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	255339	A. BUILDING _____ B. WING _____	04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Survey and nine (9) Complaint Investigations (CI) on 4-6-21 through 4-14-21. CI 00017537 related to Quality of Care (QOC) for residents not groomed was substantiated. During the survey and complaint investigations, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements of Participation. The SA cited deficiencies F600, F677, and F880 all at a D level. The investigations were (CI) 00017309 related to QOC for neglect and weight loss, (CI)00016788 related to QOC for unlicensed staff, (CI) 00017433 related to QOC for medications not being administered,(CI)00017459 related to QOC for residents being left wet for an extended time and neglect,(CI) 00017127 related to injury of unknown origin, (CI) 00017286 related to falls , 00017310 related to falls and (CI) 00017457 related to falls were all unsubstantiated. The facility census was 82 and licensed for 120 beds.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review and review of the facility policy, the facility failed to provide the necessary services to maintain good grooming and personal hygiene as evidenced by failure to provide nail care and washing of hair for two (2) of nineteen (19) residents observed for Activities of Daily	F 677	* Resident #78 nails were cleaned and cut on 4/13/2021 by the 7/3 Charge Nurse. For resident #28 her hair was washed and styled on 4/12/2021. Staff was in-serviced on 4/22/2021 on ADL care to include nail care and hair care.	6/21/21

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

Electronically Signed | 06/04/2021

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F 677	Continued From page 1 Living (ADL) care. Resident # 76 and # 28. Findings include Review of the facility's policy titled " Activities of Daily Living Policy" updated July 2014, revealed "Based on previous evaluations and current data, the nursing staff...will seek to identify the level of care a resident requires for ADLs...the nursing staff will assess the resident upon admission, quarterly and with significant changes to ensure proper assistance is provided." Resident # 76 On 4/6/21 at 10:13 AM, Resident #76 was up in his wheelchair in his room and his nails were long and dirty. He was asked about his nails and he said they are dirty. On 4/7/21 at 10:35 AM, Resident #76 was up his in wheelchair at the table in dayroom coloring. He was shaved, his nails were long, jagged and yellow. On 4/7/21 at 12:50 PM Resident # 76 was observed sitting up at table in dayroom coloring. His nails were not cut. His nails were long and jagged. On 04/08/21 at 08:23 AM, Resident # 76 was observed sitting up in his wheelchair in his room feeding himself breakfast. His nails were long and jagged. On 04/12/21 at 09:20 AM, Resident # 76 was observed sitting up in day room. His nails were long, jagged, and dirty.	F 677	* The facility was able to determine that all residents requiring nail care and hair care by staff had the potential to be affected by this alleged deficient practice. * An audit of all residents fingernails was completed by 4/20/2021 by the 7/3 Charge Nurse. Nail care was immediately provided if needed. The Staff Development Director gave an in-service on 4/22/2021 on ADL care to include providing nail care as being a part of ADL care. An audit on all residents hair was completed by 4/20/2021. Any resident that appeared to need hair care immediately received a shampoo. The Staff Development Director gave an in-service 4/22/2021 on hair care/shampooing of hair being a part of ADL care. A monitoring system has been put into place to ensure that proper nail care and shampooing of hair is provided. The 7/3 Charge Nurse will monitor the nail care/hair care weekly for 3 months and then monthly for 3 months and then random audits will be done on nails and hair care. The audit will begin on 6/7/2021. The results of the monitoring will be reported to the Director of Nursing/Assistant Director of Nursing weekly. * The Director of Nursing/Assistant Director of Nursing will review the audits weekly for any care not being provided on 6/14/2021. The results of the audit will be reported to Quality Assurance/Performance Improvement	

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F 677	Continued From page 2 On 4/12/21 at 2:37 PM, in an interview with Certified Nursing Assistance (CNA)# 1 revealed he does not resist nail care. The nurses cut his nails. State Agency (SA) asked why and she stated the nurse tell you who nails they will cut. On 4/12/21 at 3:16 PM, interview with CNA #2 revealed she has worked her for 2 years. Resident #76 does not refuse care. She further stated CNAs do not do his nail care, the nurses do. On 4/13/21 at 10:15 AM, resident was up in his wheelchair in dayroom. Fingernails were long dirty and jagged. Resident #76 stated "they are dirty." On 4 /13/21 at 2:49 PM, in an interview with the Administrator, it was confirmed the family calls and complains about his care a lot. The family also complained about his nails needing to be cut. SA and Administrator went Resident #76, and the Administrator confirmed his nails were very long. On 4/13/21 at 3:15 PM, SA went back to Resident # 76's room and asked him if the staff had trimmed his nails and he smiled and said "they sure did." Asked if he liked his nails that short and he stated "I sure do." Interview on 4/14/21 at 10:16 AM, with Registered Nurse (RN) #5, revealed nail care is trimming the nails, cleaning, and filing.. RN #5 reported "The RN's cut the residents nails if they are Diabetic." On 4/14/21 at 11:20 AM, in an interview with the Director of Nurses (DON), revealed CNA's do nail	F 677	committee quarterly beginning 5/26/2021 by the Director of Nursing/Assistant Director of Nursing to determine if compliance is maintained or if any changes in monitoring should be made.	

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care which involves cleaning the nails when they get a bath and trimming as needed.

Review of Resident #76's Quarterly Minimum Data Set (MDS) dated 3/18/21, revealed Resident #76 had a Brief Interview Mental Status (BIMS) of 10, indicating he was moderately impaired for cognition. He was also coded as being totally dependent for ADLs.

Review of Resident # 76 Nail Care Roster for 4/12/21 to 4/13/21 revealed he had received nail care on 4/12/21.

Resident #28

On 04/07/21 at 9:00 AM, in an observation of Resident # 28, revealed she was sitting in her wheelchair talking to her roommate in her room. Resident's hair was oily and greasy.

On 04/07/21 at 09:05 AM, in an interview with Resident # 28, she explained that she really likes living here and has lived here for many years. She further explained that she gets a bed bath daily but does not get her hair washed regularly. She further explained that the aides tried to wash her hair in the bed several times months ago and about drowned her and got water everywhere and does not wash her hair anymore. She explained that she and her roommate used to get their hair washed weekly in the beauty shop but since the COVID-19 virus the beauty shop has been closed and she has not got her hair washed in a long time. She reported that she would like to have her hair washed more frequently but cannot since the beauty shop is closed. She further explains that the nurses come around frequently and trim and clean nails and sometimes sneak her to the

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beauty shop to wash her hair. She explained that she has talked to the Administrator regarding get her hair washed.

On 04/08/21 at 09:50 AM, in an observation of Resident #28, resident is sitting in her wheelchair in the dining area listening and singing to music. Resident's hair is still oily and greasy. The hair is observed as so oily that it looks wet.

At 9:55 AM on 04/08/21, in an interview with Resident # 28, she explained that she got her bed bath again this morning but still not had her hair washed. She further explained that she really wishes the beauty shop would open back up.

On 04/12/21 at 11:00 AM, in an interview with Resident # 28, she reported that a nurse took her to the beauty shop on Friday and washed and styled her hair. Resident #28 reported it feels good to have her hair washed.

In an interview on 4/13/21 at 11:05 AM, with CNA #5, explained that she does give Resident #28 a daily bed bath. She further explained Resident #28 refuses to go into the shower and does not like to take showers. When asked CNA #5 about washing the resident's hair, she explained that the resident does not like to have her hair washed in the bed and refuses to let the CNAs wash her hair in the bed. CNA #5 further explained that she has not washed the resident's hair in over a month but that the Unit Manager has tried to wash Resident #28's hair.

On 4/14/21 at 9:02 AM, in an interview with DON, she explained ADL consists of head-to-toe care and would think hair wash and bath would go together. The resident's hair should have been

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washed. If resident hair is not washed for 30 days, it can cause build up on the scalp and skin irritation. It can be a dignity issue for the resident. The ADL binder should have been updated. The MDS nurse is new. The MDS nurse is responsible to update the ADL binder. It should have been updated. The ADL binder is used by the CNAs for resident care. When it is not updated the CNA's will not know if something is new or if things have changed. The ADL binder should have been updated quarterly.

Review of the Face Sheet for Resident # 28 revealed, the facility admitted Resident #28 on 07/05/12 with the diagnoses of Chronic Obstructive Pulmonary Disease, High Blood Pressure, Major Depressive Disorder, Dementia, Anxiety, and Emphysema.

Review of the Annual Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 2/4/21, for Resident #28, revealed for Section C, Resident #28 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. Section E of the MDS indicated no behaviors noted in the seven (7) day look back period, with no rejection of care. Section F of the MDS revealed Resident #28 felt that the choice of her daily activities including showers and bath was very important. Section J of the MDS revealed Resident #28 required extensive assistance of one (1) person with personal hygiene and total dependence of one (1) person assistance with bathing.

Complaint Investigation (CI) MS # 17537 related to Quality of Care for residents not groomed appropriately and CI# 17459 related to failure to monitor and services not provided were

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F 677	Continued From page 6 substantiated.	F 677		
F 880 SS=D	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 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	F 880		6/21/21

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F 880	Continued From page 7 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews and facility policy review, the facility failed to prevent the possible spread of infection for three (3) of 12 residents observed during medication pass and Percutaneous Endoscopic Gastrostomy (PEG) site care, Resident #43, Resident #19 and Resident #78.	F 880	* For resident # 43 LPN #1 received verbal counseling on 4/9 and written disciplinary action for infection control infractions on 6/3/2021. For resident # 78 LPN #1 received verbal counseling on 4/9 and written disciplinary action for failure to follow infection control practices. LPN # 1 was monitored unaware on 4/19/2021 to	

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F 880	Continued From page 8 FACILITY Findings Include: A review of facility's policy,"Infection Control Standard Precautions",dated April 2006, revealed that single use items should be properly discarded. On 04/12/21 02:15PM in an observation and interview with LPN, #1 doing Percutaneous Endoscopic Gastrostomy (PEG) tube care on Resident # 43. Resident # 43 was under observation due to leaving the facility with family. LPN #1 stated resident would be under observation until 4/18/21. LPN #1 brought unused supplies of a packet of split gauze spoonges, 100 milliliters (ml) normal saline and wound tape, out of the observation room after completing care. A review of the Physician diagnosis record revealed diagnoses of Dysphagia, Unspecified and Cerebral Infarction dated 9/13/18. A record review of the Quarterly Minimum Data Set with an Assessment Reference Date of 2/15/21, revealed a Brief Interview for Mental Status of 15 indicating Resident #43 was cognitively intact. Review of the section K of the MDS revealed Resident #43 was coded for a feeding tube. Record review of the Treatment Administration Record, dated April 2021, revealed PEG tube dressings are being changed daily. A review of an in-service sheet, dated 1/6/21 ,on Infection control revealed LPN #1's signature was listed on the sign in sheet.	F 880	determine if she was using correct procedure for medication pass. An in-service was given by Staff Development Director on 4/22/2021 on medication pass and wound care/infection control measures to facility staff. * All residents receiving medications by LPN #1 could be at risk due to this alleged deficient practice. All residents that are provided supplies off of treatment cart could possibly be effected by this alleged deficient practice. * Infection Control Nurse will monitor medication pass 2 times a week for 3 weeks, 1 times a week for 3 weeks, monthly for 3 months and then random medication passes will be observed. The monitoring will begin on 6/07/2021.The results of the monitoring will be given to the Director of Nursing/Assistant Director of Nursing for review weekly. The Infection Control Nurse will monitor LPN #1 2 times a week for 2 weeks, 1 times a week for 2 weeks, monthly x 2 months and then randomly beginning on 6/7/2021 for breaks in infection control with wound care/infection control. * The Director on Nursing/Assistant Director of Nursing will review the audits for medication pass and infection control audits for any deficient practice weekly beginning on 6/14/2021. The results of the audit will be reported to the quarterly Quality Assurance/Performance Improvement Meeting beginning 5/26/2021 by the Director of	

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F 880	Continued From page 9 On 04/14/21 at 8:47 AM, in an interview with LPN #1 stated she should have not bought unused supplies out of the room. It can cause Infection with other residents. On 04/14/21 at 8:51 AM, in an interview with the Director of Nursing (DON), stated that LPN #1 should not have bought anything out of Resident # 43's room. If an item is contaminated it could spread infection to other residents. Any item not used should be left in the observation room. On 04/14/21 at 8:57 AM, in an interview with Assistant Director of Nursing (ADON), stated nothing should have come out of the room. Medication Administration In review of the facility's "Administering Medications" policy revised April 2006, revealed "2.) The Director of Nursing Services is responsible for the supervision and direction of all personnel with medication administration duties and functions...11.) Established facility infection control procedures...must be followed during the administration of medications." On 04/09/2021 at 7:10 AM, observation of Licensed Practical Nurse (LPN) #1 preparing medications for administration to Resident #19 revealed the nurse dispensing medications into her bare hand from both the medications cards and stock medication bottles before dropping them into the medicine cup.. On 4/9/2021 at 7:20 AM, observation of LPN #1 preparing medications for administration for Resident #78 revealed the nurse dispensing medications into her bare hand from both the	F 880	Nursing/Assistant Director of Nursing to determine compliance or determine if any changes in monitoring should be addressed.	

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F 880	Continued From page 10	F 880		

medications cards and stock medication bottles before dropping them into the medicine cup.

On 04/09/2021 at 11:00 AM, in an interview with (LPN) #1, she stated she has been a LPN for 25 years and has been employed at this facility for six (6) years. The reason the nurse stated that she dispensed the pills the way she did is because when you pop pills out of the medication cards, they flip out everywhere. LPN #1 further stated by dispensing the resident's medications into her bare hand, it could cause cross contamination and spread infection to the residents receiving the medications.

On 04/09/2021 at 11:30 AM, in an interview with Registered Nurse (RN) #4/Unit Manager, she stated she was unaware that LPN #1 was dispensing medications into her bare hand and then dropping them into the medication cup. The Unit Manager stated the nurses are expected to dispense the medications directly into the medication cup. The Unit Manager further stated this practice is an infection control issue, as it can cause the spread of infection to the resident's receiving the medications.

On 04/13/2021 at 12:15 PM, in an interview with RN #1/DON, she stated she did not know that LPN #1 was dispensing medications into her bare hand prior to putting them into the medicine cup. The State Agency (SA) explained that the nurse stated she did this because the medications flip out everywhere. The DON stated this was an infection control issue.

On 04/13/2021 at 4:00 PM, in an interview with RN #3/Staff Development Nurse, it revealed there are no videotapes or educational materials the

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F 880	Continued From page 11 facility uses to orientate new nurses to the procedure for removing medications from medication cards. RN #3 stated new employees work with seasoned nurses to orientate them to the actual procedure of delivering medications to long term care residents.	F 880		