitor for adverse effects and/or specific resident behaviors for the psychotropic medications ordered and they failed to provide evidence that a quarterly GDR (gradual dose reduction) meeting was conducted. Additionally, the Antipsychotic Medication Use policy did not include all of the needed requirements. Findings include: An undated and untitled facility policy received by E2 (Interim DON) on 9/29/21 at 11:43 AM was identified as the Psychotropic Medication policy. The policy included that "PRN (as needed) orders for psychotropics ... should have limitations or [an] identified, or clinical rationale if not ... A behavior monitoring sheet will be initiated with the new behaviors identified. The Abnormal Involuntary Movement Symptoms (AIMS)	F 758	1. Policy for Anti-psychotic drug use will be revised to include the 14-day limit for PRN anti-psychotics and the required evaluation by the provider to being re-ordered. R56s AIMs assessment was completed on 6/3/21 and another one was completed on 10/11/2021. R56's care plan specifically regarding hallucinations and delusions were created on 9/29/21. Behavior monitoring and monitoring for adverse effects was also clarified on 9/29/21.R56's Diagnosis for Abilify was clarified as Psychosis on 9/27/21. R73's PRN Ativan order was completed to include a 14-day limitation. R73's reason for the administration of Ativan will be revised R73's physician was notified of the frequency that PRN Ativan was utilized. R73 had AIMS completed on	

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F 758	Continued From page 50 assessment would be done per the standards of practice." 1. 6/15/21 - A facility policy entitled Antipsychotic Medication Use included that residents will not receive PRN doses of psychotropic medications unless the medication is necessary to treat a specific condition that is documented in the clinical record. The policy did not include the 14 day limit for PRN antipsychotics and the required evaluation by the provider prior to being reordered. 9/28/21 9:22 AM - During an interview, E3 (CCC) stated the policy would be reviewed when informed about the missing time limits and the need for evaluation when orders were to be reordered. 2. Review of R56's clinical record revealed: 1/15/21 - R56 was admitted to the facility with dementia and psychosis (loss of touch with reality) and had been taking Ability (antipsychotic) prior to admission. 1/15/21 - Admission physicians' orders included Abilify for an unspecified mood disorder. There was no evidence in the record that an AIMS (Abnormal Involuntary Movement Scale) was performed as a baseline to assess for uncontrolled body movements when R56 was admitted on antipsychotic medication. 2/26/21 - A care plan for paranoia was initiated for accusatory statements regarding staff providing ADL care. An intervention included two staff to enter her room for R56's care needs.	F 758	9/28/21. No further correction needed.R 73's Klonopin order was clarified on 9/28/21 to include side effect monitoring sheet. R77 had AIMS completed R8 had AIMS completed 2. An audit of all current residents with anti-psychotics will be reviewed to ensure an AIMS assessment is completed based on regulatory guidance. Review will focus on appropriate dx, specific behavior or adverse effects manifested due to medication use. Audit of current residents receiving PRN Ativan will be conducted to ensure that 14-day limitation is addressed. Residents with an order for PRN Ativan with no end date will be clarified as per physician's order. Review will focus on conducted identifying if appropriate behavior was indicated with prn use and physician notification if if need arises to administer sooner. On the spot education will be provided to staff if non-compliance were identified. 3. Root cause was determined that a thorough review based on the regulatory requirement was not considered when the policy was recently reviewed. DON/Designee in coordination with the Pharmacy Consultant will review the policy yearly to ensure that the regulatory requirements are met. Revision will be made as necessary based on regulatory changes. Also, the Provider and staff's	

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F 758	Continued From page 51 3/2/21 - A care plan was initiated for R56 taking Abilify for psychosis with monitoring for targeted behaviors of inappropriate response to verbal communication, including accusatory statements. R56 had been taking this medication since her 1/15/21 admission. March, 2021 - The Pharmacist Consultant identified the need to clarify the physician's diagnosis of depressive mood disorder for the antipsychotic Abilify. The physician wrote to change the diagnosis to depression with psychosis on 3/4/21. However, the diagnosis on the 3/20/21 order for Abilify remained unspecified mood disorder. 4/1/21 - A Psychiatric NP note documented R56 had paranoid delusions (false beliefs). 6/3/21 - The AIMS assessment was conducted, as well as an entry for monitoring for adverse side effects of the antipsychotic was added to the eMAR for nurses to record any adverse effects, nearly five months after R56 was admitted to the facility on Abilify. 9/24/21 10:30 AM - During a random observation R56 was seen talking to someone not visible to the Surveyor. 9/27/21 8:30 AM - During a random observation, E7 (RN, UM) was heard talking to E18 (Physician) in the presence of the Surveyor. E7 described the details of R56's delusions including that the CIA (Central Intelligence Agency) was in her closet and they killed her dog. There was no evidence that the facility monitored	F 758	lack of understanding the regulatory requirements surroundings antipsychotic and antianxiety medications. Pharmacy Consultant/Designee will provide information to facility providers regarding the revised policy for PRN psychotropic medications esp. antipsychotics and antianxiety, the indication for use, appropriate diagnosis, adverse effect monitoring, and the regulatory requirement related to AIMS. Staff Development/Designee will in-service Licensed nursing staff on the completion of AIMS assessment with anti-psychotic medication use, indication for use, appropriate diagnosis, adverse effect monitoring and the 14-day limitation for PRN antianxiety medications. 4. Yearly and with regulatory requirement changes, the policy will be reviewed by the DON/Designee in coordination with the Pharmacy Consultant to ensure that the policy meets the regulatory requirement. Policy revision will be submitted to QA committee yearly. Audit by the ADON/Designee will be conducted to ensure residents with new orders of anti-psychotic has appropriate diagnosis in place, AIMS completed, and specific behavior monitoring is in place; Audits will also include 14-day limitation for PRN antianxiety medications, appropriate dx, behaviors and side effects documented. Audits will be completed weekly x 4, monthly x 2 or until 100 %	

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F 758	Continued From page 52 for delusions and/or hallucinations (hearing, seeing or feeling something that is not visible, heard or felt) even after delusions were identified in April by the Psychiatric NP. 9/28/21 1030 AM - During an interview with E3 (CCC), the Surveyor presented a list of concerns identified, including that the AIMS and adverse effects were not monitored until nearly 5 months after R56 was admitted on an antipsychotic and that behavior monitoring did not include delusions and/or hallucinations. E3 stated she would look into the issues. 9/29/21 at approximately 9:20 AM- During an interview, E3 stated that the delusions and hallucinations would be added for behavior monitoring. In regard to the AIMS, E3 stated that she spoke with the Psychiatric NP who claimed she documented by exception (only putting the abnormal findings) and that since no mention of abnormal movements was in the 2/5/21 NP note, then R56 did not have any. Review of the copy of the NP note provided showed numerous entries of normal findings including "No elopement attempts; appetite baseline; no consistently interrupted sleep pattern; compliance with medication administration" indicating that charting was not done by exception. 9/30/21 11:43 AM - E2 (Interim DON) presented the Surveyor with a copy of the Psychotropic Medication policy and said it was from E3. The policy was requested several days prior. The Surveyor pointed out that the policy had no title or date and looked like it was just typed. E3 offered no explanation. 3. Review of R73's clinical record revealed:	F 758	compliance is achieved. Audit results will be submitted to the QA committee. 5. Date of Compliance November 15, 2021	

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F 758	Continued From page 53 2/2/21 - R73 was admitted to the facility with dementia from alcohol abuse and had a history of brain surgery. a. 2/2/21 - Physicians' orders included a medication for anxiety (Ativan) to be given once a day as needed (PRN) for seven days. 2/10/21 - Physicians' orders included Ativan to be given every 8 hours PRN for aggression, agitation. This order did not have an end date. Psychotropic medications ordered PRN should have an end date after evaluation by a physician for the continued need after the initial order that should be limited to a maximum of 14 days. 9/23/21 6:45 PM- The Ativan order was rewritten with a stop date of 14 days the day after the Surveyors arrived at the facility. b. April 2021 - September 2021 - Review of R73's eMAR documentation and nursing notes revealed 43 times the PRN Ativan was administered without an adequate indication: - No behavior was identified for 24 administrations: April 9; May 10, 27 and 30; June 5, 9, 12, 20, 21 and 27; July 7, 8, 10, 15 and 21; August 6, 10, 15, 29 and 31; September 2, 5, 12, and 20. - The letter 'a' was documented for 19 administrations: April 1, 6, 14, 15, 19, 28 and 29; May 5, 19, 24 and 26; June 1, 15, 16, 22 and 23; July 6, 9 and 14. 7/14/21 10:10 PM - A nursing note documented that R73 continued to be agitated about going home. [Ativan] "does help to calm him, but does	F 758		

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F 758	Continued From page 54 not completely disarm him. Engaging him in conversations about life experiences is a great distraction, taking his mind off of going home. Unfortunately, staff does not have time to constantly engage him this way." It was unclear if the 'a' written as the reason for the administration of PRN Ativan was aggression or agitation, which was why the medication was ordered. c. 4/7/21 - Review of the eMAR documentation and nursing notes revealed Ativan PRN was administered at 10:57 AM and 6:01 PM, approximately 7 hours apart. This was an hour early as the medication was ordered every 8 hours PRN. There was no evidence in the record that the provider was contacted prior to the early administration of the PRN medication. 9/28/21 9:33 AM - During an interview, E14 (LPN) confirmed that behaviors should be documented when administering a PRN medication and if giving a PRN medication early, the provider should be contacted. d. 7/23/21 - Physicians' orders included an antipsychotic (Risperdal). There was no evidence that an AIMS assessment was conducted prior to the start of the antipsychotic to serve as a baseline for abnormal body movements, a potential side effect of this type of medication. An AIMS assessment was done 9/28/21, over two months after the antipsychotic was initiated.	F 758		

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F 758	Continued From page 55 e. 8/6/21 - Physicians' orders included an anticonvulsant (Klonopin) which can be used to prevent seizures or to treat mental disorders. The indication for this medication was psychosis. During the survey, there was no evidence in the record that the facility monitored for adverse effects of Klonopin until the surveyor asked about the monitoring. 9/28/21 1:52 PM - During an interview with E3 (CCC) the surveyor reviewed and presented E3 with a written list of the aforementioned findings about R73's psychotropic medications. E3 stated she would look into it. 9/28/21 3:53 PM - During an interview with E32 (RN), the nurse who wrote 'a' for the behavior and administered the Ativan an hour early, when asked what the 'a' meant, E32 said anxiety. The surveyor was unclear if the 'a' was for aggression or agitation for which the medication was ordered. E32 stated, "I will do better" [indicating writing resident behaviors]. 9/29/21 9:35 AM - E3 returned the written list with the findings that were addressed highlighted in yellow. The AIMS assessment was completed 9/28/21 and adverse actions of Klonopin and Risperdal were added to the eMAR for nurses to document. 4. Review of R77's clinical record revealed: 11/2/20 - R77 was admitted to the facility with dementia. 2/17/21 - Physicians' orders included an antipsychotic (Seroquel) twice a day for major	F 758		

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F 758	Continued From page 56 depression with psychosis. There was no evidence in the record that an AIMS assessment was performed to serve as a baseline for abnormal body movements. 5/4/21 - An AIMS assessment was completed, nearly three months after the antipsychotic was started. 9/28/21 10:32 AM - During an interview, the Surveyor informed E3 (CCC) about the findings regarding R77's psychotropic medications and provided a written list of the identified concerns. 9/29/21 9:35 AM - During an interview, E3 returned the written list and confirmed the AIMS was performed on 5/4/21. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		11/15/21

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F 761	Continued From page 57 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for three (Stations 1, 3 and 4) out of three medication rooms inspected, the facility failed to ensure that medications were labeled with the resident name, expired medications were removed and refrigerated drugs and biologicals were stored under proper temperature controls. Findings include: 1. Medication refrigerator temperatures on Beach Cove Unit (Station 1): Review of an undated pharmacy policy, provided by E1 (NHA), titled Storage of Medications included, "Medications requiring refrigeration are kept in a refrigerator at temperatures between 2 [degrees] C (36 [degrees] F) and 8 [degrees] C (46 [degrees] F) with a thermometer to allow temperature monitoring ...The Facility should maintain a temperature log in the storage area to record temperatures at least once a day ...". 2/27/12 - The facility form entitled Temperature Log, found on the outside of the Beach Cove's (Station 1) medication refrigerator, stated,	F 761	1. Station 1's medication refrigerator was checked and was verified in the last 7 days temperatures were logged at least daily. Station 3's treatment cart was checked. All treatment creams and supplies that are resident specific without patient labels were removed and discarded appropriately. Station 4 medication storage room will be checked for expired medications and treatment supplies. Expired items will be discarded accordingly. Check will also include opened medications and expiration dates. Medications found to be after the expiration date will be discarded accordingly. 2. Unit medication refrigerators will be checked to ensure temperatures were logged in the last 7 days. Staff will be in-serviced on the spot for compliance. Unit's treatment cart will be checked to ensure that medicated treatments have appropriate labeling and stored appropriately. Any items without proper	

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F 761	Continued From page 58 "Medication refrigerator is checked BID (two times a day) ...If refrigerator temp [temperature] falls below 36 [degrees] or goes above 46 [degrees] inform the unit manager and/or supervisor immediately so corrective action may be taken." 9/22/21 8:30 AM - During an inspection of the Beach Cove's Medication Room with E27 (RNAC), it was discovered that the medication refrigerator temperature was not checked on nine (43%) out of 21 days reviewed in September 2021. This finding was immediately confirmed by E27. 2. 9/22/21 9:15 AM - Inspection of the treatment cart in the medication room on Bay Terrace (Station 3) revealed: - top drawer labeled 'FRONT' had an open tube of zinc oxide (skin protection cream) that had been partially used without resident identification. - top drawer labeled 'BACK' with a tube of a wound gel with about half of the gel used without resident identification. 9/22/21 approximately 11:20 AM - During an interview, E7 (RN, UM) stated that stock meds should be labeled with resident information after opening. 3. 9/22/21 1:15 PM - During an inspection of the medication storage room on Seaside Way (Station 4) with E27 (RNAC). The following was observed: - A medication for nausea and vomiting expired 6/21/21. - An open and undated vial of medication was	F 761	labeling will be removed and discarded appropriately. Unit's medication storage room will be checked for expired medications and treatment supplies. Expired items will be discarded accordingly. Check will also include opened medications and expiration dates. Medications found to be after the expiration date will be discarded accordingly. 3. The root cause of the non-compliance was determined to be due to inconsistent oversight with the medication room temperature monitoring. Staff Development/Designee will in-service Licensed staff regarding compliance with refrigerator temperature monitoring. The root cause of the non-compliance was determined to be due to inconsistent oversight with the treatment cart monitoring and the lack of understanding from the staff regarding compliance with treatment supply labeling. Staff Development/Designee will in-service Licensed staff regarding compliance with labeling of resident's names for treatment supplies that are resident specific. The root cause of the non-compliance was determined to be due to the inconsistent oversight with the medication storage room monitoring and the lack of understanding from the staff regarding compliance with checking of expired items and medications requiring date of opening and expiration date.	

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F 761	Continued From page 59 found in the refridgerator without an expiration date. - An open vial of Insulin was found in the refrigerator without an expiration date. - An open Insulin Pen with an open date of 8/4/21 (Insulin expires 28 days after opening). - Two bottles of sterile salt water in an overhead cabinet with an expiration date of 6/2020. 9/22/21 1:30 PM - E27 removed the above items from the medication room and stated these would be destroyed. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON), and E3 (Corporate Clinical Consultant).	F 761	Staff Development/Designee will in-service Licensed staff regarding compliance indicating the date opened and expiration dates on a multi dose medications. 4. Audit by the Unit Manager/Designee will be conducted to ensure medication refrigerator temperatures are monitored and logged, resident specific treatment and supplies are labeled, date opened, and expiration dates are indicated on a multi dose medication. Audits will be completed weekly x 4 weeks, then monthly or until 100 % compliance is achieved Audit results will be submitted to the QA committee. .5. Date of Compliance November 15, 2021.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		11/15/21

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F 812	Continued From page 60 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that for two (1 and 3) out of four resident care units and inspection of the main kitchen, the facility failed store, prepare and serve food in accordance with professional standards for food service safety . Findings include: 7/26/21 (date of last revision) -The facility policy for "Use and storage of Food Brought to the Residents by Visitors" stated, "...Food brought into the facility by residents and family members/visitors, or resident representatives will be stored according to the type ...Any expired or unlabeled food will be discarded...". 1. 9/22/21 9:00 AM - During an inspection of the Beach Cove (Station 1) Unit's Medication Room with E27 (RNAC), it was discovered that the nutrition refrigerator temperature was not checked on nine (43%) out of 21 days reviewed in September 2021. The contents inside the aforementioned refrigerator included: - three opened bottles of expired salad dressing. - expired box of juice. - unlabeled opened packages of both sliced and shredded cheese. - opened unlabeled jar of mayonnaise. - opened soda and a pre-packaged lunch dated	F 812	1. Station 1 and station 3 nutrition refrigerator temp logs was reviewed. Items that were unlabeled, undated, expired were discarded. Facility kitchen with opened undated thickened juice and food items out of date were discarded. Signage for handwashing sink in the kitchen was replaced. Disinfection solution bucket was made available in the kitchen. Wet floor in the walk-in refrigerator was corrected. E54 was educated on storage of personal foods in appropriate area. 2. Nutrition refrigerators on units regarding were checked to assure that temperature logs were completed on October 4, 2021. Refrigerators were also checked to assure there were no Items that were unlabeled, undated and expired. Facility kitchen was inspected to assure that there were no opened undated thickened juice nor food items out of date. Observations also included Signage near handwashing sick, disinfection solution bucket and that walk-in refrigerator area was dry. 3. The facility determined that the root cause was due to the staff's (nursing, housekeeping maintenance and dietary) lack of knowledge regarding who was	

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F 812	Continued From page 61 5/29/21. - multiple sticky stains throughout the inside of the refrigerator. - freezer contained an unlabeled and undated fast-food milkshake, two cups of ice cream, and a fast-food cup of orange soda. There were splattered brown stains inside the freezer and no thermometer. These findings were immediately confirmed by E27 who stated that she will clean out this refrigerator. 2. 9/22/21 10:30 AM - During an inspection of the nutrition refrigerator in the nursing station on the Beach Cove (Station 1) Unit, it was discovered that the nutrition refrigerator temperature was not checked on 14 (67%) out of 21days reviewed in September 2021. When the refrigerator door was opened there was a foul smell. The contents inside the refrigerator included: - an unlabeled opened milk carton. - an unlabeled opened plastic bottle of soda. - an unlabeled plastic cup of mayonnaise. - a "frozen" microwavable dinner with a used by date of 8/11/21. - an unlabeled opened plastic to go container of fresh cut fruit partially full. - an unlabeled mason jar half filled with an unidentifiable green substance. - three half peanut butter and jelly sandwiches in plastic wrap, but undated. - three half peanut butter and jelly sandwiches dated to use by 9/7/21. - a to-go salad in a plastic container with an expiration date of 9/20/21. - an unlabeled slice of cheesecake in a plastic container. - an unlabeled deli sub in a stained white bag.	F 812	responsible for monitoring nutrition refrigerator temp logs, cleaning checking refrigerators for appropriate labeling and dating of food items, and drinks, Lack of a clear cleaning schedule and checking for dates and labeling of food items and thickened juices in the kitchen by the dietary staff. Also root cause was related to who was responsible for the routine inspections of the kitchen area. Staff Development or Designee will educate staff (nursing, maintenance) on recording temperature logs for refrigerators daily. Housekeeping, Dietary staff will be educated by Dietary Manger or designee on cleaning refrigerators on nursing units, making sure food/drinks are labeled appropriately Dietary manager of designee will clean walk in refrigerator throwing out all outdated food, make sure appropriate labeling is on food/drinks. Dietary manager will educate dietary staff on appropriately dating food and labeling of food. Maintenance will be educated by Administrator/designee on the importance of routine inspection of the kitchen to assure appropriate signage and disinfecting products are made available. 4. Audits will be completed of nutrition refrig temp logs, food items are dated, labeled in refrigerators on nursing units and kitchen has no opened undated thickened juice and food items out of date. Audits will include notation of Signage for handwashing sink in the kitchen, disinfection solution bucket in the kitchen and walk in refrigerator area is dry. Audits will be weekly x 4 the monthly	

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F 812	Continued From page 62 - a facility bag lunch for a dialysis resident dated 8/10/21. - an almost empty bottle of catsup labeled with a resident name, but no date. - two expired styrofoam cups of food (one dated 9/9/21 and one dated 8/9/21). - multiple sticky stains on the inside bottom of the refrigerator and the door. 9/22/21 11:00 AM - During an interview and observation, E33 (RNAC) confirmed these findings and cleaned out the refrigerator. 3. 9/22/21 8:45 AM - During an inspection of the nourishment refrigerator in Station 3's (Bay Terrace) medication room, the following was discovered: - small bag from a local store containing sliced apples and filled with air making the bag tight, with an expiration date of 9/6/21. - plastic container of yogurt with an expiration date of 7/29/21. - unlabeled peanut butter sandwiches, (5 half sandwiches and 1 whole) with several half sandwiches not sealed and open to air. - undated thickened juice boxes that had been opened with a shelf life of seven days after opening (one apple and one cranberry). - 2 undated pitchers of iced tea. - 1 undated pitcher of cranberry juice. - 3 plastic containers of unlabeled homemade food (pink container with ready-to-eat fruit and a white container) - unlabeled half of a water bottle containing frozen and an unlabeled store-bought frozen meal in the freezer. 9/22/21 11:10 AM - During a random observation, E54 (CNA) was seen in the chart	F 812	or until 100% compliance is achieved, audits findings will be reported to QA committee. 5. Date of Compliance November 15, 2021.	

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F 812	Continued From page 63 room eating her lunch from the pink container with the clear container of fruit nearby. 9/22/21 at approximately 11:20 AM - During an interview, E7 (RN, UM) confirmed and threw away the sandwiches, apples, and yogurt and stated, "I don't know who they belong to....no names on them." E7 discarded the undated thickened juice boxes, frozen bottle of yellow liquid in freezer and an unlabeled frozen meal. When the surveyor explained about the staff food and pointed out that E54 was eating hers, E7 said, "I've been asking for another refrigerator." 4. During the initial and follow-up tours of the facility kitchen between 7:46 AM and 9:13 AM on 9/22/21, the surveyor(s) observed the following: - Seven (7) opened containers of thickened juice with no "open by" or "use by" date noted on the containers, which have a shelf life of seven (7) days after opening. - A large plastic container containing shredded carrots with plastic wrap loosely draped over the opening of the container, permitting possible contamination from dust, debris, and soiled water. - A large tray labeled "mac and cheese" dated "9/14/21". Delaware Food Code 3-501.17 requires all prepared food to be discarded after seven (7) days. The day of preparation is counted as day "1". - The required signage was missing from the handwashing sink adjacent to the oven. - There was no red bucket with sanitizing solution available for food preparation surface disinfection. - Water droplets were dripping from the ceiling resulting in a wet floor in the walk-in refrigerator.	F 812		

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F 812	Continued From page 64 9/27/21 10:34 AM- Findings were reviewed with E1 (NHA) and E5 (Dietary Director). 5. During the a follow-up tour of the facility kitchen between 10:45 AM to 1:00 PM on 9/22/21, the surveyor(s) observed the following: - Walk-in refrigerator: * raw hotdogs were held above ready-to-eat foods in the walk-in refrigerator; E5 (Food Service Director) was not aware that raw hotdogs were considered potentially hazardous foods. * walk-in refrigerator vent was dusty. * desserts were partially covered with small lids and were not completely covered. * condensation (water) dripping on the floor. * wet cardboard used as shelving, many were stained with food. * shelving was rusty, making it difficult to clean. - Dry storage: * unlabeled bulk storage containers with white powder substance stored in black trash bags, the bags were showing signs of wear and were not clean to the touch. * bulk storage containers had scoops left inside of the containers. * floor was not clean. - Ice machine: * not properly maintained. * ice scoop not properly stored. - Dish washing machine area hose leaking. - Fume hood was greasy and dusty. - Hand sink with no splash guard by the kitchen microwave. - All hand washing sinks were draining poorly.	F 812		

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F 812	Continued From page 65 - Required hand washing signs were not present at the hand washing station. - Loading bay area was extremely dirty. Findings were reviewed with E5 on 9/22/21 at approximately 1:00 PM. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		11/15/21

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F 842	Continued From page 66 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 842		

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ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

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F 842	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that, for two (R33 and R73) out of nine residents sampled for accidents and personal property and one (R20) out of one resident sampled for dialyisis, the facility failed to ensure accurate and complete records. Findings include: Cross Refer F689, Example 1 1. Review of R73's clinical record revealed: 2/2/21 - R73 was admitted to the facility with dementia. 8/2/21 - An elopement risk evaluation, completed in preparation for the next quarterly MDS assessment, documented that R73 had eloped, which did not occur until 8/17/21. 8/10/21 - The quarterly MDS assessment was completed. 8/17/21 - R73 eloped from the facility and was not located for approximately 30 minutes. 9/29/21 1:05 PM - During an interview, E3 (CCC) provided printed copies of the elopement risk evaluations and confirmed the error. 2. Review of R33's clinical record revealed: 6/19/21 - R33 was admitted to the facility for rehabilitation. 6/19/21 - A "Treatment Limitations/DNR Order Form" was completed by E58 (RN, Supervisor) and was co-signed by E2 (Interim DON), but was	F 842	1. R73's most recent Elopement risk was completed on 8/17/21. No further correction needed. R33's physical Treatment Limitation was signed on 9/23/21. An electronic signature was signed on 6/22/21. No further correction needed. R20's weights were entered in the weights and vital signs information of the EMR. Staff was in-serviced on noting information on the dialysis communication form upon return to the facility. 2. Audits will be completed for residents who are at risk for elopement to ensure accuracy of assessment. Any identified discrepancy will be corrected with a new assessment. Review will be conducted to verify that treatment limitations have physician's signatures. In an event where a physical signature is not available, an electronic signature will be printed to be attached to the "Treatment Limitation Form". Residents on Dialysis will be reviewed for notation of weights in the last 7 days in the medical record and information on the communication form is noted 3. The root cause of the issue was due to the assessment being opened but was not fully completed timely. Staff Development/Designee will in-service Licensed nursing staff regarding timely completion and accuracy	

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F 842	Continued From page 68 not signed by a medical practitioner. This form indicated that R33 was a DNR (do not resuscitate), RN may pronounce, and a DNI (do not intubate- put in a breathing tube). 6/19/21 7:50 PM - E58 (RN, Supervisor) documented in the eMAR (electronic medication administration record), "Talked with daughter stated she was a DNR status. Second witness talked with daughter, DNR order signed." 6/19/21 - A physician's order was written for DNR, RN may pronounce, and DNI. 9/23/21 12:30 PM - During an interview, E19 (ADON) provided a copy of E33's "Treatment Limitations/DNR Order Form" and confirmed that it was just signed by a medical practitioner (E16 NP) today after the surveyor requested a copy. In addition, the form did not include the signature of the responsible party/resident. 9/24/21 9:30 AM - During an interview with E2 (Interim DON) and E3 (CCC), E3 stated that the facility no longer uses the "Treatment Limitations/DNR Order Form" as an order; therefore, it is not required that it be signed by a medical practitioner. E3 added that all code status orders must be ordered in the EMR (electronic medical record), not on paper. E2 (Interim DON) stated that he and E58 (RN, Supervisor) spoke to R33's daughter on 6/19/21 on the phone and confirmed that R33 was a DNR. The facility placed a "Treatment Limitations/DNR Order Form" on the resident's chart that did not indicate who the nurses spoke with to confirm R33's code status. E58 documented in the	F 842	of information when completing an Elopement risk assessment. The root cause of the non-compliance was due to the verification process did not include the verification of signatures on "Treatment Limitation Form." Staff Development/Designee will in-service Licensed nursing staff and Social Services department regarding the process of verification of the "Treatment Limitation Form" for completeness of information. The root cause of the non-compliance was due to staff's lack of consistency and understanding of the expectations when the residents return from Dialysis with the communication form. Staff Development/Designee will in-service Licensed nursing staff regarding expectation related to the Dialysis communication form upon return from Dialysis. 4. Weekly audit by the ADON/Designee will be conducted to ensure that Elopement Risk assessment is completed accurately and timely x 4 weeks until a 100% compliance is achieved. Audit by the DON/Designee will be conducted weekly x 4, monthly or until 100 % compliance is achieved to ensure that ""Treatment Limitation form" is complete and accurate. Audit by the Unit Manager/Designee will be conducted to ensure that Dialysis communication form has the Licensed	

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F 842	Continued From page 69 eMAR, not in the EMR progress notes that she spoke with R33's daughter to confirm the code status. The interdisciplinary team would not look for this information in the eMAR. 3. 6/6/19 - R20 was admitted to the facility with end stage kidney disease. 3/8/21 9:00 AM - A physician's order included: "Dialysis on Monday, Wednesday and Friday." 3/8/21 3:00 PM - A physician's order included: "Record post dialysis weight from (dialysis) treatment book every evening shift every Monday, Wednesday and Friday." 9/27/21 9:14 AM - R20 was noted to have a dialysis communication record binder that is sent with R20 on her dialysis days. There was a section of the dialysis communication sheets that had "noted by facility" for post dialysis review to initial. The post dialysis sheets in the communication book were blank on numerous instances. 9/27/21 9:51 AM - During an interview, E24 (Wound Nurse) confirmed that the space for noted by facility in the dialysis communication book was not initialed on a significant amount of the sheets. E24 reported that the post-dialysis weights are recorded in R20's medication administration record (MAR) which confirms that they had been reviewed. Review of R20's medical record revealed that R20's post dialysis weights were not documented in the MAR on 7/14, 7/28 and 8/6/21 for practitioners to review. In addition, the noted by staff line on the communication sheets in R20's	F 842	nursing staff's notation and weights are entered in the EMR. Audits will be completed weekly x 4 weeks, monthly or until a 100% compliance is achieved. Audit results will be submitted to the QA committee. 1. Date of Compliance November 15, 2021.	

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F 842	Continued From page 70 dialysis communication book were not initialed as noted by the facility on the dates in question as well. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. 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		11/15/21

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F 880	Continued From page 71 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 observation, record review and interview it was determined that the facility failed	F 880	1. E9 in charge of R105 received a 1:1 education and perform return	

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F 880	Continued From page 72 to ensure that infection control practices were implemented and maintained to prevent the spread of communicable disease, including COVID-19. Findings include: 1. The following was reviewed in R105's clinical record: 8/3/2019 - R105 was admitted to the facility with a brain injury that required a tracheostomy (also known as a trach, a breathing tube inserted through the front of the neck) to breath. A facility policy entitled Tracheostomy Care, last revised 6/2021, included: General Guidelines 1. Aseptic (sterile) technique must be used during tracheostomy tube changes, either reusable or disposable. Procedure Guidelines 1. Check Physician order. 2. Explain procedure to resident. 3. Wash hands. 4. Put exam gloves on both hands. 5. Remove old dressings (and the disposable inner cannula (a changeable replacement tube). 6. Remove gloves. 7. Wash hands. 8. Open tracheostomy cleaning kit. 9. Set up supplies on sterile field. 10. Open up supplies maintaining a sterile field. 11. Put on sterile gloves. 12. (Perform the cleaning procedure for the tracheostomy). 13. Remove gloves and discard into the	F 880	demonstration to verify competency on Tracheostomy care and handwashing. 2. Upon notification of the observation, employee face mask was changed to surgical mask and education was provided on the spot. E28 E29, E31, E34, E12 employees were educated on the spot regarding appropriate source control (mask) in healthcare facility while and appropriate donning of masks; E10 was educated on hand hygiene. R56 was assisted with hand hygiene before and after meals. Licensed nursing staff will receive in-service, and staff will perform a return demonstration to verify competency in performing Tracheostomy care. Facility staff were re-educated on source control (masks) acceptable to wear while in the facility and hand hygiene. Residents were educated on an on-going basis the importance of hand hygiene especially during meals. Staff assisting residents with smoking will be educated regarding hand hygiene when hands are contaminated. A hand sanitizer will be made available for staff to use. 3. Root cause of the non-compliance was due to the staff losing focus due to being nervous about being watched during Tracheostomy care. Staff	

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F 880	Continued From page 73 appropriate receptacle. 14. Wash hands. 10/28/20 - A physician order included: "Trach Care: Clean Inner Cannula, Cleanse area around the trach & neck every shift and as needed." 8/26/21 - A quarterly MDS assessment documented that R105 was dependent on staff for care. 9/27/21 10:55 AM - During an observation of tracheostomy care with E9 (LPN) on Station 2, it was noted that: - E9 put on clean gloves in R105's room without performing handwashing first. - E9 removed the gloves and exited the room and said she forgot something. E9 did not perform hand washing after removing the gloves. -E9 returned to the room with a pulse ox (an instrument to check a person's oxygen level) and put on clean gloves without first performing handwashing. -E9 opened a sterile supply container to suction R105's tracheostomy to remove any excess mucous from it and set up the sterile field. E9 did not perform handwashing before putting on the sterile gloves from the suction kit. E9 suctioned R105's tracheostomy. -E9 opened a sterile tracheostomy care kit and set up the supplies to perform the trach cleaning procedure and then removed the clean gloves. E9 put on the sterile gloves from the kit without first performing handwashing.	F 880	Development/Designee will in-service Licensed nursing staff regarding tracheostomy care. A return demonstration will be performed after the in-service to verify competency annually. The root of non-compliance was due to staff's lack of understanding about the type of mask acceptable to use while inside the facility. Staff Development/Designee will in-service all staff regarding the appropriate type of mask required while inside the facility. The root cause of the non-compliance was due to staff requiring more education on the importance for wearing masks properly. Staff Development/Designee will in-service all staff regarding the appropriate manner of wearing mask while inside the facility. The root cause for the non-compliance was due to the staff's lack of understanding with proper hand hygiene after contaminating the hands. Staff Development/Designee will in-service all staff regarding appropriate handwashing when hands are soiled and contaminated. The root cause of non-compliance was due to the staffs not realizing the importance of hand hygiene prior to meals. Staff Development/Designee will in-service staff regarding provision of hand hygiene before and after meals. Staff will emphasize the importance of hand hygiene at any time the resident is touching surfaces.	

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F 880	Continued From page 74	F 880		
	-E9 performed R105's tracheostomy cleansing procedure and removed the sterile gloves. E9 exited the room without performing handwashing prior to leaving the room. -E9 came back to R105's room with a pen in her hand to date the peroxide solution used during the cleansing procedure. E9 left the room again and returned with cleaning wipes. -E9 put on clean gloves to wipe the table down. E9 finished cleaning the table and removed her gloves. E9 did not perform handwashing prior to leaving R105"s room. 9/27/2021 11:20 AM - During an interview, E9 confirmed that she did not perform handwashing at the required times during the procedure. 2. The following observations were made during the survey of staff wearing cloth facemasks in the clinical areas instead of surgical masks: a. 9/24/2021 1:20 PM - E28 (RN) wore a cloth mask while administering medications on Station 2. E28 confirmed that the mask was cloth. b. 9/28/2021 08:03 AM - E28 (RN) was at the medication cart wearing a cloth mask that was not covering her nose. The observation of the cloth mask and improper use was verified by two surveyors. c. 9/28/2021 9:05 AM - E29 (CNA) was performing patient care on Station 2 while wearing a cloth mask. d. 9/28/2021 12:31 PM - E31 (SW) was talking		4. Random observation during tracheostomy care will be conducted by the Staff Development/Designee to verify Licensed nursing staff's competency with the procedure. Observations will be done weekly x 4 weeks or until a 100% compliance is achieved. Audit results will be submitted to the QA committee. Audit by direct observation by the IP/Designee will be conducted to ensure that staff are wearing the appropriate type of mask while inside the facility. Audits will be completed weekly x 4 then monthly or until 100 % compliance is achieved. Audit results will be submitted to the QA committee. Audit by direct observation by the IP/Designee will be conducted to ensure that staff are wearing their mask appropriately while inside the facility. Audits will be completed weekly x 4 then monthly or until 100 % compliance is achieved. Audit by direct observation by the IP/Designee will be conducted to ensure that staff are assisting residents to perform hand hygiene when hands are soiled or contaminated. Audits will be completed weekly x 4 then monthly or until 100 % compliance is achieved. Random audit by direct observation by the	

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F 880	Continued From page 75 with R59 in the hall by the Station 2 nursing station wearing a cloth mask. 9/28/2021 12:41 PM - During an interview, E29 (CNA) confirmed that he wore a cloth mask earlier in the day. e. 9/29/21 11:50 AM - 12:15 PM - During a random observation, E31 (SW) was seen at Station 3 nursing station interacting with residents in the common area while wearing a black cloth mask. 3. According to the CDC, source control referred to well-fitting masks to cover the person's mouth and nose to prevent the spread of respiratory secretions when they breathe, talk, sneeze or cough. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html (Accessed 10/4/21) During random observations throughout the survey numerous clinical staff were seen wearing their facemasks inappropriately, with either their nose and/or mouth exposed: a. 9/22/21 9:45 AM - E34 (CNA) was observed walking from the South Hall of Station 1 into the nursing station with her facemask under her chin and her nose and mouth exposed. 9/22/21 10:00 AM - E34 (CNA) was observed sitting at the nursing station charting and talking to other staff with her facemask under her chin and her nose and mouth exposed. When the Surveyor said "Your mask should be covering your nose and mouth", E34 pulled the mask up to cover her nose and mouth.	F 880	IP/Designee will be conducted to ensure that staff are assisting residents with hand hygiene before and after meals and as needed when the residents are touching surfaces. Audits will be completed weekly x 4 then monthly or until 100 % compliance is achieved Audit results will be submitted to the QA committee. 5. Date of Compliance November 15, 2021.	

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F 880	Continued From page 76 b. 9/24/21 4:45 PM - E11 (CNA) was observed wearing her mask at the nursing station on Station 3 with her nose exposed. After the Surveyor asked E11 her name, E11 walked into the room where the charts were stored, retrieved her identification badge, then returned to the station with her nose still exposed. c. 9/28/21 3:38 PM - E11 (CNA) was observed walking from Station 1 toward the dining room with her nose exposed. Her mask only covered her mouth. d. 9/30/21 6:15 PM - E12 (RN) was observed at the medication cart on Station 2 with his mask pulled down under his chin. When the surveyor said, "I see your nose," E12 quickly pulled up the mask to cover his nose and mouth. 9/29/21 8:20 AM - During an interview, E18 (Medical Director) expressed concern over the number of staff not wearing their facemasks appropriately as compared to another nursing home E18 visits. 4. The Centers for Disease Control and Prevention (CDC) identified when hand hygiene should be performed by healthcare providers in healthcare settings. Alcohol-based hand sanitizer would be indicated after touching a patient or the patient's immediate environment; after contact with blood, body fluids [including saliva] or contaminated surfaces. https://www.cdc.gov/handhygiene/providers/index.html (Accessed 10/4/21) 9/23/21 9:03 AM - 9:20 AM - During a random observation of supervised smoking, E10	F 880		

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F 880	Continued From page 77 (Restorative Aide) failed to follow standard precautions on several occasions: - E10 took a used cigarette butt with bare hands from R120 (from Station 4) after it was in his mouth. After placing the cigarette butt in the waste container, E10 did not perform hand hygiene. - E10 took a used cigarette butt from R139 (from Station 1) with bare hands. With the contaminated hand from the used cigarette butt, E10 touched her own shirt and crossed her arms, contaminating her other arm. - E10 took another used cigarette from both R120 and R139 with bare hands to place in the waste container. - Without performing hand hygiene [with contaminated hands], E10 picked up the red plastic tackle box containing the smoking supplies, pressed the numbers on the keypad to unlock the door and held the door open for residents to return into the building. E10 walked down the hallway to return the smoking tackle box to its storage place, then used alcohol based hand sanitizer. Cross Refer F677, Example 2 5. 9/22/21 8:05 AM - 12:30 PM: During an observation, R56 ate breakfast, then began to use colored pencils to color cards. R56 was served her lunch and was not assisted in performing hand hygiene. R56 used her contaminated fingers to assist in getting food from her fork into her mouth. 9/23/21 8:30 AM - 12:30 PM: During an observation, R56 was finishing breakfast then began to color in a coloring book. When lunch was served, R56 was not assisted in performing hand hygiene. R56 used her contaminated	F 880		

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F 880	Continued From page 78 fingers to assist in getting food from her fork into her mouth. 9/24/21: During a Resident Council meeting held between 1:30 PM - 3:00 PM, when asked if staff encouraged or assisted with hand hygiene before meals, the attendees unanimously said no. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		11/15/21

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F 883	Continued From page 79 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that, for two (R73 and R77) out of five residents sampled for immunizations, the facility failed to offer the pneumonia vaccination. Findings include: 1. Review of R73's medical record revealed: 2/2/21 - R73 was admitted to the facility with	F 883	1. R73 received Pneumococcal vaccine on 9/29/21. R77 received Pneumococcal vaccine on 9/28/21. 2. Current resident's immunization for the Pneumococcal vaccine will be reviewed. Residents eligible for the vaccine will be offered the vaccine and an	

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F 883	Continued From page 80 dementia. There was no evidence in the eMAR, consents or immunization section of the clinical record that the pneumonia vaccination was ever offered, declined or accepted. 9/28/21 at 10:33 AM - During an interview with E3 (CCC), the Surveyor requested information about R73's immunization status for the pneumonia vaccination. 9/29/21 at approximately 9:35 AM - During an interview with E6 (RN, QAPI) and E3, E6 stated that R73 would receive his pneumonia vaccination today. 2. Review of R77's clinical record revealed: 11/20/20 - R77 was admitted to the facility. There was no evidence in the eMAR, consents or immunization section of the medical record that the pneumonia vaccination was offered, declined or accepted. 9/28/21 at 10:33 AM - During an interview with E3 (CCC) the surveyor requested information about R77's pneumonia immunization status. 9/29/21 at approximately 9:35 AM - During an interview with E6 (RN, QAPI) and E3, E6 stated that R77 received his pneumonia vaccination the day prior after obtaining permission from R77's responsible party. These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 883	order will be obtained for vaccination unless medically contraindicated 3. The root cause of the non-compliance was due to inconsistent review of Pneumococcal immunization status in a timely manner. Upon identification that a resident is eligible to receive the vaccine, consent will be offered, and an order obtained. Staff Development/Designee will in-service Licensed nursing staff the importance of reviewing Pneumococcal vaccine status for timely administration of the vaccine. 4. Audit by the ADON/Designee will be conducted to ensure new admission residents' Pneumococcal vaccination is identified. Audits will be done weekly x 4 then monthly or until 100 % compliance is achieved. Audit results will be submitted to the QA committee. 5. Date of Compliance November 15, 2021	

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F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to ensure a sanitary and comfortable environment for residents and families. Findings include: Observations during the survey revealed: 1. 9/22/21 11:37 AM - The entire resident room floor was sticky from the doorway and into the bathroom. The frame around the wall-mounted bathroom call light was broken. 9/22/21 at 6:05 PM - During an interview, FM1 (R8's family member) stated that R8's floor "has always been dirty, when I would visit three times a week." FM1 added, "I would clean it myself and not say anything." 9/23/21 9:08 AM - A random observation of R102's bathroom revealed a loose towel rack. E56 (CNA) confirmed it was loose and will place a maintenance request to fix it. There was also a large amount of water between the air conditioner and R102's bed, appearing to be coming from the air conditioner. E56 got some towels to absorb the water and confirmed that this will be included in the work order. 9/23/21 8:10 AM - After the floor was cleaned by housekeeping, the floor still appeared dirty when observed from the doorway.	F 921	1. R8's floor was cleaned including being stripped and waxed. R102 towel rack has been fixed. R102's air conditioning unit has been fixed. R50's bathroom has been cleaned and odor has dissipated. R50's call light mount has been fixed. 2. A facility sweep of resident room's flooring to identify any that need to be cleaned thoroughly or stripped and waxed. Facility sweeps of resident rooms for any broken items. Facility sweeps of bathrooms for cleanliness and odor. 3. The facility determined that the root cause was due to appropriate staffing of floor technician in housekeeping. The facility determined that the root cause was also due to unclear housekeeping cleaning schedule. Also determined it was the staff' lack of knowledge regarding entering items into maintenance management system. Education on maintenance management of AC unit system, preventative maintenance of flooring and sanitation will be to provide to all staff by administrator/designee.	11/15/21

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F 921	Continued From page 82 9/23/21 before lunch - During an interview, E53 (Housekeeper) stated that she usually would clean the room when staff were assisting R8 in the bathroom to avoid R8 yelling to get out of the room. When the surveyor described that the floor still looked dirty from the doorway the other day, E33 added that the floor may need to be stripped and redone. 2. 9/23/21 8:57 AM - An observation in Room 207 revealed a black substance on the floor behind the toilet and along the wall where resident shoes were stored. The bathroom had a foul odor that was not urine or bowel movement. The odor permeated through the KN95 mask worn by the Surveyor. Additionally, the floor in front of the lounge chair was cracked and indented. 9/29/21 2:00 PM - The environmental findings were reviewed with E1 (NHA), E37 (Maintenance Director), and E38 (Regional Director of Operations). These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 921	4. Audits will be conducted by Environmental Services Director or designee to ensure flooring in resident rooms and resident's bathrooms are being cleaned appropriately. Audits will be done weekly x 4 weeks and then monthly or 100 % compliance is achieved Ambassador rounds to be done weekly and submitted to Nursing Home Administrator x 4 weeks and then monthly for next quarter. Audit report will be submitted to QA committee. 5. Date of Compliance November 15, 2021.	
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, facility contract reviews and interviews, it was	F 925	1. FTAG #925 Maintains Effective Pest Control	11/15/21

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F 925	Continued From page 83 determined that the facility failed to provide appropriate interventions to manage the presence of pests and to have an effective pest control program on three (Station 1, 2 and 3) out of four resident care units. Findings include: Cross refer F565. 1. Flies 9/22/21 2:39 PM - During an observation, a fly was noted on R140 during a resident interview (room 400-1). 9/22/21 3:32 PM - During an observation and interview a fly was noted on R92 (room 310-1). R92 stated that he had a fly swatter. R92 reported that they (the flies) come in the room a lot when the food is brought into the room and that they go away sometimes after the food is gone. R92 added that "they are bad sometimes." 9/22/21 4:59 PM - During an interview, R75 (Room 122-2) stated, "There are flies everywhere around here and mosquitoes in the day room." Two flies were observed landing on R75's overbed table and on his sheets. 9/23/21 10:00 AM - During an observation, a fly was noted flying around and landing on R79 (room 400-2) and her bed. 9/23/21 1:18 PM - During an observation a fly landed on R1's (room 200-1) table. 9/23/21 2:11 PM - During an interview, R31 (room 103-2) stated, "I have to keep a fly swatter next to me because there are so many! The other day when I came back in my room, I found four flies	F 925	SS=E 1. Stations 1, 2 and 3 were assessed to assure that no pests were noted in Rooms (R92, R140 R75, R1) were checked for flies. The loading bay doors holes were closed. Dry storage floors were kept clean and free of food particles and room free of any condensation. Dumpster lids were closed. Doors to outside with holes will be closed. 2. Facility checks will be completed by maintenance/designee of outside of building to determine how pests are coming in. Maintenance will do routine checks of resident rooms, stations to monitor for pests/rodents. Education to residents and family members will be provided about food being stored appropriately in containers with lids to prevent pests. Education will be provided to all staff regarding measures to prevent pests/rodents and reporting of pests in pest control book. 3. The facility determined that the root cause was lack of sufficient pest control program. Facility increased the pest control agency visits from one day a week to two days per week for at least one hour each visit this will continue for at least six months. Pest control agency and maintenance will work on patching hole appropriately found inside or outside of building. 4. NHA or designee will randomly speak with two residents each week on any issues related to pests/rodents and review audit pest control sheets weekly from	

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F 925	Continued From page 84 had gotten under the cover of my lunch plate." A fly was observed flying around the room during the interview. 9/28/21 10:00 AM - During an interview, E1 (NHA) stated that the facility has tried several pest control companies and provided copies of invoices. In addition, E1 said that the facility started a process improvement plan in July 2021 for mice in the facility, but they continue to have an infestation. 2. Mice 9/22/21 10:00 AM - During an interview, R78 (room 202P) stated, "If you sit here in the hall by the nursing station you will see them run across the hall. They even get in my bed." 9/22/21 12:05 PM - During an observation, mouse droppings were seen in two areas along the wall near furniture in (room 107-1) R29's room and were confirmed by E50 (CNA) and E51 (LPN). 9/22/21 12:15 PM - During an observation, mouse droppings were seen in the closet in (room 104-2) R137's room and was confirmed by E50 (CNA). 9/22/21 1:00 PM - During an interview, R124 (room 105-1) stated, "We have a lot of mice. Not long ago, there was even one climbing up the curtain between our beds." 9/22/21 1:10 PM - During an interview, R143 (room 105-2) stated, "The nurses found a dead baby mouse in a box that was on my floor with cough drops."	F 925	Pest Company for four weeks then monthly for next quarter. Maintenance or designee will audit outside of building once per week for four weeks then monthly for next quarter. Maintenance or designee will review pest control books twice per week x4 weeks then weekly until end of quarter. Audit report will be submitted to QA committee. 5. Date of Compliance November 15, 2021 Compliance by November 15, 2021	

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F 925	Continued From page 85 9/23/21 8:30 AM - During an interview, R53 (room 108-2) stated, "There was just a mouse in here the other night." Mouse droppings were observed along the wall next to her dresser and was confirmed by R14 (UM). 9/23/21 2:37 PM - During an interview, R74 (room 110-1) stated, "A little mouse stuck his head out of the bathroom door last night and we stared at each other. When I moved toward him, he ran away." 9/27/21 4:00 PM - E15 (room 201P) stated during an interview that he had a mouse that came into his room regularly. R15 also stated he has seen black bugs in the shower. 9/28/21 at 9:15 AM - While seated in the chart room on Station 1 (Beach Cove), the Surveyor saw a mouse run from behind the refrigerator, across the floor in front of the printer cabinet and disappear behind the file cabinet. The Surveyor looked behind the file cabinet and did not see the mouse, but noticed a small space between the bottom of the built-in wood chart rack and the baseboard. 9/28/21 9:24 AM - During an interview, the Surveyor informed E3 (CCC) about the mouse and E3 said she would "let them [maintenance] know" to take care of it. 9/28/21 9:36 AM - During an interview with E48 (Maintenance), the Surveyor described the path the mouse took. E48 looked behind the file cabinet and said he "will take care of it." 9/29/21 2:00 PM - During an interview, E52	F 925		

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F 925	Continued From page 86 (Housekeeper) stated, "Just this morning a mouse was caught in a sticky trap in room 110 and a mouse was seen in room 111. Mice have been a big problem for at least six months." 9/29/21 2:00 PM - The above findings were reviewed in a meeting with E1 (NHA), E37 (Maintenance Director) and E38 (Regional Director of Operations). 3. The following were observed during the food service audit between 10:45 AM through 1:00 PM: - The loading bay door had holes, making it an entry source for rodents; - The dry storage room was not kept clean with food present on the floor, making it a food source for rodents; - The condensation from the walk-in refrigerator was pooling in the dry storage room, making it a source of water for rodents; - Dumpster lids were left open which can attract pests; - Observed multiple holes on the doors to the outside, making it an entry source for pests. Kitchen findings were reviewed and confirmed on 9/22/21 at approximately 1:00 PM with E5 (FSD). These findings were reviewed during the exit conference on 9/30/21, beginning at 5:04 PM, with E1 (NHA), E2 (Interim DON) and E3 (CCC).	F 925		