Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0023	A. BUILDING: _____ B. WING _____	R-C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL H	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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{L 000}	Initial Comments An unannounced Revisit survey was conducted at Bridge Point National Harbor from November 8, 2021 through November 10, 2021. Survey activities consisted of a review of 38 sampled residents. The facility's census on the first day of the was 109. The following complaints and facility reported incidences were investigated during this survey: DC00010184, DC00010364, DC00010362, DC00010351, DC00010337 After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following deficiencies are based on observation, record review, and resident and staff interviews. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal	{L 000}	L 000-Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance.	12/08/2021

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{L 000}	Continued From page 1	{L 000}		

Regulations
D/C- Discontinue
DI- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth

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{L 000}	Continued From page 2 POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	{L 000}	L 051 1. Corrective action for resident Resident #M1 will have their comprehensive care plans reviewed and updated. Resident #39 is not currently in the facility. 2. Identify other residents An audit of all current resident's care plans was conducted and all current residents have had their care plans reviewed and updated. There were no additional findings related to this citation. 3. Systemic changes IDT team has been re-educated on the importance of ensuring that comprehensive care plans are created for each resident and updated as needed. The MDS coordinators will be responsible for ensuring that all residents have comprehensive care plans. 4. Monitor corrective actions The MDS nurses will complete monthly audits of comprehensive care plans to ensure that all residents have comprehensive care plans. Audits will be completed during resident MDS completion. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	12/08/2021
{L 051}	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing	{L 051}		

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{L 051}	Continued From page 3 employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview, for two (2) of 38 sampled residents, facility staff failed to review resident's plans of care for appropriate goals and approaches as needed. Residents' #39 and #M1. The findings include: According to the facility's Plan of Correction (POC), with a compliance date of 11/02/2021, the facility staff documented, "... IDT (interdisciplinary) team has been educated on the importance of ensuring that comprehensive care plans are created for each resident and updated as needed. The Director of Reimbursement will be responsible for ensuring that all residents have comprehensive care plans..." 1. During a tour of unit 3 west on 11/08/2021, Resident #39 was observed with a tan immobilizer (supportive garment worn around the wrist to reinforce and protect it against strains and sprains during strong use, or as a splint to help healing) applied to the left wrist. Resident #39 was admitted to the facility on 06/23/2021 with multiple diagnoses that included: Muscle Weakness, Lymphedema and Acute and Chronic Respiratory Failure. Review of the Minimum Data Set (MDS) dated 09/30/2021 revealed: In Section C (Cognitive Patterns), Brief Interview	{L 051}		

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{L 051}	Continued From page 4 for Mental Status (BIMS) summary score of "15", indicating intact cognitive response. In Section G (Functional Status) for the area, "upper extremity (shoulder, elbow, wrist, hand)", facility staff coded, "0", no impairment". Review of a physician's note dated 10/06/2021 documented, " ... Exam wrist is largely swollen ... pain severe persist ... P (plan) wrist immobilizer ..." Review of Resident #39's comprehensive care plan last revised on 10/26/2021, revealed no documented evidence that a care plan was developed (initiated) to address Resident #39's use a wrist immobilizer (wearing schedule, monitoring skin). During a face-to-face interview conducted on 11/09/2021 at 2:17 PM with Employee #56 (Vice President of Clinical Operations), she stated, "Care plans are initiated by supervisors or nurse managers." 2. Resident #M1 was admitted to the facility on 10/15/2021, with diagnoses that included: Acute Respiratory Failure with Hypoxia, Pressure Ulcer of Other site, Unstageable, Morbid Obesity, Weakness, Type 2 Diabetes Mellitus, Hypertensive Heart and Chronic Kidney Disease. According to the Quarterly MDS dated 10/22/2021, staff coded the following: In Section C (Cognitive Patterns), Resident #M1 had a Brief Interview for Mental Status (BIMS) Summary Score of "15", indicating intact	{L 051}		

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{L 051}	Continued From page 5 cognition. In Section G (Functional Status), "Total dependence" and "one-person physical assist" for toilet use. In Section H (Bladder and Bowel), "Always incontinent" for urine and bowel. In Section M (Skin Conditions), "Yes," to the question, "Does resident have unhealed pressure ulcers/injuries?" Review of the medical record revealed the following: 10/18/2021 at 11:00 PM, (physician's order) "Dakins (wound cleanser) solution ...Apply to left upper buttock topically every 12 hours for Wound care ..." 10/18/2021 at 11:00 PM, (physician's order) "Dakins (1/4 strength) solution ... Apply to right upper buttock topically every 12 hours for Wound care ..." 11/02/2021 at 4:29 PM (Nursing Progress Note) "Writer was made aware by patient advocate of resident concern regarding a male staff in her room while the female staff was changing her wound dressing..." 11/05/2021 at 12:01 PM (Email Correspondence) "I (Employee #1- Interim Administrator) spoke with daughter and son of [Resident's name]. My team spoke with the [Resident's Name] on 11/4/21. We addressed the concerns notes [noted] on the comment card: 1.The issue with looking at her wounds translated into the fact that she is uncomfortable having male caregivers.	{L 051}		

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{L 051}	Continued From page 6 That has been addressed ..." Review of the Medication Administration Record (MAR) from 11/02/2021 to 11/08/2021 documented that staff was providing wound care as ordered (Dakins solution). Review of the Comprehensive Care Plan with a revision date of 10/29/2021, lacked documented evidence that the facility's staff developed a care plan with a focus area to address the Resident #M1's preference for privacy and no male employees to provide incontinent care and wound care. During a face-to face interview conducted with Employee #42 (Unit Manager) on 11/10/2021 at 12:55 PM, she stated that she had not documented Resident #M1's preference for female care providers during incontinent care and wound care in the comprehensive care plan.	{L 051}	L 052 1. Corrective action for resident All residents have been assessed for changes in skin condition and the entire assessment form completed as intended. 2. Identify other residents Facility will complete house wide skins assessments by 12-08-2021. Any new skin issues or toe nails that need to be trimmed will be referred to the wound care team or podiatrist respectively. 3. Systemic changes Staff were educated on completing the skin assessment form in its entirety to include the proper review of completed forms. Skin assessments will be performed twice a week by the License Nursing staff during the residents showers/bed baths to document any changes in the resident' s skin condition. 4. Monitor corrective actions The DON/Designee will audit the skin assessment forms for completion twice a week for 3 months. The Administrative Assistant will do a second review to ensure that the assessment forms have been completed in their entirety. Incomplete forms will be returned to the managers for a re-assessment. The QAPI Committee is responsible for the on-going monitoring for compliance.	12/08/2021
{L 052}	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and	{L 052}		

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{L 052}	Continued From page 7 well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;, (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating; (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating independently; (i) Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide proper care to minimize pressure ulcers and to promote healing of ulcers evidenced by failure to ensure that skin assessments (skin sheets) were completed twice a week, to include, head-to-toe skin assessments, toe-nail assessments, a license nurse signature and or a Unit Manager/Designee	{L 052}	5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{L 052}	Continued From page 8 signature. The resident census on the first day of the revisit was 109. The findings include: According to the facility's Plan of Correction (POC), with a compliance date of 11/02/2021, the facility staff documented, "The assessments will be documented and stored in the departmental shower books and the DON (Director of Nursing)/Designee will audit for completion twice a week for two months." According to the directions listed on the facility's Skin Monitoring Sheet staff were to perform visual assessment of resident's skin...Repost any abnormal looking skin...to charge nurse immediately. Forward any problems to the Unit Manager/Designee for review use this form to show exact location and description of the abnormality. Review of 155 Skin Assessment Sheets for Units #1, #2, and #3 dated from 11/03/2021 to 11/08/2021 revealed the following: 1. Three (3) resident's skin sheets lacked documented evidence that a licensed nurse conducted a head-to-toe assessment. 2. One-hundred and eighteen (118) resident's skin sheets lacked documented evidence that licensed staff assessed the resident's toenails for the potential need for trimming. 3. Forty-eight (48) resident's skin sheets lacked documented evidence that the DON or Designee audited the skin sheets for completion. During a face-to-face interview conducted on	{L 052}		

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{L 052}	Continued From page 9 11/10/2021 at approximately 2:00 PM, Employee #20 (Unit Manager/ Registered Nurse) stated that nursing staff should have conducted head-to-toe assessments including toenail assessments and signed the completed skin sheets. Additionally, the nursing supervisor (or designee) should have audited the skin sheets for completeness.	{L 052}	L 056 1. Corrective action for resident The staffing coordinator and Director of Nursing have been in-serviced on how to calculate the direct nursing care hours to ensure at least 4.1 hours of direct nursing care per resident per day and at least 0.6 hours of those hours in RN hours per patient per day. 2. Identify other residents All residents had the potential to be affected by this alleged practice. 3. Systemic changes The Director of Nursing will review the nursing schedule prior to each weekend and holiday to ensure enough nursing coverage is available to meet the 4.1 hours of direct nursing care required. In addition, the nursing leadership will be on-call to come in and work in the event staff call outs cause the direct care staffing to fall below 4.1 hours per resident per resident per day. The Administrator will be contacted by the Director of Nursing for additional resources as needed to ensure appropriate staffing ratios. 4. Monitor corrective actions The Director of Nursing/Designee will complete audits of schedules as worked weekly for compliance. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. 5. Date correction action completed The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is December 3, 2021.	12/08/2021
{L 056}	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, facility staff failed to ensure a minimum daily average of four and one tenth (4.1) hours of direct nursing care per residnent was provided by facility staff. The findings include: Review of the facility's staffing revealed that for two (2) of seven (7) days from 11/02/2021 to 11/07/2021, the direct nursing care per resident was below the regulatory requirements of 4.1 hours. November 5, 2021 - 3.78 hours of direct nursing care per resident was provided by facility staff.	{L 056}		

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{L 056}	Continued From page 10 November 7, 2021 - 4.06 hours of direct nursing care per resident was provided by facility staff. During a face-to-face interview with Employee #1 (Administrator) on 11/10/2021 at approximately 2:30 PM, she acknowledged the finding.	{L 056}	L 091 1. Corrective action for resident Staff have been re-educated on infection control practices to include hand hygiene, wearing PPE as appropriate, enhance barrier precautions, and not wearing (personal outdoor) hats during patient care. 2. Identify other residents	12/08/2021
{L 091}	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation, record review and staff interview, the facility's staff failed to maintain Infection Control and Prevention Practices to minimize spread of infections. The findings include: According to the facility's Plan of Correction, with a compliance date of 11/02/2021, the facility documented that, " ... all staff would be in-serviced on the proper use of Personal Protective Equipment and the Infection Control Preventionist would be responsible for ensuring that staff utilize proper infection control and prevention practices." Review of the facility's policy entitled, "COVID-19 Guidelines for ...Healthcare Providers" with a revision date of 02/08/2021 documented under the Personal Protective Requirements section that staff are required to wear "eye shield (face	{L 091}	An initial audit of infection control practices was completed. All residents have the potential to be affected. There were no additional findings related to this citation. 3. Systemic changes Staff have been re-educated on the importance of ensuring that they follow appropriate infection control practices (including but not limited to hand hygiene, wearing PPE as appropriate, enhance barrier precautions, and not wearing (personal outdoor) hats during patient care). The Infection Preventionist will be responsible for ensuring that staff utilize proper infection control and prevention practices. 4. Monitor corrective actions The Infection Preventionist/Designee will complete random daily audits on each unit (on all shifts) of staff to ensure that proper infection control and prevention practices are being used throughout the facility across all disciplines. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-	

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{L 091}	Continued From page 11 shield) at all times when working with patients/residents..." 1. Employee #21 (Registered Nurse) failed to perform hand hygiene in between changing gloves. During an observation on unit 3 west on 11/08/2021 at 10:18 AM, Employee #21 (Registered Nurse) was observed wearing gloves, while cleaning an area on the floor in the hallway with paper towels. After she tossed the paper towels in the trash receptacle, she took off her gloves, donned a clean pair of gloves and went to start preparing medications to administer to a resident. The Employee was immediately stopped by the surveyor. Review of the facility's in-service entitled, "Donning and Doffing Personal Protective Equipment" dated 10/24/2021, revealed Employee #21's signature, indicating that she attended the training. During a face-to-face interview conducted at the time of the observation, Employee #21 acknowledged the break in infection control but made no comments about her actions. 2. Facility staff failed to properly wear Personal Protective Equipment (face shield) when entering a resident's room who was on Enhanced Barrier Precautions (EBP). During an observation on 11/09/2021 at approximately 10:00 AM, Employee #54 (Certified Nurse's Aide) was observed walking into Room #317 with her face shield pointing upward, not covering her eyes or face mask. The Employee was within 6 feet of the resident when she was	{L 091}	going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 091}	Continued From page 12 noted leaning over the resident (who was lying in bed) to pick up the food tray that was on the opposite (left) side of the resident's bed. It should be noted that the resident had a tracheostomy (medical device) and before entering the room, there was a sign indicating that the resident was on Enhanced Barrier Precautions. Review of the facility's in-service entitled, Donning and Doffing Personal Protective Equipment dated 10/24/2021 revealed Employee #54's signature indicating that she attended the training. The teaching tool documented that staff were to "apply eyewear (face shield) snugly around face and eyes ..." The teaching tool also documented, "As of 10/23/2021, all staff are required to wear face shields if they are going into the units or within 6 (six) feet of the resident". Enhanced Barrier Precautions are intended to provide an approach for gown/glove use that is based on resident risk factors and type of care, rather than based on MDRO [multidrug resistant organism] status, especially for residents at risk for acquisition (i.e., presence of indwelling medical devices or wounds). https://www.cdc.gov/hai/containment/faqs.html During a face-to-face interview on 11/09/2021 at 10:05 AM, Employee #54 was asked if there was a reason why her face shield was not covering her eyes and face mask. The Employee stated, "No, there is not a reason." The Employee then pulled her face shield down to cover her eyes and face mask and said to the surveyor, "Is that how you like it?" The surveyor replied by saying that the face shield should cover your eyes and face	{L 091}		

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	HFD02-0023	A. BUILDING: _____ B. WING _____	R-C 11/10/2021

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{L 091}	Continued From page 13 mask. 3. Employee #60 (Cosmetologist), failed to maintain Infection Control Practices while providing hair care services for Resident #37. During an observation on 11/09/2021 at approximately 11:00 AM, Employee #60 was observed standing within 6 feet of Resident #37. Further observation showed the Employee was not wearing a gown or face shield while combing Resident #37's wet hair. Resident #37 was re-admitted to the facility on 09/01/2020, with the following diagnoses: Muscle Weakness (Generalized), Hypertension, Diabetes Mellitus and Hyperlipidemia. It should be noted that Resident #37 was on Enhanced Barrier Precautions. A review of Employee #60's education transcript revealed that she completed the facility's education course entitled, "Isolation and Standard Precautions," on 11/14/2020. During a face-to-face interview conducted on 11/09/2021 at 12:36 PM, Employee #60 stated that she was aware of the facility's policy for personal protective equipment requirements while in resident care areas. The Employee further stated that she removed the face shield and gown because they had gotten wet. 4. Employee #61 (Licensed Practical Nurse) failed to maintain Infection Control Practices while providing activity daily living (ADL) care for Resident #M2. During an observation on 11/08/2021 at 9:25 AM,	{L 091}		

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{L 091}	Continued From page 14 Employee #61 was observed coming out of Resident #M2's room into the hallway, while wearing her personal outdoor hat. It should be noted that Resident #M2 was on Enhanced Barrier Precautions. During a face-to-face interview conducted on 11/08/2021 at 9:30 AM, Employee #61 stated that she was aware of the facility's policy for wearing (personal outdoor) hats during patient care and that she had forgotten to remove her hat before providing resident care. When asked about providing care to other residents, Employee #61 said she had provided care to four (4) other residents prior to entering Resident M2's room.	{L 091}	L 128 1. Corrective action for resident The nurse signed out the medication that had been previously given and all counts were reconciled and correct. Nurses have been re-educated on completing the narcotic count as a part of nursing report/hand-off and the importance of accurate accounting of narcotic medications and documentation of medication administration. 2. Identify other residents Narcotic books were reviewed. No residents were affected. There were no additional findings related to this citation.	12/08/2021
{L 128}	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a) Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b) Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d) Establish a system of records of receipt and disposition of all controlled substances in	{L 128}	3. Systemic changes Nursing staff have been re-educated on the importance of accurate accounting of narcotic medications and documentation of medication administration and requirement to perform a narcotic count as a part of report/hand-off. The Director of Nursing will be responsible for ensuring that nurses accurately count and document narcotic medications. 4. Monitor corrective actions The Director of Nursing/Designee will complete random weekly audits 5 narcotic count sheets and randomly observe shift report to ensure that narcotic counts occur at change of shift, medication counts match the medication on hand correctly, and are documented when given. The results will be reported to the QAPI Committee monthly x 3 months for review and	

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{L 128}	Continued From page 15 sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics in two (2) of two (2) observations. The findings include: According to the facility's Plan of Correction (POC), with a compliance date of 11/02/2021, the facility staff documented, "Nursing staff have been educated on the importance of accurate accounting of narcotic medications and documentation of medication administration. The Director of Nursing will be responsible for ensuring that nurses accurately count and document narcotic medications." 1. During an observation on unit 3 west on 11/10/2021 at 9:19 AM, Employee #57 (Licensed Practical Nurse) was observed taking out a narcotic medication from the narcotic box. After popping the mediation into the medication cup, Employee #57 went into the room and administered the medication to the resident. The Employee then came out the resident's room and continued doing her work. Employee #57 failed to sign the narcotic book to reflect that a narcotic medication had been administered. During an observation later on that day at 11:49 AM, it was observed and noted that Employee #57 still had not signed the narcotic book to reflect that she had administered a narcotic	{L 128}	recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{L 128}	Continued From page 16 medication. During a face-to-face interview conducted on 11/10/2021 at 11:49 AM, Employee #57 stated, "I haven't signed for any of the medications I've given this morning even the narcotic. I will go back and sign for them later." When asked to further explain, Employee #57 stated that is her normal practice even though it is not the standard of practice at the facility. 2. During a review of the, "Shift Verification of Controlled Substances Count" form for unit 3 west, side 1, on 11/10/2021 at 11:55 AM, it was observed that the nurse's signature in the section "on-going signature" did not reflect the name of the nurse who had the key for the narcotic box. During a face-to-face interview conducted with Employee #57 at the time of the observation, when asked about performing the narcotic count, she stated, "The nurse [off-going nurse] and I did not count. I had already started working on another unit when I was told I was being moved to this unit (3 west). The nurse met me on my unit and gave me the keys."	{L 128}	L 191 1. Corrective action for resident Medication carts are free of unopened bottles of insulin. 2. Identify other residents An audit of all medication carts was completed. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that no unopened bottles of insulin are left on medication carts. The Director of Nursing will be responsible for ensuring that no unopened bottles of insulin are left in medication carts. 4. Monitor corrective actions The Unit Managers and Supervisors/Designee will complete random weekly audits of 1 unit to ensure that no unopened bottles of insulin are in medication carts. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	12/08/2021
{L 161}	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on an observation and staff interviews, the facility's staff failed to properly store unopened insulin in the refrigerator. The findings include: During an observation of unit 3 east's Medication	{L 161}		

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{L 161}	Continued From page 17 Cart #1 on 11/08/2021 at 11:39 AM, it revealed an unopened bottle of Novolog Insulin being stored at room temperature. During a face-to-face interview on 11/08/2021 at 11:40 AM, Employee #20 (Registered Nurse) stated that the unopened Insulin should be stored in the refrigerator and not in the cart. During a telephone interview conducted on 11/10/2021 at approximately 2:00 PM, Employee #55 (Pharmacist) stated, "All unopened Insulin should be stored in the refrigerator until opened and activated."	{L 161}	L 199 1. Corrective action for resident Resident #48's therapy discharge summary has been corrected. 2. Identify other residents An audit of other residents discharged from therapy will be completed. 3. Systemic changes Rehab staff have been educated on the importance of ensuring that discharge summaries are accurate. The Director of Rehabilitation will be responsible for ensuring that therapy discharge summaries are complete and accurate. 4. Monitor corrective actions The Director of Rehabilitation/Designee will complete weekly audits of all residents discharged from therapy to ensure that discharge summaries are complete and accurate. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	12/08/2021
{L 199}	3231.10 Nursing Facilities Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on record and staff interview for one (1) of 38 sampled residents, the Speech Therapist failed to accurately document Resident #48's discharge summary information in the residents' medical record. The findings include: Resident #48 was admitted to the facility on 04/19/2019, with multiple diagnoses including: Paraplegia, Aphasia, Dysphagia, Muscle Weakness, Other Muscle Spasm, Pain Unspecified, and Respiratory Failure. Review of the Quarterly Minimum Data Set (MDS) dated 06/13/2021, revealed that facility	{L 199}		

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{L 199}	Continued From page 18 staff coded in Section B (Hearing Speech Vision), B0600 Speech clarity "2" indicating "No Speech"; B0700 Makes self-understood "3", indicating "Rarely/never understood". In Section C (Cognitive Patterns), "Should a brief interview for mental status be conducted" "0", indicating "No". Review of the physician's orders revealed: 08/27/2021 "SLP (Speech Language Pathology) eval (evaluation) & (and) Treat (treatment) 2x/wk (week) x 30 days (two times per week for 30 days) for dysphagia tx (treatment) speech/language tx, therapeutic PO (by mouth) trials ..." Review of the document entitled "Speech Therapy SLP (Speech Language Pathology) Discharge Summary" dated 09/16/2021, revealed in the section labeled "D/C (discharge) Reason, facility staff documented "other". There was no additional information in the clinical record to describe what "other" meant. During a face-to -face interview conducted on 11/10/2021 at approximately 11:00 AM with Employee #13 (Director of Rehabilitation) stated, "She [The speech language therapist that signed the document] clicked the box for 'other' instead of documenting highest practical level achieved."	{L 199}		
{L 204}	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following:	{L 204}		

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{L 204}	Continued From page 19 (a)The date, time, and description of the incident; (b)The name of the witnesses; (c) The statement of the victim; (d) A statement indicating whether there is a pattern of occurrence; and (e) A description of the corrective action taken. This Statute is not met as evidenced by: Based on observations, record reviews, resident staff interviews, for three (3) of 38 sampled residents, facility staff failed to complete a thorough investigation. Residents' #M1, #38 and #107. The findings include: According to the facility's Plan of Correction (POC), with a compliance date of 11/02/2021, documented, "Staff and Leadership have been educated on the importance of ensuring that all allegations of abuse are reported and investigated appropriately to ensure that residents are not subjected to potential abuse. The Administrator will be responsible for ensuring that residents are not subjected to potential abusive situations secondary to the failure to properly investigate allegations of abuse." Review of the facility's policy entitled, "Abuse Investigation and Reporting" with a review date of 08/2020 revealed, " ...The individual conducting the investigation will, as minimum... interview the resident (as medically appropriate) ... interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident ... interview other residents to	{L 204}	L 204 1. Corrective action for resident Investigations were completed/reviewed and/or reinvestigated and appropriate actions taken to resolve the concerns for all residents. Resident #M1 will have her concern reinvestigated. Residents #8 and #107 will have their falls investigated. 2. Identify other residents An audit of other resident's concerns and falls from November 3, 2021 to present will be completed. 3. Systemic changes Nursing staff and Leadership will be educated on the importance of ensuring that all concerns and incidents are investigated appropriately to ensure that residents are not subjected to potential abuse. A new process for monitoring and investigating falls will be put in place. The Administrator will be responsible for ensuring that residents are not subjected to potential abusive situations secondary to the failure to properly investigate allegations of abuse. 4. Monitor corrective actions The Administrator will complete weekly audits of all Incidents Reported by the Facility to ensure that all investigations are investigated thoroughly. The results will be reported to the	12/08/2021

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{L 204}	Continued From page 20 whom the accused employee provides care or services ..." 1. Facility staff failed to conduct a thorough investigation of an alleged violation of privacy to Resident #M1. Review of a comment card written by the Resident #M1's son given to the facility on 11/02/2021 documented, "[Resident #M1] feels uncomfortable with to[o] many people coming to view her bed sore like a sideshow!" During a face-to face-interview conducted with Resident #M1 on 11/08/2021 at 10:58 AM, she reported that a few weeks ago, while her female nurse was changing her incontinent brief and the dressing on her buttocks, a male nurse appeared in the doorway of the resident's room and started talking to the female nurse. When the resident asked the male nurse, why he was there, she reports that he said nothing to her. The resident stated that she spoke with the Unit Manager about the incident. Resident #M1 was admitted to the facility on 10/15/2021, with diagnoses that included: Pressure Ulcer of Other site, Unstageable [pressure ulcer], Morbid Obesity and Weakness. According to the Quarterly Minimum Data Set (MDS) dated 10/22/2021, staff coded Resident #M1 as: In Section C (Cognitive Patterns), Brief Interview for Mental Status (BIMS) Summary Score of "15", indicating intact cognition. In Section G (Functional Status), "Total dependence, one-person physical assist" for toilet use.	{L 204}	QAPI Committee monthly x 2 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{L 204}	Continued From page 21 In Section H (Bladder and Bowel), "Always incontinent" for urine and bowel. In Section M (Skin Conditions), "Yes" to question, "Does resident have unhealed pressure ulcers/injuries?" A review of the physician's orders revealed: 10/18/2021 at 11:00 PM, "Dakins (a dilute solution of sodium hypochlorite and other stabilizing ingredients, traditionally used to cleanse wounds to prevent infection), (1/4 strength) solution ...Apply to left upper buttock topically every 12 hours for Wound care ..." 10/18/2021 at 11:00 PM, "Dakins (1/4 strength) solution ... Apply to right upper buttock topically every 12 hours for Wound care ..." A review of the medication administration record (MAR) from 11/02/2021 to 11/08/2021 documented that staff was applying Dakins solution for wound care every shift during this time. Review of a nursing progress note dated 11/02/2021 at 4:29 PM, documented the following, "Writer was made aware by patient advocate of resident concern regarding a male staff in her room while the female staff was changing her wound dressing. Writer went to talk to resident. Resident was very friendly expressing her concern no[t] to be change[d] or wound to be done by male staff or in present [presence] of male staff. Writer apologized to the resident and let her know she will take her concern in consideration and will communicate it to the staff."	{L 204}		

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{L 204}	Continued From page 22 Review of an email correspondence dated 11/05/2021 at 12:01 PM documented, "I (Employee #1- Interim Administrator) spoke with daughter and son of [Resident's name]. My team spoke with the [Resident's Name] on 11/4/21. We addressed the concerns notes [noted] on the comment card: 1.The issue with looking at her wounds translated into the fact that she is uncomfortable having male caregivers. That has been addressed ..." Review of the facility's documents and the resident's medical record revealed that facility staff failed to, 1. Report the incident to the state agency and 2. Failed to thoroughly investigate the allegation (interview staff members on all shifts who have had contact with the resident during the period of the alleged incident). During a face-to-face interview conducted on 11/09/2021 with Employee #1(Interim Administrator) at 10:30 AM, she stated that she had received the comment card filled out by the Resident's son. The Employee further stated that she had contacted Resident #M1's son and daughter via email to address the issue. Moving forward the resident will not have any male staff to provide incontinent care or wound care. 2. Facility staff failed to conduct investigations of the unwitnessed falls of Residents' #8 and #107. A. Resident #8 was admitted to facility on 03/27/2021 with multiple diagnoses that included: Restlessness and Agitation, Aphasia, Anemia and Type 2 Diabetes Mellitus. Review of two (2) facility reported incidents documented the following:	{L 204}		

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{L 204}	Continued From page 23 10/09/2021 at 7:53 PM " ... Resident was observed on the floor by her bedside lying on her left side ... [Physician's Name] made aware, order given for start (sp) bi-lateral and femur X-ray ... neuro check in progress ..." 10/29/2021 at 6:08 PM "Writer was called to resident rom (sp) at 0947 AM ... Per residents charge nurse resident was observed in the floor matt (sp) at her bedside ... [Physician's Name] made aware ... order for neuro-check ..." Review of the Significant Change MDS dated 10/01/2021 revealed that facility staff coded the following: In Section C (Cognitive Patterns), a BIMS summary score of "04", indicating severe cognitive impairment. In Section E (Behavior), "0" indicating that there was no behavior concerns. In Section G (Functional Status), bed mobility, "extensive assistance, one person physical assist", transfer, "total dependence, two persons physical assist", lower extremities, "impairment on both sides", mobility devices, "none of the above". Review of the care plan with the focus area, "[Resident #8's Name] has a communication problem ..." revised on 05/23/2021 had the following intervention(s): " ... ensure/provide a safe environment call light within reach, adequate low glare light, bed in lowest position and wheels locked ..." Review of the care plan with the focus area,	{L 204}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 204}	Continued From page 24 "[Resident #8's Name] is a high risk for fall ..." revised on 10/12/2021 had the following intervention(s): "... review information on past falls and attempt to determine cause of falls. Record possible root causes ..." Review of the progress notes revealed: 10/09/2021 at 2:39 PM (Nursing Progress Note) "Writer's attention was called by housekeeper on the unit who had just left resident's room, she came back to empty the trash when she observed resident on the floor ... head to toe assessment was done, resident denies hitting head ..." 10/29/2021 at 12:04 PM (Nursing Progress Note) "Writer was called to resident rom (sp) at 0947 AM ... per the resident's charge nurse resident was observed in the floor matt (sp) at her bedside. When asked what happened, resident was given conflicted answers due to confusion ..." 10/29/2021 at 1:00 PM (Nursing Progress Note) "Resident observed on the floor, full assessment done, no injury found, MD (medical doctor) and family notify." Review of the facility's investigations folder for the two (2) reported falls, revealed that there was no investigation or documented evidence of an investigation being conducted for either of the facility reported incidences (falls on 10/09/2021 and 10/29/2021). During a face-to-face interview conducted on 11/09/2021 at 10:57 AM, Employee #1 (Interim Administrator) stated, "Right now unless it is something unusual that happened, I would not do a full investigation. We did not investigate further	{L 204}		

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	HFD02-0023	A. BUILDING: _____ B. WING _____	R-C 11/10/2021

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{L 204}	Continued From page 25 because they were just falls." B. Resident #107 was admitted to the facility on 05/21/2021, with diagnoses that included: Unspecified Focal Traumatic Brain Injury with Loss of Consciousness of Unspecified Duration, Person Injured in Unspecified Motor -Vehicle Accident, Traffic, Parkinson's Disease, Anxiety Disorder, Unspecified Abnormalities of Gait and Mobility and Weakness. The Department of Health received a Complaint /Incident Report submitted electronically on 11/04/2021, at 4:32 PM that documented, " ... Writer was made aware by resident charge nurse of fall sustained around 11:20PM ...resident was returning from Physical therapy ... was observed sitting on the floor in front of his wheelchair. When (asked) what happened resident stated he was trying to go to the bathroom. Resident did not initiate his call bell prior to the incident ... per charge nurse ..." Review of the Quarterly MDS, dated 09/15/2021, staff coded the following: In Section C (Cognitive Patterns), nothing was documented In Section G (Functional Status), "Total dependence", for locomotion on and off unit, dressing, toilet use and personal hygiene. In Section H (Bladder and Bowel), "Always incontinent" for urine and bowel continence. In Section O (Special Treatments, Procedures and Programs), Therapy start date for physical therapy is documented as: "08-01-2021".	{L 204}		

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{L 204}	Continued From page 26 Review of the physician's orders revealed: 11/04/2021 at 12:12 PM "X-ray for back pain STAT (immediately) for S/P (status post) fall." 11/04/2021 at 12:45 PM "X-ray to lumbar spine/lower back one time only for back pain STAT (immediately) for S/P fall for 1 Day." An X-ray report dated 11/04/2021 revealed: "... presents with a history of low back pain associated with injury/fall; Technique: Lumbar spine, 2 views; Findings... Bones: Vertebral bodies and posterior elements appear intact. ... Conclusion: No acute fracture/malalignment identified... " Review of the progress notes revealed: 11/03/2021 at 11:01 PM (Nursing Progress Note) "Resident remain alert, oriented, and verbally responsive. At about 11: 20 am, resident was observed on the floor, resident "stated he is trying to go to the bathroom. Upon assessment ROM (range of motion) WNL (within normal limits), a small abrasion measured 0.1 x 0.1 cm (centimeters) noted on his sacral, area cleansed with soap and water, DON (Director of Nursing), Family member [Name of Resident Representative] and [Name of Physician] notified ...Denies pain. Nursing will continue to monitor this progress." Review of the facility's documents and the resident's medical record revealed that facility staff failed to thoroughly investigate the incident (... interview staff members on all shifts who have had contact with the resident during the period of the alleged incident) on 11/03/2021.	{L 204}		

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{L 204}	Continued From page 27 During a face-to face interview conducted on 11/10/2021 at 10:41 AM with Employee #1 (Interim Administrator) stated, "Right now unless it is something unusual that happened, I would not do a full investigation."	{L 204}	L 410 1. Corrective action for resident The floor tiles in room 343 have been cleaned. 2. Identify other residents An audit of other areas throughout the facility were inspected. There were no additional findings related to this citation. 3. Systemic changes Engineering/Environmental staff have been re-educated on the importance of maintaining a safe, clean, and comfortable environment. The Director of Engineering will notify the Director of Environmental Services if their facility improvement projects result in areas that need to be cleaned. The Director of Engineering and Director of Environmental Services will be responsible for maintaining a safe, clean, and comfortable environment. 4. Monitor corrective actions The Director of Environmental Services/Designee will complete random audits of floor tiles on one unit weekly and will follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 2 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	12/08/2021
{L 410}	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observation and staff interview, facility's staff failed to provide housekeeping services necessary to maintain the interior of the facility in a safe, sanitary, orderly and comfortable manner. The findings include: According to the facility's Plan of Correction (POC), with a compliance date of 11/02/2021, documented that the facility's engineering staff, "... have been educated on the importance of maintaining a safe, clean, and comfortable environment. The Director of Plant Operations will be responsible for maintaining a safe, clean, and comfortable environment." During a tour of unit 3 west on 11/08/2021 at 10:16 AM, a large, brown, soiled area was noted on the floor in room 343, on the right side, near the head of the resident's bed (bed A). During a face-to-face interview conducted at the time of the observation with Employee #51 (Painter), he stated, "There was a wardrobe there	{L 410}		

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{L 410}	Continued From page 28 that was changed out last week. EVS (environmental services) has to clean the floor." During a face-to-face interview conducted on 11/08/2021 at 10:18 AM with Employee #52 (EVS Supervisor), she acknowledged the finding and stated, "I didn't know they moved the wardrobe. I'm going to get the floor tech (technician) to take care of it now."	{L 410}	L 430 1. Corrective action for resident No areas are greater than 81°F. Rooms #337, #336, #339, #335, and #334 will the individual heating/cooling units replaced. 2. Identify other residents An audit of resident rooms and common areas did not reveal any areas at or greater than 81°F. There were no additional findings related to this citation.	12/08/2021
L 430	3258.1 Nursing Facilities The facility shall have detailed plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing residents. This Statute is not met as evidenced by: Based review of facility's documents and staff interview, facility staff failed to maintain that all essential mechanical, electrical, and patient care equipment in safe operating condition evidenced by failure to ensure the air handler was working. The findings include: The facility's plan of corrective action stipulated: "1. The air handler is being addressed. Residents were checked with no concerns raised about individual room temperatures. 2. Identify other residents - An audit of resident rooms and common areas did not reveal any areas at or greater than 81°F (degrees Fahrenheit) ....There were no additional findings related to this citation. 3. Systemic changes -Staff have been educated	L 430	3. Systemic changes Staff have been re-educated on the importance of ensuring that mechanical, electrical, and patient care equipment are in safe working condition (to include initiating service requests for equipment in need of repair/servicing and accurate reporting of the status of equipment operational status). The Director of Engineering, will be responsible for ensuring that mechanical, electrical, equipment are in safe working condition. Materials Management and Biomedical departments will be responsible for ensuring that patient equipment is in safe working condition. 4. Monitor corrective actions Director of Engineering/Designee will complete weekly audits of mechanical, electrical service requests to ensure that they are in safe working condition. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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L 430	Continued From page 29 on the importance of ensuring that mechanical, electrical, and patient care equipment are in safe working condition (to include initiating service requests for equipment in need of repair/servicing). The Director of Engineering, Materials, and Biomedical Engineering Technician will be responsible for ensuring that mechanical, electrical, and patient care equipment are in safe working condition. 4. Monitor corrective actions - Engineering/Designee will complete weekly audits of mechanical, electrical, and patient care equipment service requests to ensure that they are in safe working condition." The facility's date of alleged compliance is November 2, 2021. During a face-to-face interview conducted on 11/10/2021 at approximately 9:30 AM with Employee #52 and Employee #37, they stated that the air handler has not been repaired. They further stated that the facility has stand-alone units. The individual units [in resident rooms on 3 West] had nothing to do with the air handler. The air handler is out for the kitchen. 3 West does not have an air handler. The facility staff provided the writer with an invoice form [Company Name] showing that the facility purchased Heat and Air Conditioner Units. Review of the facility's work order tickets showed that heating and air conditioning units were replaced in the following rooms: 330, 331, 332, 333, 341, 342, 343, and 344. The five (5) resident rooms cited during the recertification survey on 08/23/2021 were: 337, 336, 339, 335, and 334.	L 430	5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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L 430	Continued From page 30 During a telephone interview with the facility on 11/15/2021 at 12:35 PM, Employees' #57, #37 and #1 acknowledged the findings. {L 521} 3269.1d Nursing Facilities (d) To be treated with respect and dignity and assured privacy during treatment and when receiving personal care; This Statute is not met as evidenced by: Based on observation and staff interview for one (1) of 38 sampled residents the facility's staff failed to ensure a resident was provided dignity and privacy due to not covering the urine catheter/collection bag. Resident #S1. The findings include: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey ending 09/16/2021 stipulated: ".... 2. An audit of other residents with urine collection bags did not identify any other residents affected... 3. Staff have been educated on the importance of resident's rights to include privacy... 4. The Director of Therapeutic Recreation/Designee will complete audits of 10 resident rooms per week for privacy." The facility's date of alleged compliance is 11/02/2021.	L 430 {L 521}	L 521 1. Corrective action for resident Resident #S1 has been given a privacy bag. 2. Identify other residents An audit of other residents with urine collection bags did not identify any other residents affected. There were no additional findings related to this citation. 3. Systemic changes Staff have been re-educated on the importance of resident's rights to include privacy. The Director of Nursing and Unit Managers will be responsible for validating privacy rounds/inspections and subsequent follow up on findings. 4. Monitor corrective actions The Director of Therapeutic Recreation/Designee will complete audits of 10 resident rooms per week for privacy rounds/inspections to assess compliance and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 2 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	12/08/2021

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{L 521}	Continued From page 31 Review of the facility's policy entitled "Patients' Rights" with a revision/review date of 9/2020, revealed," ...Personal privacy during personal hygiene activities (e.g., toileting, bathing, dressing) during medical/nursing treatments and when requested as appropriate ..." Resident #S1 was admitted to the facility on 11/03/2021 with multiple diagnoses including Diabetes Mellitus Type 2, Morbid Severe Obesity, Rheumatoid Arthritis, and Encounter for Attention to Gastrostomy. On 11/08/2021 at approximately 10:00 AM Resident # S1 was observed in her room, laying in bed with a urine collection bag hanging on the Resident's bedframe uncovered. Review of the physician's order dated 11/04/2021, directed "Foley Catheter care every shift ..." "Change foley bag every 2 weeks every night shift every 14 days ..." During a face-to-face interview conducted on 11/08/2021 at approximately 10:00 AM Employee #42 (Registered Nurse) stated "I will check it." Employee #42 went to residents' room and later returned and stated, "It is covered".	{L 521}		