STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195341	A. BUILDING _____ B. WING _____	C 02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	**5301 TULLIS DRIVE NEW ORLEANS, LA 70131**

(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 Complaint #LA00054406. No deficiencies cited as a result of this complaint.	F 000		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195341	A. BUILDING _____ B. WING _____	05/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	5301 TULLIS DRIVE NEW ORLEANS, LA 70131

(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 A COVID-19 Focused Infection Control Survey was conducted on 05/06/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Residents: 154	F 000		

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

Electronically Signed | 08/19/2020

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

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	195341	A. BUILDING _____ B. WING _____	C 06/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	**5301 TULLIS DRIVE NEW ORLEANS, LA 70131**

(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 Complaint # LA00055359 was conducted and no deficiencies were cited as a result of this complaint. A COVID-19 Focused Infection Control Survey was conducted on 06/19/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and prevention (CDC) recommended practices to prepare for COVID-19. Total Residents: 165	F 000		

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

Electronically Signed | 08/19/2020

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	195341	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	5301 TULLIS DRIVE NEW ORLEANS, LA 70131

(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 A COVID-19 Focused Infection Control Survey was conducted on 07/15/2020 per QSO-20-20-All. F880 was cited as a result of this survey.	F 000		
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 infections before they can spread to other persons in the facility;	F 880		8/31/20

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Electronically Signed | 07/27/2020

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	195341	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	5301 TULLIS DRIVE NEW ORLEANS, LA 70131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 (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 record review the facility failed to maintain the Centers for Disease Control (CDC) Infection Control Guidance for Healthcare Professionals about	F 880		

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	195341	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	5301 TULLIS DRIVE NEW ORLEANS, LA 70131

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F 880	Continued From page 2	F 880		

Coronavirus (COVID-19) by:
1.) Failing to ensure residents and staff adhered to their infection prevention and control practices of ensuring residents and/or staff wore face mask (Resident R1, Resident R2, Resident R3, Resident R4, Resident R5, Resident R6, Resident R7, Resident R8, and Resident R9, S3Dietary Staff, S4Dietary Staff); and
2.) Failing to ensure residents and/or staff maintained social distancing (Resident R7, Resident R9, S3Dietary Staff and S4Dietary Staff).
This deficient practice was identified for 9 randomly observed residents (Resident R1, Resident R2, Resident R3, Resident R4, Resident R5, Resident R6, Resident R7, Resident R8, and Resident R9) and 4 staff members observed (S3Dietary Staff, S4Dietary Staff, S5Certified Nursing Assistant (CNA) Supervisor, and S7Housekeeper), but had the potential to affect any of the 171 residents as documented on the facility's Census List.
Findings:

Review of the CDC website for Infection Control Guidance for Healthcare Professionals (HCP) about Coronavirus (COVID-19) as of July 15, 2020 revealed in part, the CDC recommended using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as a part of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed SARS-CoV-2 infection. These practices include to use facemasks to cover a person's mouth and nose. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are

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	195341	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	5301 TULLIS DRIVE NEW ORLEANS, LA 70131

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F 880	Continued From page 3	F 880		

recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. Further review revealed patients may remove their cloth face covering when in their rooms but should put it back on when around others or leaving their room. HCP should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. The above mentioned CDC guidance further revealed to encourage physical distancing between people of at least 6 feet apart.

In interview on 07/15/2020 at 9:45am, S1Director of Nursing (DON) indicated it was the facility's policy for all staff to wear mask during their entire shift, and for residents to wear mask when not in their room.

Observation on 07/15/2020 at 9:47am, with S1Director of Nursing (DON) present, revealed Resident R1 was walking down the hall without a mask to the smoker's patio.

Observation on 07/15/2020 at 9:48am, with S1DON present, revealed 15 residents were on the smoker's patio area 11 of which were less than 6 feet apart from each other. Further observation revealed no staff was outside monitoring residents at this time, and numerous staff members were walking past and not assisting residents with social distancing.

In interview on 07/15/2020 at 9:51am, the above was discussed with S1DON. S1DON indicated, all residents were supposed to wear a facemask when they were not in their room and the residents should be at least 6 feet apart from each other. S1DON indicated nobody was

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	5301 TULLIS DRIVE NEW ORLEANS, LA 70131

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F 880	Continued From page 4	F 880		

assigned to supervise the smoker's patio, and that staff were supposed to assist with residents when they make rounds, but nobody was assigned to monitor the smoker's patio or to ensure social distancing. S1DON further indicated it wouldn't matter if residents were separated, because they would just go back together anyway.
Observation on 07/15/2020 at 9:54am, with S1DON present, revealed Resident R2 was in the hallway without a facemask. Further observation revealed staff walked by Resident R2 and did not remind and/or assist the resident with putting on a facemask.

Observation on 07/15/2020 at 9:56am, with S1DON present, revealed Resident R3 was in the hallway without a facemask. Further observation revealed staff walked by Resident R3 and did not remind and/or assist the resident with putting on a facemask. S1DON asked Resident R3 where her facemask was, and Resident R3 stated, "They didn't put one on me today".

Observation on 07/15/2020 at 9:58am, with S1DON present, revealed Resident R4 was sitting in a wheelchair in the hallway and was not wearing a facemask. Further observation revealed staff walked by Resident R4 and did not remind and/or assist the resident with putting on a facemask. Resident R4 was asked where his facemask was, and Resident R4 indicated he did not know, he lost it yesterday.

In interview on 07/15/2020 at 9:59am, S1DON indicated all residents are provided with facemasks.

Observation on 07/15/2020 at 10:00am, with

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	195341	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	5301 TULLIS DRIVE NEW ORLEANS, LA 70131

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F 880	Continued From page 5 S1DON present, revealed Resident R5 was walking down the hallway without a facemask. Further observation revealed staff was walking by Resident R5 and did not remind and/or assist the resident with putting on a facemask. Observation on 07/15/2020 at 10:01am, with S1DON present, revealed Resident R6 was walking down the hallway without a facemask. Further observation revealed staff was walking by Resident R6 and did not remind and/or assist the resident with putting on a facemask. Observation on 07/15/2020 at 10:04am, revealed 8 residents were in the dining room, 3 of which did not have a facemask on, and were not eating or drinking at the time. Further observation revealed 4 residents were sitting less than 6 feet apart.	F 880		

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	195341	A. BUILDING _____ B. WING _____	R 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	**5301 TULLIS DRIVE NEW ORLEANS, LA 70131**

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{F 000}	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 07/15/2020 per QSO-20-20-All. F880 was cited as a result of this survey. A desk review and approval of the facility's Directed Plan of Correction was conducted for previous deficiency cited on 07/15/2020. The deficiency was cleared.	{F 000}		

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	195341	A. BUILDING _____ B. WING _____	10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	5301 TULLIS DRIVE NEW ORLEANS, LA 70131

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 10/12/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 172	F 000		

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Electronically Signed | 10/16/2020

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	**5301 TULLIS DRIVE** **NEW ORLEANS, LA 70131**

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K 000	INITIAL COMMENTS River Palms Nursing & Rehab, L L C is in compliance with the requirements of Title 42 Code of Federal Regulations, Part 483.70(a) (Life Safety Code). The facility is sprinklered, licensed for 186 beds and a census of 176 at time of survey.	K 000		
K 321 SS=C	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K 321		11/30/20

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	**5301 TULLIS DRIVE** **NEW ORLEANS, LA 70131**

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K 321	Continued From page 1 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to maintain the separation of hazardous areas from other parts of the building, including the egress corridor. Hazardous areas within a supervised sprinklered facility are required to be constructed to resist the passage of smoke and provide a door that self closes and self latches properly. The deficient practice had the potential to affect 51 of 176 residents. 1 of 6 smoke compartments have hazardous areas that are not separated. Findings: During the facility tour on October 20, 2020 between the hours of 9:00 am to 2:00 pm it was observed the approximately 60 square feet storage room located in the dining room nearest the kitchen had two doors that lacked a self closing device. NFPA 101: 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. NFPA 101: 19.3.2.1.1 An automatic extinguishing system, where used in hazardous areas, shall be permitted to be in accordance with 19.3.5.9. NFPA 101:19.3.2.1.2* Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4.	K 321		

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K 321	Continued From page 2 NFPA 101: 19.3.2.1.3 The doors shall be self-closing or automatic-closing. Interview with the maintenance manager revealed the facility was not aware that the doors to the hazardous areas were required to self-close and self-latch in the frame. A one-time waiver is approved for this survey due to the COVID -19 pandemic.	K 321		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the complete, supervised, automatic sprinkler system was inspected and tested in accordance with the requirements of NFPA 13.	K 353		11/30/20

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	**5301 TULLIS DRIVE** **NEW ORLEANS, LA 70131**

(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
K 353	Continued From page 3 Activation of the sprinkler system shall trigger notification of the emergency to the fire alarm system within 90 seconds, which results in protection of life and property. This deficiency has the potential to affect 176 of 176 residents. The findings include: During the record of review on October 20, 2020 , between the hours of 9:00 am to 2:00 pm it was observed the sprinkler system had lacked quarterly inspections of the wet sprinkler system by either a qualified person or a licensed agent for the second, third quarter of 2020 and the fourth quarter of 2019. NFPA 25:5.1.1.2 Table 5.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. (Quarterly inspections) The interview with the maintenance manager revealed the facility was not aware the automatic sprinkler system was required to be inspected quaterly as per NFPA 25. A one-time waiver is approved for this survey due to the COVID -19 pandemic.	K 353		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of	K 712		11/30/20

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	195341	A. BUILDING **01** B. WING _____	**10/20/2020**

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K 712	Continued From page 4 established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on visual observation and record review the facility failed to maintain documentation for fire drills conducted during each quarter on each shift. Fire drills provide training in procedures in cases of emergency. The deficient practice had the potential to affect 176 of 176 residents. 1 of 4 quarters in 2019-2020 were deficient. Findings: During the record review on October 20, 2020, between the hours of 9:00 am to 2:00 pm it was observed the first shift of the fourth quarter for the year 2019 was lacking. NFPA 101:19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. Interview with the maintenance manager revealed the facility was not aware the fire drill for the first shift of the year 2019 was lacking. A one-time waiver is approved for this survey due to the COVID -19 pandemic.	K 712		

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F 000	INITIAL COMMENTS Recertification Survey Complaint Survey #LA00055479 and #LA00056256. Complaint Survey #LA00055479. Tag #F726 cited as a result of Complaint #LA00055479. Complaint Survey #LA00056256. No deficiencies cited as a result of this complaint. A COVID-19 Focused Infection Control Survey was conducted on 10/22/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 173	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	F 656		11/30/20

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

Electronically Signed | 11/09/2020

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under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure a physician's order was transcribed and implemented as required in the person centered care plan. This deficient practice was identified for 1 (Resident #124) of 58 residents reviewed in the investigation stage, and had the potential to affect any of the 173 residents who resided in the facility as documented on the Resident Census and Conditions of Residents Form CMS-672.
Findings:

Review of the record revealed Resident #124 was

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admitted to the facility on 11/02/2015 with a diagnoses, in part, of Major Depressive Disorder and Insomnia.

Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/10/2020 revealed, in part, Resident #124 received an antidepressant 7 of 7 days during the look back period.

Review of Resident #124's care plan with a problem onset date of 09/10/2020 revealed, in part, medication observation for significant side effects related to need for antidepressant medications (Trazadone), with an approach to administer medications as ordered. Further review revealed Resident #124 had impaired thought processes related to a diagnosis of depression, with one approach included, in part, Psychiatric consult as appropriate.

Review of Resident #124's record revealed a physician's order dated 10/16/2020 to increase Trazadone (an antidepressant) to 50 milligrams (mg) by mouth at bedtime; Melatonin (a sleep aid) 5mg by mouth at bedtime; Psych consult due to increased agitation and insomnia. Further review revealed the area on the order labeled signature of nurse receiving order, date, and time, was blank. Further review revealed on the lower portion of the order an area titled Nurse: please initial the documentation record as performed was also blank.

Review of Resident #124's October 2020 Medication Administration Record (MAR) revealed documentation of administration of Trazadone 50mg tablet, give 1/2 tablet (25mg) by mouth every night. Further review revealed no

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F 656	Continued From page 3 documentation of change in treatment to indicate Trazadone was increased to 50mg every night, and no addition of Melatonin on the MAR. Review of Resident #124's clinical record revealed no documented evidence of a Psychiatric consult as ordered on 10/16/2020. In an interview on 10/21/2020 at 1:33pm, S4CorporateNurse reviewed Resident #124's physician's orders dated 10/16/2020 and confirmed that the orders had not yet been transcribed and/or implemented.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		11/30/20

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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 the facility failed to revise a resident's care plan after a fall for 1 (Resident #20) of 58 sampled residents reviewed. This deficient practice had the potential to affect any of the 173 residents that resided in the facility as documented on the Residents Census and Conditions form (CMS-672) Census List.
Findings:

Record review revealed Resident #20 was admitted to the facility on 04/27/12 with diagnoses, in part, of Seizure Disorder and Hypertension

Review of Resident #20's Minimum Data Set (MDS) with an Assessment Reference Date dated 08/13/2020 revealed a Brief Interview for Mental Status (BIMS) score of 11 and required limited assistance with one person physical assist for bed mobility, transfers, dressing, bathing and locomotion. Further review revealed Resident #20 had arthritis and suffered from seizures.

Review of the medical record revealed a care plan was not revised for Resident #20's fall that was reported to nursing on 08/03/2020.

Review of Resident #20's nurse's notes dated 08/03/2020 at 11:00am revealed, in part, Resident #20 stated she fell the day before out of her chair and complained of mid-ower back pain.

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F 657	Continued From page 5 Further review of Resident #20's nurse's notes revealed Resident #20 was transferred to a local hospital via ambulance. Review of Resident #20's incident report dated 08/03/2020 revealed equipment involved was a wheelchair. Review of the physical therapy plan of care dated 08/17/2020 revealed, in part, Resident #20 was hospitalized 08/03/2020-08/13/2020 for an injury that occurred while transferring from her bed to wheelchair resulting in a left superior pubic fracture. In an interview on 10/21/2020 at 2:28pm, Resident #20 indicated she fell while transferring from her bed to her wheelchair, but did not report it to the nurse until the next day. In an interview on 10/21/2020 at 2:40pm, S1Administrator stated the care plan did not reflect an updated or revision for Resident #20 after her fall.	F 657		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate	F 676		11/30/20

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treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview the facility failed to ensure 1 (Resident#78) of 58 residents reviewed in the investigation stage received showers every other day and the facility failed to ensure 1 (Resident #139) of 58 residents reviewed in the investigation stage received nail care. This deficient practice had the potential to affect any of the 173 residents who resided in the facility as documented on the Resident Census and Conditions of Residents Form (CMS-672).
Findings:

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Resident #78
Review of Resident #78's record revealed an admit date on 05/08/2020 with diagnosis of, in part, Heart Failure, Major Depressive Disorder, Chronic Kidney Disease, and Type 2 Diabetes Mellitus.

Review of Resident #78 's Minimum Data Set with an Assessment Reference Date of 08/06/2020 revealed a Brief Interview for Mental Status score of 11 (score of 8-12 was moderately impaired) and he required one person physical help, with transfers only, for bathing.

Review of Resident #78's Care Plan revealed in part, a problem identified for activities of daily living (ADL) self-care deficit with personal hygiene and bathing related to disease process with approaches to report changes in activities of daily living self-performance to nurse.

In an observation and interview on 10/19/2020 at 9:28am, Resident #78 was questioned if he gets a shower every other day and Resident #78 stated "no", he only gets a shower when he asks for one. Resident #78 was sitting in his wheelchair with a long ungroomed beard. When surveyor asked him if he wanted a shave he stated yes, but he had to purchase his own razors and was waiting for his check.

Review of Resident #78's Certified Nursing Assistant (CNA) ADL sheets dated September 2020 revealed only documentation of a shower was on 09/02/2020 and the only refusals for a shower was documented on 09/01/2020, 09/03/2020, 09/10/2020, 09/12/2020. Further review of Resident #78's September 2020 CNA

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ADL sheet revealed no other documentation of a shower or refusals of a shower for the month of September 2020.

Review of Resident #78's Certified Nursing Assistant (CNA) ADL sheets dated October 2020 revealed only documentation of a shower was on 10/01/2020, 10/02/2020, 10/03/3030, 10/12/2020, 10/14/2020, and 10/17/2020. Further review of Resident #78's October 2020 CNA ADL sheet revealed no other documentation of a shower or refusals of a shower for the month of October 2020.

In an interview on 10/20/2020 at 1:50pm, S2Director of Nursing (DON) stated a resident can have a bath/shower every day if they want one, but all other residents receive a shower every other day. S2DON stated the facility does not have a shower team and the CNAs working on each hall are responsible for showering their own residents.

In an interview on 10/21/2020 at 11:15am, S13CNA stated the even numbered rooms are showered on Monday, Wednesday and Friday and the odd numbered rooms are showered on Tuesday, Thursday and Saturday. S13CNA stated the "A" beds are done in the morning and the "B" beds are done in the evening. S13CNA stated Resident #78 would be showered in the mornings because he was in an "A" bed. S13CNA stated they document showers on the ADL flowsheet.

In an interview on 10/21/2020 at 11:35am, S2DON was informed of Resident #78 stating he was not receiving his showers at least every other day. S2DON stated she was unaware Resident

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#78 was not getting his showers. After reviewing Resident #78's CNA ADL sheets dated September 2020 and October 2020, S2DON confirmed there was no documentation of Resident #78 receiving his shower every other day. S2DON stated if a resident refused a shower/bath then the CNAs should document an "R" for refusal.

Resident #139
Record review revealed Resident #139 was admitted on 09/21/2020 with diagnoses, in part, of Cerebral Vascular Accident (CVA) with left side hemiplegia and Diabetes.

Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/08/2020 revealed Resident #139 had a Brief Interview for Mental Status score (BIMS) of 12 which indicated mild impairment and required extensive assistance with one person physical assist with personal hygiene.

Review of Resident #139's medical record revealed a care plan was developed for care deficit related to CVA with hemiplegia with a goal date to have activity of daily living (ADL) needs met every day with appropriate assistance, groomed, dressed, bathed, fed, transferred with approaches, in part, to keep fingernails neat and trimmed.

Review of Resident #139's Medication Administration Record (MAR) for September and October 2020 did not reveal documentation of nail care.

Observation on 10/19/2020 at 1:21pm revealed Resident #139 with long fingernails with dark

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F 676	Continued From page 10 substance underneath nails on both hands. Observation on 10/21/2020 at 3:20pm revealed Resident #139 with long fingernails with dark colored material underneath on both hands. In an interview on 10/21/2020 at 3:21pm, Resident #139 indicated he would like to have his fingernails clipped and cleaned. In an interview on 10/21/2020 at 3:29pm, S16Charge Nurse indicated the nurse was responsible for performing nail care to a Diabetic resident.	F 676		
F 695 SS=E	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, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a resident's oxygen humidifier bottle was changed and kept filled per facility policy. This deficient practice was identified for 1 (Resident #34) of 58 residents reviewed in the investigation stage, and had the potential to affect any of the 173 residents who resided in the facility as documented on the Resident Census and Conditions of Residents Form (CMS-672).	F 695		11/30/20

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Findings:

Review of the facility's policy titled Department (Respiratory Therapy) - Prevention of infection revealed, in part, Check water levels of refillable Humidifier units daily. If the water level falls below the fill line: discard residual solution. Pour a small amount of distilled water into the reservoir and swish around to rinse all surfaces. Discard water refill with distilled water to fill line. Use distilled water for humidification per facility protocol.
Review of Resident #34's record revealed, in part, an admit date of 02/21/20 with diagnoses of Shortness of Breath, and Heart failure.
Review of Resident #34's Minimum Data Set with an Assessment Reference Date of 05/7/2020 revealed, in part a Brief Interview for Mental Status score of 15 (cognitively intact), and recieved oxygen therapy.
Review of Resident #34's Care plan revealed, in part, a problem identified for impaired breathing patterns related to disease process; need for continuous oxygen for shortness of breath with an onset date of 05/07/2020. Further review of the care plan revealed approaches, in part, uses oxygen, and if not in use place cannula in plastic bag, and change oxygen tubing every week.
Review of Resident #34's Physician orders for September, August, and October 2020 revealed, in part, an order for continuous oxygen at two liters per minute by nasal cannula.
Review of Resident #34's Medication Administration Record (MAR) for July, August, September, and October 2020 revealed, in part, change of oxygen humidifier bottle (distilled water) every week, order dated 02/25/20.
Further review of Resident #34's MAR pertaining to the order to change of oxygen humidifier bottle (distilled water) every week revealed, in part, the

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following: July 2020 not documented as being done; August 2020 MAR revealed, in part, documented one day; September 2020 revealed, in part, documented four times; and October 2020 revealed, in part, docuemented three times.
Observation on 10/18/20 at 12:16pm revealed Resident #34's using the oxygen condenser per nasal cannula, and the oxygen condenser humidifier bottle was dated 07/05/2020 and empty.
Observation on 10/19/2020 at 09:23am revealed Resident #34 was using his oxygen condenser per nasal cannula, and the oxygen condenser humidifier bottle was dated 07/05/2020 and empty.
Observation on 10/20/2020 at 10:32am revealed Resident #34's oxygen was in use per nasal cannula, and the oxygen condenser humidifier bottle was dated 07/05/2020 and had no distilled water for humidified oxygen.
Observation 10/20/2020 at 11:30am revealed Resident #34's oxygen humidifier bottle dated 07/05/2020 was empty and oxygen condenser was in use.
In an interview on 10/20/2020 at 10:32am, Resident #34 stated no one had ever refilled his humidification bottle nor had it been changed since 07/05/2020 as dated on the bottle.
In an interview on 10/20/2020 at 1:03pm ,S12Licensed Practical Nurse (LPN) stated she did not check Resident #34's humidification bottle today. She stated she only checked that his oxygen was on.
In an interview on 10/20/2020 at 12:40pm, S3Corporate Nurse stated the date on the bottle was 07/05/2020 and it was empty. She further stated that the bottle should have been changed according to policy and should not have been empty.

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F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure nursing competencies as evidenced by: 1.) Failing to ensure controlled medications were accurately counted (#41, #42, #60, #115, #131,	F 726		11/30/20

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#136, and #148);
2.) Failing to ensure controlled medications were documented as administered (#41, #66. #115, #131, #136, and #148); and
3.) Failing to transcribe medications correctly onto the Individual Patient's Narcotics Record (#41 and #66).
This deficient practice was identified for 8 (#41, #42, #60, #66, #115, #131, #136, and #148) of 58 residents reviewed in the investigation stage, and had the potential to affect any of the 173 residents who resided in the facility as documented on the Resident Census and Conditions of Residents Form CMS-672.
Findings:

An observation of medication storage of Cart B was conducted on 10/20/2020 at 3:11pm. The following discrepancies were found:

Resident #41:
Review of Resident #41's pill punch card labeled Hydrocodone/APAP 5:325milligrams (mg) (pain medication substituted for Norco) revealed there were 24 pills left on the card.
Review of Resident #41's Individual Patient's Narcotics Record sign out sheet revealed the page was not labeled with the resident's name, and/or the name of the medication. Further review revealed the amount remaining was 25 tablets. Further review revealed between 10/13/2020 and 10/19/2020, 14 doses of this medication was signed out as dispensed to Resident #41.
Review of Resident #41's October 2020 Medication Administration Record revealed between 10/13/2020 and 10/19/2020, there was only 3 documented doses administered.
In an interview on 10/20/2020 at 3:11pm,

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S14Licensed Practical Nurse (LPN) confirmed the Individual Patient's Narcotic Record sign out sheet was for Resident #41's Hydrocodone/APAP 3:325mg pain medication, confirmed the count was incorrect, and confirmed the doses were not documented on the October 2020 MAR.

Resident #42:
Review of Resident #42's pill punch card labeled Clonazepam 0.5mg (anticonvulsant substituted for Klonopin) revealed there were 18 pills left on the card.
Review of Resident #42's Individual Patient's Narcotics Record sign out sheet revealed the amount remaining was 19 tablets.

Resident #60:
Review of Resident #60's pill punch card labeled Vimpat tablets 100mg (anticonvulsant) revealed there were 15 pills left on the card.
Review of Resident #60's Individual Patient's Narcotics Record sign out sheet labeled Vimpat 100mg revealed the amount remaining was 16 tablets.

Resident #66:
Review of Resident #66's pill punch card labeled Oxycodone Hydrochloride (HCL) 5mg tablet (pain medication substituted for Roxicodone) revealed there were 13 tablets left on the card.
Review of Resident #66's Individual Patient's Narcotics Record sign out sheet labeled Percocet 5mg revealed between 10/12/2020 and 10/21/2020, there were 18 doses documented as dispensed to Resident #66.
In an interview on 10/20/2020 at 3:11pm, S5LPN confirmed the sign out sheet labeled Percocet 5mg was being used as the sign out sheet for Oxycodone HCL 5mg tablets.

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Review of Resident #66's October 2020 MAR revealed no documented doses of Oxycodone HCL 5mg were administered to Resident #66.
Review of Resident #66's October 2020 physician's orders revealed no order for Percocet.
In a telephone interview on 10/22/2020 at 09:01am, the facility's contracted pharmacist confirmed that Percocet is not Oxycodone, and Resident #66 was ordered Oxycodone 5mg tablets as verified with the prescription number.

Resident #115:
Review of Resident #115's pill punch card labeled Tramadol 50mg tablets (pain medication substituted for Ultram) revealed there was 8 pills left on the card.
Review of Resident #115's Individual Patient's Narcotics Record sign out sheet labeled tramadol 50mg revealed the amount remaining was 9 pills.
Further review revealed between 10/06/2020 and 10/18/2020, there was 21 pills signed out as dispensed to Resident #115.
Review of Resident #115's October 2020 MAR revealed only 3 doses were documented as administered to Resident #115 between 10/06/2020 and 10/18/2020.

Resident #131:
Review of Resident #131's pill punch card labeled Acetaminophen Codeine Phosphate 300/30mg (pain medication substituted for Tylenol with Codeine #3) revealed there were 10 tablets left on the card.
Review of Resident #131's Individual Patient's Narcotics Record sign out sheet labeled Tylenol #3 revealed the amount remaining was 11 pills.
Further review revealed between 10/06/2020 and 10/19/2020, there were 19 pills signed out as dispensed to Resident #131.

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Review of Resident #131's October 2020 MAR revealed only 2 doses were documented as administered to Resident #131 between 10/06/2020 and 10/19/2020.

Resident #136:
Review of Resident #136's pill punch card labeled Methadone 10mg tablets (used for pain relief and to treat drug addiction) revealed there were 6 tablets left on the card.
Review of Resident #136's Individual Patient's Narcotics Record sign out sheet labeled Methadone 10mg revealed the amount remaining was 7 tablets.
Review of Resident #136's pill punch card (2 cards) labeled Hydrocodone/APAP 10-325mg tablets revealed there were 35 tablets left on the cards.
Review of Resident #136's Individual Patient's Narcotics Record sign out sheet labeled Hydrocodone/APAP (Norco) 10-325mg tablets revealed the amount remaining was 36 tablets.
Further review revealed between 10/18/2020 and 10/20/2020, there were 9 tablets signed out as being dispensed to Resident #136.
Review of Resident #136's October 2020 MAR revealed only 2 doses documented as administered to Resident #136 between 10/18/2020 and 10/20/2020.

Resident #148:
Review of Resident #148's pill punch card labeled Lorazepam 1mg tablet (antianxiety) revealed there were 5 tablets left on the card.
Upon review of Resident #148's Individual Patient's Narcotics Record sign out sheet labeled Lorazepam 1mg during medication storage, it was noted the amount remaining was 6 tablets.
Upon receipt of the requested copy of the sheet,

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F 726	Continued From page 18 it was noted that the count remaining was changed to 5 tablets. Further review revealed between 10/17/2020 and 10/20/2020, there was 6 tablets signed out as dispensed to Resident #148. In an interview of 10/20/2020 at 3:30pm, S5LPN confirmed she altered the document prior to providing the surveyor with a copy, and confirmed she administered the medication, but did not complete the count sheet at that time. Review of Resident #148's October 2020 MAR revealed there was no documented doses administered to Resident #148 between 10/17/2020 and 10/20/2020. Review of the facility's policy titled Documentation of Medication Administration revealed, in part, the facility shall maintain a medication administration record to document all medications administered. A nurse shall document all medications administered to each resident on the resident's medication administration record. (MAR). Administration of medication must be documented immediately after (never before) it is given. In a joint interview on 10/22/2020 at 10:30am, S3Corporate Nurse and S4Corporate Nurse reviewed the above findings with this surveyor, and confirmed the count for the controlled medications were not documented accurately, confirmed incomplete and incorrect transcription of medications onto the Individual Patient's Narcotics Records sign out sheets, and confirmed medications were not documented as given on the MARs.	F 726		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)	F 806		11/30/20

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§483.60(d) Food and drink
Each resident receives and the facility provides-

§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;

§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure residents food preferences were honored for 2 (Resident #67 and Resident #102) of 58 residents reviewed in the investigation stage, and had the potential to affect any of the 173 residents, who received food from the kitchen, as documented on the Resident Census and Conditions of Residents Form CMS-672.
Findings:

Review of the facility's policy titled "Resident Food Preferences" revealed in part, upon the resident's admission the Dietitian or nursing staff will identify a resident's food preferences. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes.

Resident #67
Review of Resident #67's record revealed an admit date of 05/08/2020 with diagnoses of, in part, Hypertension, and Acute Kidney Failure.
Review of Resident #67's Minimum Data Set (MDS) with an Assessment Reference Date

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(ARD) of 08/06/2020 revealed in part, a Brief Interview for Mental Status score of 12 (score of 8-12 was moderately impaired), and received a therapeutic diet.
Review of Resident #67's October Physician's orders revealed in part, low concentrated sugar diet with large portions.
In an interview on 10/18/2020 at 11:07am, Resident #67 stated he told the kitchen staff that he did not like broccoli on his tray, he requested double portions and filled out a preference paper already. Resident #67 stated the kitchen person told him they needed another order for double portions when he came back from the hospital and Resident #67 stated nothing was done. Resident #67 stated he was not receiving double portions with his meals as requested.
Review of Resident #67's meal ticket on 10/19/2020 at 12:42pm revealed no concentrated sweet (NCS)/regular diet and milk with all meals. Further review of Resident #67's meal ticket revealed under Special Notes: no oatmeal, no green beans, low fat milk at all meals, no brussels sprout, no black eye peas, no fried food, no juice, water, and double portions.
In an interview on 10/19/2020 at 12:40pm, Resident #67 stated he told the kitchen people he did not like red beans and that was what they were serving him for lunch.
Observation of Resident #67's meal tray on 10/19/2020 at 12:43pm revealed Resident #67 was not served double portions as requested and red beans and rice were on his lunch meal tray.
In an interview on 10/19/2020 at 12:45pm, S9Registered Dietician looked at Resident #67's meal tray and stated Resident #67's meal tray was a large portion and not a double portion. S9RD reviewed Resident #67's meal ticket and confirmed there was no documentation of his

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preference for no broccoli and no red beans.
In an interview on 10/20/2020 at 11:30am, S6Dietary manager stated double portions for the lunch meal would consist of two scoops of rice, six meatballs and two egg rolls.
In an interview on 10/20/2020 at 2:30pm, Resident #67 stated for his lunch meal he had one and half scoops of rice, three meatballs and no egg rolls on his meal tray. Resident #67 denied having double portions for his lunch meal on 10/20/2020.
In an interview and observation on 10/22/2020 at 8:30am, Resident #67 was sitting on the side of his bed with his breakfast meal in front of him. His breakfast meal consisted of two strips of bacon, one biscuit, one serving of grits and one serving of eggs and a carton of chocolate milk. Resident #67 stated he did not receive double portions on his breakfast tray this morning or last night for his supper meal. Review of Resident #67's breakfast meal ticket revealed in part, double portions and no chocolate milk listed.
In an interview on 10/22/2020 at 8:35am, S10Certified Nursing Assistant (CNA) stated she delivered Resident #67's breakfast tray to him and she did not read his meal ticket before giving Resident #67 his breakfast tray. S10CNA stated she did not read his ticket that stated no chocolate milk and she served Resident #67 chocolate milk on his breakfast tray. S10CNA walked with the surveyor to Resident #67's room and when S10CNA was asked if Resident #67 was served double portions on his breakfast tray, she replied "no" it was not double portions.
In an interview on 10/19/2020 at 12:55pm S9Registered Dietician stated she was aware there was an issue with resident meal preferences.

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Resident #102
Review of the record revealed Resident #102 was admitted to the facility on 07/01/2019 with diagnoses which included, in part, Adult Failure to Thrive.
Review of Resident #102's Minimum Data Set with an Assessment Reference Date of 09/10/2020 revealed, in part, a Brief Interview for Mental Status score of 6 (severe cognitive impairment). Impairment), required extensive assistance with most activities of daily living and required limited assistance with eating.
Review of Resident #102's Care Plan Revealed in part, mechanical soft diet (onset 07/11/2019) with approaches to weigh resident as scheduled and document results and monitor dietary regime compliance by resident.
Review of Resident #102's October 2020 Physician orders revealed, in part the following orders:
06/05/2020 - pureed diet, double portions, double gravy, chocolate milk with all meals
02/26/2020 - Med pass, administer 8 ounce portion each day; and
09/10/2020 - puree with double gravy portion on meat. Change med pass to 4 ounces three times a day. Increase Z-calorie to 80 ounce bolus 4 times a day.
Review of Resident #102's monthly weights from 4/16/2020 thru 10/07/2020 revealed, in part:
On 04/16/2020, the resident weighed 127.90 lbs.
On 10/07/2020, the resident weighed 122.5 pounds which is a -4.22 % Loss.
On 07/03/2020, the resident weighed 124.10 lbs.
On 10/07/2020, the resident weighed 122.5 pounds which is a -1.29 % Loss.
On 09/02/2020, the resident weighed 123.60 lbs.
On 10/07/2020, the resident weighed 122.50 pounds which is a -0.89 % Loss. No significant

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weight loss identified.
Review of Resident #102's nutritional consult done 09/09/2020 revealed, in part: Clarify diet order to puree with double portion gravy on meat.
An observation on 10/21/2020 at 5:30 pm revealed a plate with 2 scoops of potatoes, 1 large scoop of pureed casserole, pudding, large serving of pureed vegetable and chocolate milk.
An observation of Resident #102's Breakfast tray on 10/22/2020 at 7:40am revealed, in part, a meal ticket stating: Special notes: Chocolate Milk with all meals, double portion. Double butter, double gravy.
An observation of Resident #102's breakfast tray on 10/22/2020 at 7:40am revealed, in part, servings: observed 1 bowl oatmeal, puree sausage, scramble eggs and chocolate milk.
In an interview on 10/22/2020 at 7:40am, S11Certified Nursing Assistant (CNA) stated Resident #102's meal tray was not double portions.
In an interview on 10/22/2020 at 9:40am, S6Dietary Manager stated a double portion of this morning's breakfast would consist of 2 scoops of scrambled eggs, 2 bowels of oatmeal, 2 puree biscuits and 2 portions of puree sausage.She further stated Resident #102 was suppose to have a double portion tray.
In an interview on 10/22/2020 at 9:45am, Resident #102 stated he only ate some of his eggs. He stated he did receive another plate of breakfast food, but was not hungry this morning.
In an interview on 10/22/2020 at 9:50am, S12Licensed Practical Nurse, (LPN) stated she noted Resident #102 did not have double portions this morning for his breakfast.
In an interview on 10/22/2020 at 10:15am, S11CNA stated Resident #102 was supposed to get double portions at meals.

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F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure snacks are served at times in accordance with resident's needs, preferences and requests. The facility failed to offer snacks to residents outside of scheduled meal service times for 2 (Resident #67 and Resident #161) of 58 residents reviewed in the investigation stage, and had the potential to affect any of the 173 residents, capable of consuming a snack, who resided in the facility as documented on the Resident Census and Conditions of Residents Form (CMS-672). Findings: Resident #67	F 809		11/30/20

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Review of Resident #67's record revealed an admit date of 05/08/2020 with diagnoses of, in part, Hypertension, and Acute Kidney Failure.

Review of Resident #67's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/2020 revealed in part, a Brief Interview for Mental Status score of 12 (score of 8-12 was moderately impaired), and received a therapeutic diet.

Review of Resident #67's October Physician's orders revealed, in part, an order for night time sandwich.

Review of Resident #67's September 2020 Certified Nursing Assistant (CNA) Activity of Daily Living (ADL) Tracking Form revealed in part, no documentation of a bedtime snack offered and/or accepted from 09/01/2020 through 09/11/2020 and from 09/20/2020 through 09/30/2020.

Review of Resident #67's October 2020 CNA ADL Tracking Form revealed in part, no documentation of a snack offered on 10/14/2020, 10/16/2020, and 10/19/2020.

In an interview on 10/18/2020 at 11:07am, Resident #67 stated he had asked the kitchen staff for a night time sandwich and he was not getting his night time sandwich. Resident #67 stated the facility was not consistent with giving him his night time sandwich. He stated in the last few weeks the Certified Nursing Assistants (CNAs) were not passing out his night time sandwich.

In an interview on 10/21/2020 at 10:00am, S6Dietary Manager stated the kitchen staff

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distributes the snacks to each unit around 7:30pm to 8:00pm. S6Dietary Manager stated they bring out fruit, cookies, and sandwiches to the nurses station. S6Dietary Manager stated she completes a nutrition screen for preferences, but the preference for snacks was not on her screening tool. S6Dietary Manager stated she does not receive a list of residents' snack preference; therefore, she was unaware if each resident was offered their preference of snacks and did not know how many residents requested a night time sandwich. Surveyor reviewed Resident #67's October 2020 Physician's orders with S6Dietary Manager and surveyor identified Resident #67's order for a night time sandwich. S6Dietary Manager confirmed she did not know if a sandwich was offered to Resident #67 nightly.

In an interview on 10/21/2020 at 10:40am, Resident #67 stated he had not received his night time sandwich, as his snack, from 10/18/2020 through 10/20/2020. During the interview, S9Registered Dietician entered Resident #67's room and began questioning Resident #67 about his snack preferences.

Resident #161
Review of Resident #161's record revealed an admit date of 09/18/2019 with diagnoses of, in part, Manic Depression and Anxiety Disorder.

Review of Resident #161's MDS with an ARD of 09/17/2020 revealed a BIMS score of 12 (moderately impaired).

In an interview on 10/21/2020 at 11:00am, Resident #161, who was Resident #67's roommate, stated he did not get a preference for snacks. Resident #161 stated he had to get up

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F 809	Continued From page 27 out of bed and go get snacks at the nursing station, and when he gets to the nursing station all the snacks are all gone by the time he gets to the desk. Resident #161 stated the CNA's don't come to his room to pass out snacks every evening. In an interview on 10/21/2020 at 10:50am S9Registered Dietician confirmed the resident's should receive their meal and snack preferences. In an interview on 10/21/2020 at 11:30am, S2Director of Nursing (DON) was informed of Resident #67 and Resident #161 not getting an evening snack or their snack preference. S2DON confirmed CNAs should go to each resident and offer a snack and then document on the CNA ADL sheet whether the resident accepted or refused the snack.	F 809		
F 812 SS=E	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.	F 812		11/30/20

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§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 observations and interview the facility failed to store, prepare, distribute and serve food under sanitary conditions. This deficient practice was evidenced by the facility failing to ensure:
1.) a cart for storing clean dishes was free from crumbs;
2.) a manual can opener was clean and free of food;
3.) a microwave was clean;
4.) a dusty fan was not present in the kitchen near the food steam table;
5.) a dusty blower was not present in the kitchen area;
6.) a stove was clean with no dried up grease on the back panel;
7.) oven was clean with no black particles on the inside bottom wall;
8.) food in the refrigerator was dated;
9.) rice was discarded within the proper timeframe after cooking;
10.) food temperature logs were accurate;
11.) automatic dishwasher was in working order; and
12.) sanitizer was maintained at the appropriate level for the three-compartment sink.
This deficient practice had the potential to affect any of the residents in the facility who received food from the facility's kitchen. The facility's census was 173 as documented on the Resident Census and Conditions of Residents Form CMS-672.
Findings:

During the initial tour of the kitchen on 10/18/2020

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at 9:40am, the following was observed:
1.) a rolling cart used to store clean plates and covers had visible crumbs on the bottom of each shelf;
2.) a manual can opener had a build-up of a black substance on the sides of the can opener;
3.) a microwave had dried up food particles on the inside walls;
4.) a fan, with a buildup of dust on the inside blades and outside grill, located on top of the ice machine located next to the food steam table;
5.) a blower with a buildup of dust on the outside located on a shelf under the microwave;
6.) stove had dried up black particles under the top grill and dried up grease on the back panel;
7.) oven had black particles on the inside bottom wall of the oven;

In an interview on 10/18/2020 at 9:42am S6Dietary Manager stated the rolling cart needed to be cleaned and she needed to purchase a new can opener and it needed to be cleaned. S6Dietary Manager stated the microwave was not clean and it should be cleaned daily.

In an interview on 10/18/2020 at 9:50am, S6Dietary Manager stated there was no documentation of cleaning equipment in the kitchen, but stated the oven should be cleaned every other day and confirmed the oven was not clean and should have been cleaned on Friday. S6Dietary Manager confirmed the top of the stove had dried up black particles under the top grill and dried up grease on the back panel of the stove and both needed to be cleaned.

Review of the facility's policy titled "Refrigerators and Freezers" revealed in part, all food shall be appropriately dated to ensure proper rotation by

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expiration dates. "Use by" dates will be completed with expiration dates on all prepared food in refrigerators.

During the initial tour of the refrigerator on 10/18/2020 at 9:55am, the following was observed:
1.) an opened bag of cookie dough, an opened bag of garlic biscuits and an opened bag of bread dough with no open date on either bag;
2.) nine styrofoam bowls with a piece of chocolate cake in each bowl with no date on the plastic covering;
3.) two bowls of cereal with no date on the plastic covering; and
4.) a metal container full of rice located on the top shelf of the refrigerator covered with plastic wrap dated 10/13.

Observation of the pantry area on 10/18/2020 at 10:05am revealed two packs of gravy mix were opened and not dated and a pack of marshmallows were opened and not dated.

In an interview on 10/18/2020 at 10:00am S6Dietary Manager stated all items in the refrigerator and pantry should have a date on them and confirmed there was no date on the items mentioned above. S6Dietary Manager confirmed the container of rice should have been discarded within 24 hours after being cooked.

Review of the facility policy titled "Sanitization", with a revised date of October 2018, revealed in part, manual washing and sanitizing will employ a three-step process for washing, rinsing and sanitizing:
a. Scrape food particles and wash using hot water and detergent;

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b. Rinse with hot water to remove soap residue; and
c. Sanitze with hot water or chemical sanitizing solution.

During the kitchen observation on 10/18/2020 at 10:20am S8Dietary Staff was washing an item in the three-compartment sink with only water and suds in the wash compartment. There was no water in the rinse compartment sink and no water in the sanitize compartment sink. There was a pan that had baked on food particles in the sanitize sink compartment.

In an interview on 10/18/2020 at 10:21am S8Dietary Staff stated she was washing dishes in the three-compartment sink and S7Dietary Staff checked the sanitizer daily, but not the wash water temperature. S8Dietary Staff confirmed there was no water in the rinse compartment sink and no water or sanitizer in the sanitizer compartment sink.

In an interview on 10/18/2020 at 10:23am, S6Dietary Manager confirmed there was no water in the rinse compartment sink and no water in the sanitize compartment sink and S8Dietary Staff was washing dishes.

In an interview on 10/19/2020 at 1:30pm, S9Registered Dietician (RD) stated her last inspection was on 09/08/2020 and she found some of the same things surveyor found in the kitchen. S9RD confirmed food should be discarded after 48 hours of being cooked.

Review of the dishwashing temperature/sanitizer record dated September and October 2020 revealed a wash temperature of 200, a rinse

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temperature of 120 and sanitizer was documented as 50 parts per million (PPM) for breakfast, lunch, and supper.

Review of the facility's automatic dishwasher on 10/19/2020 at 11:54am revealed two different stickers on the dishwasher. One sticker stated the rinse temperature needed to be at least 125 degrees and another sticker on the dishwasher stated the rinse temperature needed to be at least 120 degrees.

Observation on 10/19/2020 at 11:55am revealed S7Dietary Staff made three attempts to run the dishwasher, but the dishwasher did not reach a temperature of higher than 115 degrees.

In an interview on 10/19/2020 at 11:58am, S7Dietary Staff stated the water temperature of the dishwasher has never gotten above 115 degrees and it should be 120 degrees. S7Dietary Staff stated he did not notify anyone of the problem with the water temperature not being at least 120 degrees.

In an interview on 10/20/2020 at 3:25pm, S6Dietary Manager stated S7Dietary Staff did not inform her of any problems with the dishwasher temperature gauge.

Review of the food temperature logs for September and October 2020 revealed at the top of the page a heading titled Hot Foods 160 degrees-140 degrees Fahrenheit and Cold Foods 34 degrees Fahrenheit and below. Further review of the September and October 2020 logs revealed 160 degrees documented as the temperature on most of the food items for each day of the logs and 33 degrees documented as

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the temperature for most of the cold items for each day of the logs.

In an interview on 10/20/2020 at 3:14pm, S6Dietary Manager reviewed the food temperature logs August, September and October 2020 with surveyor and confirmed the temperature logs were not accurate because there was no way all the food temperatures could be 160 degrees Fahrenheit for each food item daily.

In an interview on 10/22/2020 at 9:25am, Resident #32 stated when he gets his food it was cold all the time. Review of Resident #32's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/2020 revealed a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact).

In an interview on 10/22/2020 at 9:30am, Resident #125 stated when he gets his food it was cold all the time. Review of Resident #125's MDS with an ARD of 09/10/2020 revealed a BIMS score of 15 (cognitively intact).

In an interview on 10/22/2020 at 9:35am, Resident #101 stated when she gets her food it was cold all the time. Review of Resident #101's MDS with an ARD of 09/17/202 revealed a BIMS score of 13 (cognitively intact).

In an interview on 10/22/2020 at 9:40am, Resident #168 stated when he gets his food it was cold all the time. Review of Resident #168's MDS with an ARD of 10/05/2020 revealed a BIMS score of 15.

In an interview on 10/22/2020 at 9:30am,

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F 812	Continued From page 34 S6Dietary Manager confirmed there was a fan and a blower in the kitchen and she was not sure who brought either of them into the kitchen. S6Dietary Manager confirmed the fan was dusty and should not be in the kitchen. S6Dietary Manager also confirmed the blower should not be in the kitchen and needed to be cleaned. In an interview on 10/22/2020 at 11:00am S9Registered Dietician confirmed the temperature of each food item could not be 160 degrees on a daily basis and stated the logs were inaccurate.	F 812		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Quality Assurance (QA)	F 865		11/30/20

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committee identified quality deficiencies and failed to develop and implement an appropriate plan of action to correct the deficient practices.
The facility failed to have a system in place to ensure:
1.) A physician's order was transcribed and implemented;
2.) Revise a care plan after a fall;
3.) Activities of Daily Living were maintained for shower and nail care;
4.) A resident's oxygen humidifier bottle was changed per facility policy;
5.) Controlled medications were accurately counted, documented as administered and transcribed correctly onto the Individual Patient's Narcotics Record;
6.) Food preferences are honored;
7.) Snacks were served at times in accordance with resident requests;
8.) The kitchen was kept clean and sanitary;
9.) An effective infection prevention control program was maintained;
10.) Oxygen cylinder was stored in proper location;
11.) The sanitizer was maintained in the three compartment sink.
The facility had a total census of 173 who resided in the facility as documented on the facility's Resident Census and Conditions of Residents Form (CMS-672).
Findings:

Cross reference to F656, F657, F676, F695, F726, F806, F809, F812, F880, and F908.

In an interview on 10/22/2020 at 11:55am, S1Administrator confirmed and presented the facility's Quality Assurance (QA) plan and stated they have corporate rounds monthly with a

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F 865	Continued From page 36 calendar of scheduled items for review. If during the corporate reviews something would be identified as a concern, S1Administrator would develop a QA at that time if necessary. S1Administrator stated during the daily morning meetings the staff could also bring up any quality concerns that would need to be addressed. In an interview on 10/22/2020 at 11:55am, S1Administrator confirmed the facility had not identified any of the above mentioned findings.	F 865		
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	F 880		11/30/20

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	195341	A. BUILDING _____ B. WING _____	C 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PALMS NURSING & REHAB, L L C	5301 TULLIS DRIVE NEW ORLEANS, LA 70131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37	F 880		

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 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

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F 880	Continued From page 38	F 880		

IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program to provide a safe and sanitary environment to help prevent the development and transmission of communicable disease and infections by failing to:
1.) Ensure shower rooms were clean and in good repair for Hall A, Hall B, Hall C, and Hall D.
2.) Ensure dirty laundry was kept off the floor.
3.) Ensure respiratory equipment was maintained in a sanitary manner (Resident #54)

This practice had the potential to affect any of the 173 residents who resided in the facility as documented on the Resident Census and Conditions of Residents Form (CMS-672).
Findings:

Observation of Hall B shower room on 10/21/2020 at 11:30am revealed the second stall to the left side of the door with tile missing and several tile with missing grout and several chipped tile with a gray substance. Further observation revealed the shower stall to the right of the door note with moist black substance on a 3 inch x 4 inch section of tile.

Observation of Hall C shower room on 10/21/2020 at 11:40am revealed a thick loose black/brown/white debris behind the door; debris to the base of the Hoyer lift; multiple debris under the wooden bench to the right of the shower room; 1st shower stall to the left of the door had a container holder mounted to the wall which was 75% rusted and 25% blue paint and debris to the floor; the 2nd shower stall to the left of the door

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F 880	Continued From page 39	F 880		

revealed a bariatric chair with several areas of rust on the seat with gray residue; white chalk like residue to the shower chair back and same rusted container holder; back section of the shower room had a thick brown crusty substance on the floor approximately 1 foot in length by 6 inches wide; floor mats with waterproof outer layer peeled and exposing mats; a dead roach was on the floor; and a trach oxygen mask on the floor not contained.

Observation of Hall D shower room on 10/21/2020 at 11:46am revealed several loose brown streaks on the floor; which wiped off when rubbed with the sole of surveyors shoe.

Observation of Hall A shower room on 10/21/2020 at 11:50am revealed a bag of dirty laundry on the floor contained in bag; the 1st shower stall to the right of the door revealed a shower chair with 2 areas of broken plastic to the shower chair seat.

During an infection control/environment rounds on 10/21/2020 at 1:02pm S1Administrator confirmed the above findings.
In an interview on 10/21/2020 at 1:02pm, S1Administrator stated Hall B shower room was supposed to be redone this week, but was halted due to the survey activity stated it was part of Quality Assurance (QA) once it was identified; Hall C shower room S1Administrator stated the debris needed to be cleaned; bariatric shower chair was not in use, but couldn't dispose of because the outside dumpster was filled with flooring debris; S1Administrator stated the equipment in the back was due to be disposed of and the dead roach was due to pest control having sprayed Monday. S1Administrator further stated the brown substance on the floor would be

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F 880	Continued From page 40	F 880		

handled when floors were changed. Surveyor then asked S1Administrator if an area can be cleaned should it be cleaned and S1Adminitrator stated if the area cannot be cleaned then the next level would be to change the flooring which it was due to be changed. S1Administrator had a housekeeper come to the area and an unknown floor cleaner was used on the floor and the housekeeper was able to wet mop all the thick brown substance that was on the floor. S1Administrator stated the area was able to be cleaned and should have been cleaned. S1Administrator confirmed the streaks on Hall D can be cleaned. She confirmed the shower chair on the Hall A should be repaired or disposed of.

Resident #54
Review of Resident #54's record revealed an admit date of 3/07/2019 with diagnoses, in part, of Acute Respiratory Failure with Hypoxia, Obstructive sleep Apnea (adult), and Morbid Obesity.
Review of Resident #54's Minimum Data Set with an Assessment Reference Date of 07/30/2020 revealed, in part, a Brief Interview for Mental Status of 15 (13-15 cognitively intact), required an limited assistance with a one person assist for transfers, bed mobility, toileting, and eating.
Review of Resident #54's August, September, and October 2020 Physician's order revealed, in part, Continuous Positive Airway Pressure (CPAP) at a Fraction of Inspired Oxygen (FiO2) of 21%, Positive End Expiratory Pressure (PEEP) of 10 every night, on 9:00pm and off 6:00am.
Review of Resident #54 Care Plan revealed, in part, the following problems and interventions: Diagnosis of Sleep Apnea related to need for CPAP. Ensure resident is using equipment appropriately, assist resident with CPAP

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F 880	Continued From page 41 equipment each night, monitor sleep patterns for adequate amounts of sleep, monitor worsening symptoms of sleep apnea and report to physician and evaluate. Evaluate resident each morning for signs of decreased oxygen, confusion. Review of Resident #54's Medication Administration Record for dated October 2020 revealed, in part, documentation of Resident #54's CPAP mask being cleaned daily with soap and water, patted dry and allowed to air dry. An observation on 10/18/20 at 11:32am revealed Resident #54's CPAP machine was on his bedside table uncontained and the mask was visibly dirty. An observation on 10/19/20 at 9:30am revealed on his bedside table uncontained and the mask was visibly dirty. An observation on 10/20/2020 at 9:05am revealed Resident #54's CPAP machine was on his bedside table uncontained and the mask was visibly dirty. In an interview on 10/20/2020 at 9:05am, Resident #54 stated his CPAP mask broke and he had to super glue it back together. He stated his oxygen tubing for his CPAP was last replaced in December 2018. In an interview on 10/20/2020 at 9:10am, S15CNA stated she had never cleaned Resident #54's CPAP mask or tubing. In an interview on 10/20/2020 at 12:50pm, S3Corporate Nurse stated Resident #54's mask should not be in the condition it was.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.	F 908		11/30/20

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F 908	Continued From page 42	F 908		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to maintain the safety of oxygen cylinders, by not storing oxygen cylinders in the proper location. This deficient practice had the potential to affect any of the 173 residents residing in the facility as documented on the facility's Resident Census and Conditions of Residents form (CMS-672).
Findings:

Review of facility's policy titled "Fire Safety and Prevention" revealed in part, store oxygen cylinders in racks with chains, sturdy portable carts or approved stands. Never leave oxygen cylinder free standing. Do not store oxygen cylinders in any resident room or living area.

Observation on 10/18/2020 at 10:05am, Resident #2 was lying on his bed with a nasal cannula connected to a portable oxygen unit. Further observation revealed three oxygen cylinders were located against the wall in Resident #2's room. One oxygen cylinder was standing up in the corner of the room not contained in a metal holder and two oxygen cylinders were in a metal holder against the wall.

In an observation and interview on 10/19/2020 at 11:00am, Resident #2 was lying in his bed with an oxygen cannula in his nares that was connected to a portable oxygen humidifier. Further observation revealed three oxygen cylinders were located against the wall in Resident #2's room. Resident #2 stated he keeps his oxygen on at all times and the three oxygen cylinders located against his wall have always been there. Resident #2 stated he uses the oxygen cylinders

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F 908	Continued From page 43	F 908		

when he goes out of the facility.

Observation on 10/19/2020 at 1:00pm, three oxygen cylinders remained in Resident #2's room against the wall.

Observation on 10/20/2020 at 8:14am, three oxygen cylinders remained in Resident #2's room against the wall.

In an interview on 10/20/2020 at 3:00pm, S2Director of Nursing (DON) stated oxygen tanks should be stored in the oxygen room and not in a resident room.

In an interview on 10/20/2020 at 3:45pm, S2DON confirmed there were three oxygen cylinders located in Resident #2's room and they should not have been in his room.

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F 000	INITIAL COMMENTS Based on record review, CMS determined that between 11/09/20 and 11/15/20, the facility did report information to National Health Safety Network about COVID-19 in the standardized format and frequency as specified by CMS and the Centers for Disease Control. The facility was found to be in compliance with 42 CFR 483.80(g)(1)-(2).	F 000		

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

11/16/2020

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

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F 000	INITIAL COMMENTS Based on record review, CMS determined that between 11/16/20 and 11/22/20, the facility did report information to National Health Safety Network about COVID-19 in the standardized format and frequency as specified by CMS and the Centers for Disease Control. The facility was found to be in compliance with 42 CFR 483.80(g)(1)-(2).	F 000		

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11/23/2020

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F 000	INITIAL COMMENTS Based on record review, CMS determined that between 11/23/20 and 11/29/20, the facility did report information to National Health Safety Network about COVID-19 in the standardized format and frequency as specified by CMS and the Centers for Disease Control. The facility was found to be in compliance with 42 CFR 483.80(g)(1)-(2).	F 000		

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11/30/2020

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F 000	INITIAL COMMENTS Based on record review, CMS determined that between 11/30/20 and 12/06/20, the facility did report information to National Health Safety Network about COVID-19 in the standardized format and frequency as specified by CMS and the Centers for Disease Control. The facility was found to be in compliance with 42 CFR 483.80(g)(1)-(2).	F 000		

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12/07/2020

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F 000	INITIAL COMMENTS Based on record review, CMS determined that between 12/07/20 and 12/13/20, the facility did report information to National Health Safety Network about COVID-19 in the standardized format and frequency as specified by CMS and the Centers for Disease Control. The facility was found to be in compliance with 42 CFR 483.80(g)(1)-(2).	F 000		

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12/14/2020

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F 884 SS=F	Reporting - National Health Safety Network CFR(s): 483.80(g)(1)(i)-(ix)(2) §483.80(g) COVID-19 reporting. The facility must-- §483.80(g)(1) Electronically report information about COVID-19 in a standardized format specified by the Secretary. This report must include but is not limited to- (i) Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19; (ii) Total deaths and COVID-19 deaths among residents and staff; (iii) Personal protective equipment and hand hygiene supplies in the facility; (iv) Ventilator capacity and supplies in the facility; (v) Resident beds and census; (vi) Access to COVID-19 testing while the resident is in the facility; (vii) Staffing shortages; (viii) The COVID-19 vaccine status of residents and staff, including total numbers of residents and staff, numbers of residents and staff vaccinated, numbers of each dose of COVID-19 vaccine received, and COVID-19 vaccination adverse events; and (ix) Therapeutics administered to residents for treatment of COVID-19. §483.80(g)(2) Provide the information specified in paragraph (g)(1) of this section at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention ' s National Healthcare Safety Network. This information will be posted publicly by CMS to support protecting the health and safety of residents, personnel, and the general	F 884		12/21/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/21/2020

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F 884	Continued From page 1 public. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to report complete information about COVID-19 to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) during a seven-day period that reporting was required by regulation. The CDC submitted data from the NHSN to the Centers for Medicare and Medicaid Services (CMS). Based on review of that data, CMS determined that between 12/14/2020 and 12/20/2020, the facility did not report complete information to NHSN about COVID-19 in the standardized format and frequency as specified by CMS and the CDC. This failure to report has the potential to cause more than minimal harm to all residents residing in the facility.	F 884		

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	195341	A. BUILDING _____ B. WING _____	C 12/22/2020

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F 000	INITIAL COMMENTS Complaint Survey #LA00056681. F609 was cited as a result of this complaint. A COVID-19 Focused Infection Control Survey was conducted on 12/22/2020. The facility was found to be in non-compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. F880 was cited as result of the COVID-19 survey. Total Residents: 174	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		1/8/21

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

Electronically Signed | 01/07/2021

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F 609	Continued From page 1	F 609		

investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to immediately report an incident in which a cognitively impaired resident sustained an unwitnessed fall with injury and was transported to the hospital.This deficient practice was evidenced by the facility's failure to report the incident in the state agency's Statewide Incident Management System (SIMS) for 1 (Resident #1) of 5 sampled residents. The deficient practice had the potential to affect any of the facility's total census of 174 residents documented on the facility's census list.
Findings:
Review of the facility's Abuse Investigating and Reporting policy revealed, in part, an alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:

a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury; or
b. Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/23/2020 revealed, in part, Resident #1 was severely cognitively impaired and no interview was conducted due to Resident #1

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F 609	Continued From page 2 being rarely or never understood Review of the Incident and Accident Report for the months of October through December 2020 revealed in part; Resident #1 had an unwittnessed fall on 12/03/2020 at 4:30am in his room and sustained a laceration to his forehead. Review of the facility's administrative documentation revealed no Statewide Incident Management System (SIMS) reports for the last 30 days for Resident #1's unwitnessed fall on 12/3/2020. In an interview on 12/18/2020 at 1:00pm, S1Administrator stated Resident #1 went to the emergency room after an unwitnessed fall on 12/03/2020 and no SIMS report was completed for Resident #1's fall on 12/03/2020.	F 609		
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	F 880		1/8/21

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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 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.

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F 880	Continued From page 4 §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 record review the facility failed to maintain the Centers for Disease Control (CDC) Infection Control Guidance for Healthcare Professionals for Coronavirus (COVID-19) by failing to ensure staff adhered to their infection prevention and control practices by failing to ensure: 1) facility staff wore a face mask covering their nose and mouth. 2) laundry staff followed infection control practices when wearing Protective Personal Equipment (PPE) in the laundry department. This deficient practice was identified for S3/Laundry Staff, S5/Certified Nursing Assistant (CNA), S6/Housekeeper and S/7 Activity Director, and had the potential to affect any of the 174 residents in the facility as documented on the facility's Census List. Findings: Review of the facility's Policy titled Corona Disease COVID-19 Infection Prevention and Control revealed documentation in part; While in the facility personnel are required to strictly adhere to established infection prevention and control policies, including in part; appropriate use of PPE and laundry practices. Further review	F 880		

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revealed documentation staff should wear a facemask at all times when in the facility.

Review of the CDC website for Infection Control Guidance for Healthcare Professionals (HCP) about Coronavirus (COVID-19) as of July 15, 2020 revealed in part, the CDC recommended using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as a part of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed SARS-CoV-2 infection. These practices include to use facemasks to cover a person's mouth and nose. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. Further review revealed patients may remove their cloth face covering when in their rooms but should put it back on when around others or leaving their room. HCP should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers.

Observation on 12/22/2020 at 12:30pm revealed S3/Laundry Staff in the laundry room dressed in Personal Protective Equipment (PPE) which included gloves, mask and gown as she loaded the washing machine with dirty laundry. Observation further revealed S3/Laundry Staff then walked over to the clean side of the laundry room with the same PPE she used to load the washer with the dirty laundry. S4/Laundry Manager was standing outside of the laundry

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F 880	Continued From page 6 room with the surveyors during this observation. In an interview on 12/22/2020 at 12:30pm S4/Laundry Supervisor stated he observed S3/Laundry Staff as she was walking over to the dryer with her dirty PPE to the clean side of the laundry room. He indicated the PPE was contaminated and S3/Laundry Staff should have changed her PPE prior to walking over to the clean side of laundry room. In an observation on 12/22/2020 at 12:50pm S5/CNA was wearing a facial mask covering her mouth and not covering her nose. In an observation on 12/22/2020 at 1:00pm S6/Housekeeper entered the breakroom not wearing a facial mask covering her mouth and nose. In an observation on 12/22/2020 at 2:45pm S7/Activity Director was wearing a facial mask covering her mouth and not covering her nose. In an interview, S2/Assistant Administrator was notified S6/Housekeeper did not have a facial mask covering her nose and mouth, and both S5/CNA's facial mask and S7Activity Director's facial mask did not cover their nose. S2/Assistant Administrator acknowledged S6/Housekeeper should be wearing a facial mask covering her mouth and nose and S5/CNA and S6/housekeeper should wear their facial mask to cover their nose and mouth.	F 880		