DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road Suite 200
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Foulk Manor North LLC, Nursing Home **DATE SURVEY COMPLETED: May 27, 2022**

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 May 19, 2022 through May 27, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 40. The survey sample totaled 22 residents.	Foulk Manor will be in compliance as of July 5, 2022.	
3201.0	**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.**		

Provider's Signature Janet Bullock Title DON/Clinical Claims Date 6/20/22

NAME OF FACILITY: Foulk Manor North LLC, Nursing Home **DATE SURVEY COMPLETED: May 27, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
5.0	**Personnel/Administrative**		
5.5	**The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:**		
5.5.3	**Results of criminal background check.** This requirement was not met as evidenced by: Based on interview and review of facility documentation provided to the Surveyor, it was determined that for three (E7, E19 and E20) out of fifteen (15) employees reviewed, the facility's personnel records lacked evidence of criminal background checks. 5/31/22 at 3:27 PM – Review of employee fingerprinting documentation revealed: E7 (Certified Nurse Assistant) was missing evidence of a criminal background check. E19 (Registered Nurse, MDS Coordinator) was missing evidence of a criminal background check. E20 (Registered Nurse) was missing evidence of a criminal background check. 6/3/22 at 12:23 PM – Findings were discussed and confirmed during a telephone conference with E2 (DON) and E3 (ADON).	5.5.3 Corrective Action: Corrective actions have been ensured by the Administrator. Employee #7 has now had a criminal background completed with no concerns noted on the employee background. Employee #19 has now had a criminal background completed with no concerns noted on the employee background. Employee #20 has now had a criminal background completed with no concerns noted on the employee background. Identification of Other Residents: All Residents have the potential to be affected. Residents will be protected by ensuring that all employees meet the regulatory requirement for pre-employment screening and background checks. A 100% audit of employee background checks has been completed to ensure proper completion of pre-employment screening and background checks. This audit identified several of employees that did not have background checks completed; these background checks have since been completed for these employees as required. System Changes: The Root Cause of the concern was a failure to complete the background checks as required for Employee #7, Employee #19,	

Provider's Signature Jean Bellew Title DON/Acting Admin Date 6/20/22

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		and Employee #20. The facility system for pre-employment screenings and background checks has been updated to ensure that no employee begins working until their background check is completed. The facility policy for "Background Screening Investigations" (rev. 3.2019) was reviewed and found to meet professional standards. The Administrator or Designee will complete education for all human resources staff regarding the pre-employment background screening investigations policy. The administrator will provide oversight to ensure ongoing compliance. Success Evaluation: A random sample of 10% of employees will be completed to ensure that all employees meet the regulatory requirement for pre-employment screening and background checks; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

Provider's Signature Jared Bibbs Title DON/Acting Admin Date 6/20/22

NAME OF FACILITY: Foulk Manor North LLC, Nursing Home **DATE SURVEY COMPLETED: May 27, 2022**

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16 Del. Code, Ch. 11 Sub-Chapter IV §1141	**Abuse, Neglect, Mistreatment, or Financial Exploitation of Residents or Patients.** **Criminal background checks.** **(a) *Purpose.* — The purpose of the criminal background check and drug screening requirements of this section and § 1142 of this title is the protection of the safety and well-being of residents of long-term care facilities licensed pursuant to this chapter. These sections shall be construed broadly to accomplish this purpose.** **(c) An employer may not employ an applicant for work in a facility before obtaining a criminal history. The criminal history of any person not employed directly by the facility must be provided to the facility upon the person's commencement of work.** **(d) The requirements of subsection (c) of this section may be suspended for 60 days if the employer wishes to employ the applicant on a conditional basis.** **(1) Before an employer may offer conditional employment, the employer must receive verification that the applicant has been fingerprinted by the SBI for purposes of the criminal history.** This requirement was not met as evidenced by: Based on interview and review of facility documentation provided to the Surveyor, it was determined that the facility failed to ensure fingerprinting was completed for	16 Del. Code, Ch. 11 Sub-Chapter IV §1141 Corrective Action: Corrective actions have been ensured by the Administrator. Employee #7 has now had fingerprinting completed with no concerns noted on the employee background. Employee #19 has now had fingerprinting completed with no concerns noted on the employee background. Employee #20 has now had a fingerprinting completed with no concerns noted on the employee background. Identification of Other Residents: All Residents have the potential to be affected. Residents will be protected by ensuring that all employees meet the regulatory requirement for pre-employment screening and fingerprinting. A 100% audit of employee background checks has been completed to ensure proper completion of pre-employment screening and fingerprinting. This audit identified several of employees that did not have fingerprinting completed; the fingerprinting has since been completed for these employees as required. System Changes: The Root Cause of the concern was a failure to complete the fingerprinting as required for Employee #7, Employee #19, and Employee #20. The facility system for pre-employment screenings	

Provider's Signature Janet Bell Title DON/Acting Admin Date 6/2/22

NAME OF FACILITY: Foulk Manor North LLC, Nursing Home

DATE SURVEY COMPLETED: May 27, 2022

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	three (E7, E19 and E20) out of fifteen (15) sampled staff. Findings include: 5/27/22 at 4:00 PM – During the exit conference with E2 (DON) and E3 (ADON), it was explained that findings are contingent on BCC (Background Check Center) review of a sample of staff. 1. E7 (Certified Nurse Assistant) 5/27/22 – Review of the State Agency Personnel Audit Form completed by the facility revealed that E7's first day working in the facility was 10/4/21. 5/31/22 at 3:27 PM – Review of the State of Delaware fingerprint database revealed that E7's fingerprint clearance was not in the State BCC database. 6/1/22 at 2:19 AM – In an email correspondence, E3 stated that E7 filed for fingerprinting under a different name which he then provided to the Surveyor. 6/1/22 at 3:43 PM – In an email correspondence with E2 and E3, the Surveyor requested the facility's evidence of E7's fingerprint clearance, including clearance of her alternate name. 6/2/22 at 7:52 AM – A review from the State fingerprinting database revealed that E7 (and E7's alternate name) had no record of fingerprinting filed for Long Term Care. 6/2/22 at 12:23 PM – In a telephone conference, the Surveyor requested from E2 and E3 evidence of E7's fingerprint clearance.	and fingerprinting has been updated to ensure that no employee begins working until their fingerprinting is completed. The facility policy for "Background Screening Investigations" (rev. 3.2019) was reviewed and found to meet professional standards. The Administrator or Designee will complete education for all human resources staff regarding the pre-employment background screening investigations policy. The administrator will provide oversight to ensure ongoing compliance. Success Evaluation: A random sample of 10% of employees will be completed by the Director of Nursing or designee to ensure that all employees meet the regulatory requirement for pre-employment screening and fingerprinting; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

Provider's Signature Jane Rubin Title DNS/Acting Admin Date 6/20/22

NAME OF FACILITY: Foulk Manor North LLC, Nursing Home **DATE SURVEY COMPLETED: May 27, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	6/22 at 1:32 PM – In an email correspondence, E3 documented that E7 was taken off the schedule and was sent for fingerprinting "today" (6/2/22). 2. E19 (Registered Nurse, MDS Coordinator) 5/27/22 – Review of the State Agency Personnel Audit Form completed by the facility revealed that E19's first working day was 5/3/22. 5/31/22 at 3:27 PM – Review of the State of Delaware fingerprint database revealed that E19's fingerprint clearance was not in the State database. 6/1/22 at 2:19 PM - In an email correspondence, E3 stated that, "... She (E19) is still in her 30 day-window for submitting her fingerprints upon hire." 6/1/22 at 3:43 PM – In an email correspondence to E2 and E3, the Surveyor requested the facility's evidence of E19's fingerprint clearance. 6/2/22 at 12:23 PM – In a telephone conference, the Surveyor followed up with E2 and E3 for evidence of E19's fingerprint clearance and no evidence of fingerprint was available. 6//22 at 1:32 PM – In an email correspondence, E3 documented that E19 was taken off the schedule and was sent for fingerprinting "today" (6/2/22). 2. E20 (Registered Nurse)		

Provider's Signature Janet Bullen Title DON/Acting Admin Date 6/20/22

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	5/27/22 – Review of the State Agency Personnel Audit Form completed by the facility revealed that E20's first working day was 3/14/22. 5/31/22 at 3:27 PM – Review of the State of Delaware fingerprint database revealed that E20's fingerprint clearance was not in the system. 6/1/22 at 3:43 PM – In an email correspondence to E2 and E3, the Surveyor requested the facility's evidence of E20's fingerprint clearance. 6/2/22 at 11:45 PM – Further review of the State fingerprint database revealed that E20 was last fingerprinted for Long Term Care on 1/15/21. 6/2/22 at 11:50 AM – Review of the state fingerprint database website revealed a posting that stated, "Effective July 2018, the Criminal History Reports (fingerprints) are valid for 6 months from the last fingerprint date." 6/2/22 at 1:32 PM – In an email correspondence, E3 sent multiple files as attachments including E20's fingerprint receipt/verification dated 1/15/21. In addition, E3 documented that, "...BCC was down but sent attached letter and record showing eligibility and also included a copy of the receipt." 6/2/22 at 2:07 PM – Further review of the attached files revealed that documents were coming from a different state agency and did not come from the approved State database.		

Provider's Signature [signature] Title DON/Acting Administrator Date 6/20/22

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	6/2/22 at 2:40 PM – In a telephone conference, E3 notified the Surveyor that E20 was taken off the schedule and was sent for fingerprinting "today" (6/2/22).		
16 Del. Code, Ch. 11 §1144	**Influenza Immunizations** **(a) Nursing and assisted living facilities shall annually offer, beginning no later than October 1 and extending through March 1 of a calendar year, onsite vaccinations for influenza vaccine to all employees with direct contact with patients at no cost and contingent upon availability of the vaccine.** **(b) The facility shall keep on record a signed statement from each employee stating that the employee has been offered vaccination against influenza and has either accepted or declined such vaccination.** **This requirement is not met as evidenced by:** Based on interview and review of other facility documentation, it was determined that for three (E24, E25 and E29) out of seven employees sampled for annual influenza (flu) vaccination, the facility failed to provide evidence of influenza vaccination or declination for the prior flu season. Findings include: Review of documentation provided by the facility revealed that E24 (OTA), E25 (hairdresser), and E29 (dietary) lacked evidence	16 Del. Code, Ch. 11 §1144 Corrective Action: Corrective actions have been ensured by the Director of Nursing. Employee #24 has been offered the Influenza Vaccine and now has a documented declination as required. Employee #25 has been offered the Influenza Vaccine and now has a documented declination as required. Employee #29 has been offered the Influenza Vaccine and now has a documented declination as required. Identification of Other Residents: All Residents have the potential to be affected. Residents will be protected by ensuring that all employees are offered the Influenza Vaccine and have documentation of either receiving or declining the vaccine. A 100% audit of all employees to ensure Influenza vaccination or a documented declination has been completed. No new concerns regarding pain management were identified as a result of this audit. System Changes: The Root Cause of the concern was a failure to obtain the documented influenza vaccine declination as required for Employee #24, Employee #25, and Employee #29. The facility system for influenza vaccination declination has been updated to include an Interdisciplinary Team (IDT)	

Provider's Signature Janet Belles Title DON/Acting Admin Date 6/20/22

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	of the annual influenza vaccination or declination documentation during the 2021 - 2022 flu season. 5/24/22 1:00 PM - During an interview, E3 (ADON) confirmed the above findings. Findings were reviewed with E2 (DON) and E3 (ADON) during the Exit Conference on 5/27/22 beginning at 4:00 PM. This requirement is not met as evidenced by the following: Cross refer to CMS 2567-L survey completed May 27, 2022: F656, F657, F684, F689, F695, F697, F732, F812, F814, F880 and F888.	meeting involving the Administrator, Human Resources Director, Director of Nursing, and Infection Preventionist thirty days after the facility begins offering the annual Influenza Vaccine each year in order to ensure that all requirements for Influenza vaccination of facility staff are met. Moving forward, all new hires will receive the Influenza Vaccination or complete a documented declination upon hire. The facility policy for "Influenza Vaccine" (rev. 10.2019) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the Influenza vaccination or documented declination requirements. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: A random sample of 10% of employees will be completed by the Director of Nursing or designee to ensure that all employees meet the regulatory requirement for Influenza vaccination or documented declination; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

Provider's Signature _____ Title DON/Acting Admin Date 6/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A011	A. BUILDING _____ B. WING _____	05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOULK MANOR	1212 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from May 19, 2022 through May 27, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 40. The survey sample totaled 22 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; CRS - Clinical Reimbursement Specialist; DON - Director of Nursing; HOS - Hospice; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; SW - Social Worker; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0-7: Severe impairment; cc (cubic centimeter) - unit of volume; BMP - (Basic Metabolic Panel) - set of tests that measure blood sugar, calcium levels, kidney function, and chemical and fluid balance; CBC - (Complete Blood [cell] Count) - blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/14/2022

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 Dycem- a non-slip material used to help stabilize objects, hold objects firmly in place, or to provide a better grip; MDS (Minimum Data Set) - a standardized set of assessments completed in nursing homes; Sacrum - tailbone.	F 000		
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 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	F 656		7/5/22

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	08A011	A. BUILDING _____ B. WING _____	05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOULK MANOR	1212 FOULK ROAD WILMINGTON, DE 19803

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F 656	Continued From page 2 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 interview and record review, it was determined that the facility failed to develop a comprehensive care plan for one (R1) out of one sampled resident for hospice investigation. Findings include: Cross refer F697 Review of R1's clinical record revealed: 11/16/21 - R1 was admitted to the facility under Hospice services. 11/16/21 - The Admission Nursing Comprehensive Pain Assessment documented that R1 verbalized abdominal pain. 11/29/21 - The Admission MDS Assessment documented that R1 was receiving scheduled routine and as needed pain medications and was not receiving non-medication intervention(s) for pain. 12/8/21 - The facility developed and implemented a care plan which stated that R1 was on pain medication therapy, however, there was lack of	F 656	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. Resident #1 has been assessed for current pain status and a pain goal has been established. The care plan has been updated to include the location of pain, as well as pharmacological and non-pharmacological interventions for pain, including repositioning and emotional support. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that all pain care plans are complete and accurate. A 100% audit of resident pain care plans and pain care plan interventions has been completed to ensure proper care plans for pain management, including the location of pain, a pain goal, and pharmacological and non-pharmacological interventions. No new concerns regarding resident pain care plans were identified as a result of this audit.	

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F 656	Continued From page 3 evidence of interventions to address R1's abdominal pain that was verbalized and documented on the admission nursing pain assessment dated 11/16/21. The care plan lacked both pharmacological and non-pharmacological interventions for pain. 2/16/22 - The facility developed and implemented a care plan that R1 was at increased risk for alteration in comfort, however, there was lack of evidence of the location of the pain, what specific pharmacological and non-pharmacological interventions were to be utilized, as well as the goal for pain management. 5/26/22 - The above findings were reviewed and confirmed with E2 (DON) and E3 (ADON). Findings were reviewed with E2 (DON) and E3 (ADON) during the Exit Conference on 5/27/22, beginning at 4:00 PM.	F 656	System Changes: " The Root Cause of the concern was the failure to accurately complete the pain management care plan to include the required elements in the policy Pain Assessment and Management (revised 6.10.22). The facility system for pain care plans has been updated to include a quarterly review of all pain care plans to ensure that each pain care plan includes the location of pain, a pain goal, and pharmacological and non-pharmacological interventions. The facility policy Care Plans, Comprehensive Person-Centered (revised 12.2016) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the requirements that a pain care plan must include the location of pain, a pain goal, and pharmacological and non-pharmacological interventions. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of 10% of residents pain management care plans will be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive	

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F 656	Continued From page 4	F 656	evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 657	Corrective Action:	7/5/22

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F 657	Continued From page 5 determined that for two (R1 and R15) out of 22 sampled residents, the facility failed to ensure that the care plan was prepared by an IDT (Interdisciplinary Team) and held with the Attending Physician or his/her designee, the Nurse's aide with responsibility for the resident, a staff member from Nutrition/Food Service staff, and other professionals in disciplines as determined by the resident's needs. Findings include: Review of the facility's policy titled Care Plan, with a revision date of 9/2013, stated that IDT includes other appropriate staff or professionals as determined by the resident's needs or as requested by the resident. 1. Review of R1's clinical records revealed: 11/16/21 - R1 was admitted to the facility under Hospice services. 11/29/21 - The Admission MDS Assessment was completed. 12/9/21- Review of the Plan of Care Conference Summary lacked evidence that R1's Attending Physician or designee, the Nurse's Aide responsible for the resident, and staff from the Hospice Agency participated in the IDT care planning process. 3/1/22 - The Quarterly MDS Assessment was completed. 3/17/22 - Review of the Plan of Care Conference Summary lacked evidence that R1's Attending Physician or designee, the Nurse's Aide responsible for the resident, and staff from the	F 657	Corrective actions have been ensured by the Director of Nursing. The care plan for Resident #1 was reviewed by the Interdisciplinary Team (IDT), including the attending physician, registered nurse, hospice staff, and social services; this review found the resident care plan to be up to date and accurate. The care plan for Resident #15 was reviewed by the Interdisciplinary Team (IDT), including the attending physician, nursing management, and social services; this review found the resident care plan to be up to date and accurate. Identification of Other Residents: • All Residents have the potential to be affected. Other residents will be protected by ensuring that all care plans are prepared by the Interdisciplinary Team, to include the Attending Physician or designee, Registered Nurse, the Nurse's aide, Food Service staff, and others involved in providing care to the resident. A 100% audit of all resident care plans and care conference records has been completed to ensure evidence of an IDT Care Plan meeting with participation from the attending physician, nursing staff, the nurse's aide, and food service staff. No new concerns regarding resident pain care plans were identified as a result of this audit. System Changes: • The Root Cause of the concern was the failure to accurately adhere to the required elements in the policy "Care	

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F 657	Continued From page 6 Hospice Agency participated in the IDT care planning process. 5/23/22 1:10 PM - An interview with HOS RN1 (Hospice RN) revealed that she has been providing skilled nursing services on a weekly basis and verbalized that she has not been invited or attended any of the IDT Care Plan meetings since R1's admission to the facility on 11/16/21. 5/24/22 11:16 AM - An interview with E4 (Social Worker) revealed it was the facility's practice to invite staff of Hospice agencies to the IDT Care Plan meeting either verbally or via email. E4 stated that for R1, the Hospice Liaison was informed of the IDT Care Plan meetings. The Surveyor requested evidence of the invitation for the IDT Care Plans meetings held on 12/9/21 and 3/17/22. 5/25/22 10:15 AM - A follow-up interview with E4 (SW) revealed that the facility was unable to provide evidence that R1's Hospice Agency was invited to the IDT Care Plan meeting. 2. Review of R15's clinical records revealed: 6/4/21 - R15 was admitted to the facility. 6/17/21 - The Admission MDS Assessment was completed. There was lack of evidence that the facility conducted an IDT Care Plan meeting after completion of the admission MDS Assessment dated 6/17/21. 9/17/21 - The Quarterly MDS Assessment was	F 657	Planning – Interdisciplinary Team" (revised 9.2013). The facility policy "Care Planning – Interdisciplinary Team" (revised 9.2013) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all registered nurses and other nursing staff and social services staff have been educated on the requirements for care conference participation and records for evidence of care conference participation. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: • An audit of a random sample of 10% of resident care plans and care conference records will be completed will be completed by the Director of Nursing or Designee to ensure evidence of an IDT Care Plan meeting with participation from the attending physician, the registered nurse, the nurse's aide, and the dietitian; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 657	Continued From page 7 completed. 9/23/21 - Review of the Plan of Care Conference Summary lacked evidence that R15's Attending Physician or designee, the Nurse's Aide responsible for the resident, and staff from Nutrition/Food Services participated in the IDT care planning process. 12/17/21 - The Quarterly MDS Assessment was completed. There was lack of evidence that the facility conducted an IDT Care Plan meeting after completion of the quarterly MDS Assessment dated 12/17/21. 3/10/22 - The Quarterly MDS Assessment was completed. 3/24/22 - Review of the Plan of Care Conference Summary lacked evidence that R15's Attending Physician or designee and the Nurse's Aide responsible for the resident participated in the IDT care planning process. 5/26/22 1:45 PM - An interview with E4 (SW) confirmed that the facility was unable to provide evidence that a IDT Care Plan meeting was held after completion of the MDS Assessments on 6/17/21 and 12/17/21. In addition, the facility was unable to provide evidence that R15's Attending Physician/designee and the Nurse's Aide responsible participated in the IDT care planning process. 5/26/22 - The above findings were reviewed and confirmed with E2 (DON) and E3 (ADON).	F 657		

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F 657	Continued From page 8 Findings where reviewed with E2(DON) and E3 (ADON) during the Exit Conference on 5/27/22, beginning at 4:00 PM.	F 657		
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 record review, interview and review of facility documents, it was determined that for one (R23) out of 22 sampled residents, the facility failed to ensure that R23's physician's order for laboratory tests was completed. Findings include: Review of R23's clinical record revealed: 3/20/22 - R23 was admitted to the facility with diagnoses including high blood pressure, bradycardia (slow heart rate) and DVT (Deep Vein Thrombosis - occurs when a blood clot (thrombus) forms in one or more of the deep veins in the body, usually in the legs). 3/30/22 (revised 4/12/22) - A care plan was developed for R23's potential for actual alteration in cardiovascular status related to high blood pressure, bradycardia and DVT with interventions including to obtain and report lab work as ordered by the healthcare practitioner.	F 684	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. Resident #23 had the ordered labs completed per the physician order on 5/26/22. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that all lab orders have been completed as ordered. A 100% audit of resident lab orders has been completed to ensure completion per the physician order. No new concerns regarding resident lab orders were identified as a result of this audit. System Changes: " The Root Cause of the concern was a scheduling error for the lab to be completed on a day that the lab does not	7/5/22

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F 684	Continued From page 9 4/8/22 - A physician's order was received for a CBC (Complete Blood Count - blood test used to evaluate overall health and detect a wide range of disorders) and BMP (Basic Metabolic Panel - set of tests that measure blood sugar, calcium levels, kidney function, and chemical and fluid balance) one time only for a baseline for R23. 5/27/22 at 2:10 PM - Review of R23's clinical record lacked evidence of results for the CBC and BMP ordered on 4/8/22. Review of the Lab Form Book on the third floor revealed R23's lab slip was placed for a blood draw on 4/10/22 (Sunday) instead of Monday, 4/11/22 (the day the lab came to the facility to draw routine blood samples). 5/27/22 at 2:35 PM - In an interview, E5 (RN Supervisor) confirmed that R23's CBC and BMP were not done. E5 further stated that a doctor's order was just obtained "now" for a stat (immediate) CBC and BMP to be done "today" (5/27/22) for R23. 5/27/22 at 2:45 PM - Findings were discussed with E2 (DON), E3 (ADON) and E5. Findings where reviewed with E2 (DON) and E3 (ADON) during the Exit Conference on 5/27/22, beginning at 4:00 PM.	F 684	come. The facility system for daily clinical review meeting has been updated to include a review of all physician orders for labs to ensure that all labs have been scheduled correctly and drawn as ordered. The facility policy Lab and Diagnostic Test Results □ Clinical Protocol (revised 11.2018) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the scheduling of labs and adherence to physician orders regarding labs. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of 10% of residents lab orders will be completed by the Director of Nursing or Designee to ensure completion per the physician order; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		7/5/22

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F 689	Continued From page 10 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R26) out of three (3) sampled residents reviewed for accident investigations, the facility failed to provide assistive devices to prevent falls. Finding include: The following was reviewed in R26's clinical record: 2/23/22 - A physician's order was written for a Dycem on top of the wheelchair cushion daily to promote good positioning and to decrease the risk for sliding. 5/26/22 10:00 AM - R26 requested E7 (CNA) to transfer R26 from a recliner to her wheelchair. Once seated in the wheelchair, R26 began to independently self propel herself in the unit. 5/26/22 10:11 AM - R26 requested E5 (RN) to transfer R26 from her wheelchair back to the recliner. The Surveyor observed the lack of Dycem on top of the wheelchair cushion. E5 immediately went into R26's room, located the Dycem which was in R26's bathroom and placed the Dycem in R26's wheelchair. 5/26/22 - The above findings were reviewed with	F 689	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. The Dycem for Resident #26 was immediately placed per the care plan when the nursing staff was notified that it was not in place. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that all care planned fall prevention interventions are in place. A 100% audit of all resident fall prevention interventions has been completed to ensure compliance with resident care plans. No new concerns regarding resident fall interventions were identified as a result of this audit. System Changes: " The Root Cause of the concern was a failure to replace the dycem on the wheelchair after cleaning. The facility system for daily interdisciplinary rounds has been updated to include nursing management monitoring of fall interventions. The facility policy for Falls and Fall Risk, Managing (rev. 3.2018) was reviewed and found to meet professional	

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F 689	Continued From page 11 E2 (DON) and E3 (ADON). Findings where reviewed with E2(DON) and E3 (ADON) during the Exit Conference on 5/27/22, beginning at 4:00 PM.	F 689	standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for managing fall risks and ensuring care planned interventions are in place. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of 10% of residents who have fall prevention interventions will be completed by the Director of Nursing or Designee to ensure that all fall interventions are in place per the plan of care; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		7/5/22

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F 695	Continued From page 12 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R9) out of one resident sampled for respiratory care investigation, the facility failed to provide respiratory care consistent with professional standards of practice. Findings include: Review of R9's clinical record revealed: 11/16/21 - R9 was admitted to the facility with multiple diagnoses including chronic respiratory failure with hypoxia (low oxygen level reaching the tissues). 11/30/21 - A physician's order was written for oxygen therapy via nasal cannula (NC) at 2 liters per minute (LPM). 5/20/22 10:05 AM - During a random observation, R9 was observed with oxygen via NC infusing at 2 LPM via an oxygen concentrator, however, the concentrator failed to have a filter present. 5/20/22 10:10 AM - A joint observation with E6 (LPN) confirmed the absence of the filter. E6 immediately removed the concentrator, obtained a new oxygen concentrator with a filter, connected R9's oxygen tubing to the new machine and placed the NC into R9's nostrils. 5/26/22 - The above findings were reviewed with E2 (DON) and E3 (ADON). Findings were reviewed with E2 (DON) and E3 (ADON) during the Exit Conference on 5/27/22, beginning at 4:00 PM.	F 695	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. When the missing concentrator filter for Resident #9 was identified, the concentrator was immediately replaced with a new concentrator that had a filter. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that all oxygen concentrator filters are changed weekly when other oxygen tubing and equipment is changed. A 100% audit of all oxygen concentrators has been completed to ensure that each concentrator has a filter. No new concerns regarding oxygen concentrator filters were identified as a result of this audit. System Changes: " The Root Cause of the concern was a failure to check oxygen concentrator filters when checking other oxygen equipment routinely. The facility system for weekly routine oxygen tubing and equipment changing has been changed to include oxygen concentrator filters are changed weekly. The facility policy for Departmental (Respiratory Therapy) □ Prevention of Infection (rev. 11.2011) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for infection control considerations related to	

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F 695	Continued From page 13	F 695	oxygen administration and oxygen concentrator filters. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of 10% of residents who have oxygen concentrators will be completed by the Director of Nursing or Designee to ensure that each concentrator has a filter; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of one resident sampled for pain investigation, the facility failed to ensure that a complete pain assessment was	F 697	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. A referral was made to the Physician for a review of the	7/5/22

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F 697	Continued From page 14 conducted to evaluate the effectiveness of pain medication. Findings include: The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. The facility's Pain Management policy, dated March 2020, did not address the need for consistent assessment using the same pain scale before and after administration of routine pain medication when the pain level is more than zero. Policy General Guidelines Section 5 states that acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. Cross refer F656 The following was reviewed in R1's clinical record: 11/16/2021 - R1 was admitted to the facility under the continued care of hospice from her previous care setting and with multiple diagnoses, including chronic vascular disorders of the intestine. 11/16/21 - The Admission Nursing Pain Evaluation documented that R1 verbalized pain in the abdominal area and described it as aching.	F 697	pain management regimen and care plan for Resident #1; the review has been completed and the determination has been made that the current resident pain management regimen meets the current resident need for pain management. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that all reports of pain receive effective interventions and follow-up assessment to ensure effectiveness. A 100% audit of resident orders for pain medication has been completed to ensure proper assessment and management of pain, including post-analgesic pain assessments as needed. No new concerns regarding pain management were identified as a result of this audit. System Changes: " The Root Cause of the concern was a failure to follow the policy for Pain Assessment and Management (rev. 6.10.22) and complete an appropriate follow-up assessment of pain. The facility system for daily clinical review meeting has been updated to include a review of resident pain scores to ensure effective pain assessment and management. The facility policy for Pain Assessment and Management (rev. 6.10.22) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for pain assessment and management. The nursing management team will provide oversight	

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F 697	Continued From page 15 11/29/2021- The Admission MDS Assessment documented that R1 verbalized aching pain with a pain level of 3 (three) out of 10 (with 0 being no pain and 10 being the worst possible pain) in the abdominal area. 11/22/2021 - A physician's order for routine pain medication by mouth was scheduled three times a day at 8 AM, 2 PM, and 8 PM. 12/8/2021 - The Care Plan stated that R1 was on pain medication therapy with interventions to include: administer medications as ordered by physician, monitor side effects and effectiveness every shift, review narcotic pain medication for efficacy, and assess whether pain intensity is acceptable to the resident. 12/21/2021 - A physician's order was written for as needed pain medication every 6 hours for mild pain (pain scale from 1 to 4). 1/24/2022 - A physician's order was written for narcotic pain medication as needed every 4 hours for pain. 3/25/22 5:00 PM - Review of the Medication Administration Record (MAR) documented that R1's pain level was a "5" prior to the administration of routine narcotic pain medication. There was lack of evidence that the facility reassessed the effectiveness of the medication after it was administered. 5/8/22 5:00 PM - Review of the MAR documented that R1's pain level was "8" prior to the administration of routine narcotic pain medication. There was lack of evidence that the	F 697	to ensure ongoing compliance. Success Evaluation: " An audit of a random sample of 10% of residents who have physician orders to treat pain will be completed by the Director of Nursing or Designee to ensure effective pain assessment and management; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 697	Continued From page 16 facility reassessed the effectiveness of the medication after it was administered. 5/19/22 5:00 PM - Review of the MAR documented that R1's pain level was "4" prior to the administration of the routine narcotic pain medication. There was lack of evidence that the facility reassessed the effectiveness of the medication after it was administered. 5/24/22- 2:10 PM - An interview with E5 (RN) confirmed the lack of evidence of reassessment of R1's pain after the administration of pain medication on the above dates and times. 5/26/22 - The above findings were reviewed with E2 (DON) and E3 (ADON). Findings where reviewed with E2 (DON) and E3 (ADON) during the Exit Conference on 5/27/22, beginning at 4:00 PM.	F 697		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F 732		7/5/22

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F 732	Continued From page 17 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post the nurse staffing in a prominent place, readily accessible to residents and visitors for two out of two nursing units. Findings include: 2nd Floor Observation 5/27/22 at 2:00 PM - An observation on the 2nd floor nursing station revealed that nursing staffing data was posted on the desk at the nursing station. The letter or font size was noted to be small to the point that the words could barely be read from a two foot distance. 3rd Floor Observation	F 732	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. The font size of the Nurse Staffing Posting on each floor has been enlarged so that Resident #16, and other residents, will be able to read it more easily. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that the Nurse Staffing Posting is posted daily in a font size large enough to be read easily.	

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F 732	Continued From page 18 5/27/22 at 2:05 PM - An observation on the 3rd floor nursing station revealed that nursing staffing data was posted on the desk at the nursing station. The letter or font size was noted to be small to the point that the words could barely be read from a two foot distance. 5:27/22 at 2:35 PM - The Surveyor asked R16, who was sitting in her wheelchair in front of the nursing station, if she could read the staffing posting, a two foot distance away from the nursing station desk. R16 stated that she could not read the posting, stating the words were too small and she asked the Surveyor to read the words for her. 5/27/22 at 2:40 PM - Findings were discussed with E2 (DON) and E3 (ADON). Findings were reviewed with E2 (DON) and E3 (ADON) during the Exit Conference on 5/27/22, beginning at 4:00 PM.	F 732	System Changes: " The Root Cause of the concern was a failure to ensure that the font size of the Nurse Staffing Information posting was large enough to be easily read by residents. The facility system for daily Nurse Staffing Information posting has been updated to include completing a nurse staffing information sheet that has a larger font size. The facility policy for Posting Direct Care Daily Staffing Numbers (7.2016) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for the daily nurse staffing information posting requirements and font size. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " A nurse staffing information audit to ensure the proper posting of nurse staffing information in a readable font size will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the	

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F 732	Continued From page 19	F 732	audits will be reviewed by the Quality Assurance Team.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documents and interview, it was determined that the facility failed to ensure that the Food Service Department maintained the kitchen and stored food under sanitary conditions. Findings include: The following were observed on 5/19/2022 from 9:30 AM to 11:30 AM during the initial kitchen tour: -The ice cream scoops were dirty and stored in an unsanitary container;	F 812	Corrective Action: " Corrective actions have been ensured by the Administrator. Upon observation of the noted concerns, they were immediately corrected. The ice cream scoops were cleaned and placed in a sanitary container. The ice cream cart holding 5 gallon ice cream containers was cleaned and the bottom of the cart was cleaned. The ice tray was removed from the ice cream containers. The Styrofoam drinking cups were removed from the counter. The	7/5/22

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F 812	Continued From page 20 -The cart holding the 5 gallon ice cream containers was not cleaned and the bottom of the cart was covered in melted and refrozen ice cream; -A tray of non-potable ice was left on top of the ice cream containers creating cross contamination with ready to eat foods; -There were uncovered styrofoam drinking cups left all over the kitchen on the food service counter; -The kitchen floor was not cleaned and showed signs of significant disrepair and cracks making it not easily cleanable; -The 3 compartment sink was being used to store dirty dishes in the designated "sanitized" compartment of the 3 compartment sink, creating a cross contamination of clean dishes; -The wall behind the dishwasher had significant signs of mold and mildew; -The grease trap maintenance pipe was not removed and showed significant grease blockage; -A cardboard box was used as a trash can in the cooking area; -The microwave at the cooking area was dirty on the inside, while the door handle was not clean to the touch; -Frozen meat was left in the prep sink without running cold water; this is an improper thawing method; -Significant water pooling observed in the walk-in refrigerator. Findings were confirmed with E32 (Food Service Director) on 5/19/2022 at approximately 11:50 AM. 5/27/22 4:00 PM - Findings were reviewed with E2 (DON) and E3 (ADON) during the Exit	F 812	kitchen floor was cleaned. The 3 compartment sink was cleaned and dirty dishes were removed from the sanitized compartment. The wall behind the dishwasher was cleaned and sanitized. The grease trap was cleaned. The cardboard box was removed and the trash disposed of. The microwave was cleaned on both the inside and outside. The frozen meat in the prep sink was discarded. The water pooling was resolved in the walk-in refrigerator. All dietary staff were re-educated on the professional standards for food service safety in the storage, preparation, and service of food items. Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that the kitchen and stored food is maintained according to all food safety requirements. System Changes: " The Root Cause of the concern was a failure to follow the policy for Preventing Foodborne Illness □ Food Handling (rev. 7.2014). The facility system for kitchen sanitation rounds has been updated to include weekly rounds with the dietician and food service director to ensure adherence to the Preventing Foodborne Illness □ Food Handling policy (rev. 7.2014). The facility policy for Preventing Foodborne Illness □ Food Handling policy (rev. 7.2014) was reviewed and found to meet professional standards. The Administrator or Designee will complete education for all dietary staff regarding	

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F 812	Continued From page 21 Conference.	F 812	appropriate standards for kitchen sanitation, food storage, and maintaining food safety. The facility has hired a new food and beverage director. Success Evaluation: " A food safety audit to ensure compliance regarding kitchen sanitation and food storage will be completed by the Administrator or designee; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility did not properly ensure that the facility was properly maintained to prevent pests. Finding include: During the initial kitchen tour on 5/19/2022 at	F 814	Corrective Action: " Corrective actions have been ensured by the Administrator. The dumpster has been replaced to remove the risk presented by the hole in the top of the dumpster.	7/5/22

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F 814	Continued From page 22 approximately 10:00 AM, the outside dumpster was observed to be in disrepair with a hole on the top which could allow pests to enter. This finding was reviewed and confirmed by E32 (Food Service Director) on 5/19/22 at approximately 11:50 AM.	F 814	Identification of Other Residents: " All Residents have the potential to be affected. Other residents will be protected by ensuring that the dumpster is maintained in order to mitigate the risk of pests. System Changes: " The Root Cause of the concern was a failure to inspect the dumpster for holes or other risks of pests. The facility system for garbage disposal has been updated to include regular audits of the dumpster to ensure no holes or other risks of pests. The facility policy Departmental (Maintenance) □ Plumbing, HVAC and Related Systems (rev. 6.2011), which addresses pest prevention and dumpster security, was reviewed and found to meet professional standards. The Administrator or Designee will complete education for all dietary and maintenance staff regarding appropriate standards for garbage and refuse disposal. Success Evaluation: " A safety audit to include disposal of garbage and refuse to ensure that the dumpster is maintained in order to mitigate the risk of pests will be completed by the Administrator or designee; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then	

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F 814	Continued From page 23	F 814	monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
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		7/5/22

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F 880	Continued From page 24 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, interview, and review of facility documentation, the facility failed to ensure	F 880	Corrective Action: " Corrective actions have been ensured by	

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F 880	Continued From page 25 that staff were fit tested for N-95 masks creating an unsafe environment by not implementing appropriate infection control practices as recommended by the Centers for Disease Control and Prevention (CDC). Findings include: 9/3/21 (last reviewed) - On the CDC website, the document entitled Fit Test FAQ included, "You should be fit tested at least annually to ensure your respirator continues to fit you properly." 2/2/22 (last updated) - On the CDC website, the document entitled Strategies for Optimizing the Supply of N95 Respirators included, "...Proper use of respiratory protection by HCP requires a comprehensive program (including medical clearance, training, and fit testing) ...". September 2021 (last revised) - The facility policy, entitled Contingency and Crisis Use of N-95 Respirators, indicated conventional capacity measures include adopting "just in time" fit testing. September 2021 (last revised) - The facility policy, entitled Using Personal Protective Equipment included "Personnel who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection ...use a NIOSH-approved N95 or equivalent or higher respirator, gowns, gloves, and eye protection." Of the eight staff sampled for compliance with infection prevention and control national standards, the facility was not able to provide evidence of N-95 mask fit testing in the past year. Two staff members (E28 Dietary and E30 LPN) were last fit tested in December of 2020. The facility had no records of fit testing for the	F 880	the Director of Nursing. Compliance will be achieve by all employees receiving fit testing. Fit testing for employees has been scheduled with an outside vendor for June 21, 2022 and June 22, 2022. Identification of Other Residents: " All Residents have the potential to be affected. Residents will be protected by ensuring that all employees receive fit testing as required. System Changes: " A root cause analysis was completed in review of this alleged deficient practice. The root cause analysis response team consists of the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee, and corporate management team members. The root cause to this fit testing not being completed included previously scheduled testing with an outside vendor being cancelled. A new vendor has since been obtained and fit testing for all staff scheduled for June 21, 2022 and June 22, 2022. The facility policies and procedures for Infection Control, including Coronavirus Disease (COVID-19) □ Infection Prevention and Control Measures (rev. 9.2021) and Coronavirus Disease (COVID-19) □ Using Personal Protective Equipment (rev. 9.2021) regarding the use and Fit Testing of N95 masks was reviewed and found to meet professional standards and requirements from CMS and the Center for Disease Control. Two Staff Members (DON & Infection Preventionist) will receive	

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F 880	Continued From page 26 following six staff: E4 (Social Services), E24 (OTA), E25 (hairdresser), E26 (CNA), E27 (CNA), and E29 (dietary). 5/25/22 3:30 PM - During an interview, E3 (ADON) confirmed that the last time fit testing was completed for facility staff was in December of 2020, and therefore any staff that were hired since then have not been fit tested. E3 confirmed that during the January 2022 COVID-19 outbreak, staff wore full PPE (personal protective equipment) including N-95 masks to provide care to residents. 5/26/22 11:45 AM - During an interview, E2 (DON) confirmed that none of the agency or contract staff have been tested by their agency. E2 explained that the facility has contracted with a vendor to perform N-95 mask fit testing for all staff members. 5/26/22 2:00 PM - During an interview, the above findings were reviewed and confirmed with E3 (ADON). 5/27/22 4:00 PM - Findings were reviewed with E2 (DON) and E3 (ADON) during the Exit Conference.	F 880	train-the-trainer education on June 21 & 22, 2022 and moving forward, all new hires will have N95 Fit Testing completed upon hire. In addition, all employees will have fit testing completed annually as required. Staff education will be provided to all staff to ensure that fit testing requirements are understood and completed. In addition, staff education will be completed for all employees regarding N95 mask use with isolation of COVID-19 positive residents when a COVID-19 distinct unit is not available to prevent transmission to other residents and education regarding PPE use, including N95 respirators. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: " An employee fit testing audit to ensure that all staff have completed fit testing as required will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 888	Continued From page 27	F 888		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct	F 888		7/5/22

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F 888	Continued From page 28 contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff	F 888		

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	08A011	A. BUILDING _____ B. WING _____	05/27/2022

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F 888	Continued From page 29 COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section	F 888		

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F 888	Continued From page 30 are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, it was determined that for one (E4 Social Services) out of eight staff reviewed for COVID-19 vaccination compliance, the facility failed to properly approve and implement an exemption to the COVID-19 vaccination mandate/requirement. Findings include: 4/5/22 (Revised) - The CMS memo QSO-22-07-ALL indicated if a facility demonstrates that "less than 100% of all staff have received at least one dose of a single-dose vaccine, or all doses of a multiple-dose vaccine series, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the facility is non-compliant under the rule ...". Facilities are required "to ensure those staff ...who have ...been granted an exemption ...adhere to additional precautions that are intended to mitigate the spread of COVID-19 ...Medical exemption documentation must specify which authorized or licensed COVID-19 vaccine is clinically contraindicated for the staff member and the recognized clinical reasons for the contraindication. The documentation must also include a statement recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements based on the medical contraindications ...".	F 888	Corrective Action: " Corrective actions have been ensured by the Director of Nursing. The COVID-19 vaccination requirement has been corrected by Employee #4 applying for and receiving an approved medical exemption from the COVID-19 vaccine due to a previously documented adverse reaction to the vaccine. Employee #4 has been educated on her requirement per the exemption to wear an N95 mask at all times while at work and to produce a negative COVID-19 test every 7 days, or more frequently if required by state guidelines. Identification of Other Residents: " All Residents have the potential to be affected. Residents will be protected by ensuring that all employees meet the regulatory requirement for COVID-19 vaccination or an approved medical exemption. System Changes: " The Root Cause of the concern was a failure to complete the medical exemption as required for Employee #4. The facility system for medical exemption review and approval has been updated to include an	

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F 888	Continued From page 31 11/21/21 (last updated) - The facility policy, entitled COVID-19 Vaccination Policy", included "[The facility's management company] will require employees to be fully vaccinated for COVID-19 and to produce written confirmation that the vaccine was received or obtain an approved exemption as an accommodation ...Employees seeking an exemption from this policy due to a medical reason ...must submit a completed Request for Exception form to [The facility's management company] COVID-19 Vaccination Accommodations & Compliance team ...If the exemption is approved, the employee will be allowed to return to work. If the exemption is not approved and the employee declines vaccination ...the employee's employment will end and will be considered a voluntary termination ...Vaccination and tracking will be managed by the community ...". 5/13/21 - E4 (Social Services) was hired by the facility. 5/20/22 10:00 AM - Review of the facility provided COVID-19 vaccination status matrix revealed that 97 of 98 employees were completely vaccinated and one employee was granted an exemption. 5/24/22 11:00 AM - E4 was observed wearing only a surgical mask. 5/24/22 11:00 AM - During an interview, E4 stated that she always wears a surgical mask because she cannot breathe properly when wearing a N-95. She explained that she has been getting COVID-19 tested twice a week, social distancing, and using zoom / telephone meetings when possible.	F 888	Interdisciplinary Team (IDT) meeting involving the Administrator, Human Resources Director, Director of Nursing, and Infection Preventionist in order to ensure that all requirements for COVID-19 vaccination of facility staff are met. The facility policy for Skilled Nursing Facility COVID-19 Vaccine-Employees/Staff (rev. 5.26.22) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for all nursing staff regarding the COVID-19 vaccination requirements. Moving forward, all new hires will have COVID-19 vaccination completed prior to hire. Success Evaluation: " A random sample of 10% of employees will be completed to ensure that all employees meet the regulatory requirement for COVID-19 vaccination or an approved medical exemption will be completed by the Director of Nursing or designee; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F 888	Continued From page 32 5/24/22 1:00 PM - During an interview, E3 (ADON) explained that the facility submitted E4's medical records to the new management company when they began in November 2021, but did not receive documentation that E4's exemption was approved. E3 added that E4's medical exemption was grandfathered in from the previous management company, but the facility did not have this documentation either. 5/25/22 2:30 PM - During an interview, E2 (DON) provided an undated copy of a letter from the facility's current management company stating, "We have received and reviewed a request from your employee [E4] for an exemption from the requirement to receive the COVID-19 vaccination. This is to advise that the employee's request has been approved ...The employee's exemption has the following requirements: The employee must wear a N95 mask at all times while at work; The employee must produce a negative COVID-19 test twice a week ...Please ensure that the employee's N95 has been properly fitted ...This approval is in place until June 7, 2022 ...". This documentation did not specify the following required information: that the exemption was based on medical contraindications, which COVID-19 vaccine was contraindicated, or the clinical reason. 5/25/22 2:35 PM - During an interview, E3 (ADON) stated E4 does not have a physician's note, but cannot tolerate wearing the N-95 mask because of medical conditions. E3 stated he was aware that E4 has only been wearing a surgical mask in the facility and she has not been fit tested for a N-95 mask.	F 888		

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F 888	Continued From page 33 5/27/22 4:00 PM - Findings were reviewed with E2 (DON) and E3 (ADON) during the Exit Conference.	F 888		