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	255105	A. BUILDING _____ B. WING _____	05/06/2021

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DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertificaton survey at the facility from 05/03/21 to 05/06/21. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid Requirements of Participation.The SA cited deficiencies at F677, F689,F693, F695, F880, and F921. The facility had a census of 83 at the time of the survey and was licensed for 120 beds.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to provide nail care to a dependent resident as evidenced by long, jagged fingernails for one (1) of 21 residents observed for ADL's. Resident #26. Findings include: Review of the facility's policy titled, "Care Delivery Procedures", effective date January 2021, revealed Diversicare utilizes Perry and Potter-Clinical Nursing Skills and Techniques as a guideline for performing skilled procedures while providing care for our resident. On 05/05/21 at 08:05 AM, an observation and interview with Licensed Practical Nurse (LPN) #1 revealed, Resident #26 revealed resident with jagged, long fingernails with sharp points. The left	F 677	-Resident #26 fingernails were cleaned and trimmed on 5/10/21 by an RN. All residents have the potential to be affected by this alleged deficient practice. -An audit was conducted on 5/6/2021 by a Licensed Nurse on all residents to ensure that their fingernails were clean and trimmed. (Exhibit I) An audit was done on 5/11/21, 5/18/21 and 5/25/21 which was one (1) time a week for three (3) weeks on all residents to ensure that their fingernails were cleaned and trimmed by the Director of Nursing Services/Unit Manager. (Exhibit J) An in-service was conducted on 5/5/21 with the nursing staff on keeping residents fingernails clean and trimmed by the Director of Clinical Education. (Exhibit K)	7/12/21

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

Electronically Signed | 07/02/2021

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F 677	Continued From page 1 ring fingernail was short, with the other nails one half to one inch in length, discolored to a dingy, dull, brownish shade. LPN #1 described residents' fingernails as being long, jagged and discolored and stated they needed to be trimmed. When asked who is responsible for keeping his nails trimmed, LPN #1 reported it is usually the aides who trim nails but sometimes it is the nurse, I would need to check. I could trim them, if he will allow it. On 5/05/2021 at 8:45 AM, an observation and interview with Registered Nurse (RN) #2 confirmed Resident #26 with long, jagged nails. RN #2 reported his nails would be taken care of today if he will allow it. On 05/05/2021 at 3:10 PM, an interview and record review of the Order Summary Report and Care Plans with RN #3 Supervisor confirmed there was no order for nail care and the Care Plan stated the RN was to trim nails as ordered and as needed. She reported she has trimmed the nails in the past. When asked when was the last time she trimmed the residents nails she reported she could not recall but that it had to be a couple months. On 05/05/2021 at 4:50 PM, an interview with the RN Consultant revealed the facility has a policy to refer to Perry and Potter Instructions for resident care areas. On 5/6/2021 at 10:25 AM, an interview with the Director of Nurses (DON) revealed the Certified Nurses Assistants (CNA's) would report to the nurse if a resident had long nails and they could not trim them, the nurses trim all diabetics and Residents with blood thinners.	F 677	-Systemic changes will include rounds by Director of Nursing Services/Wound Care Nurse/Unit Managers/Charge Nurse to ensure that all fingernails are clean and trimmed one (1) time a week for twelve (12) weeks or until sustained compliance can be achieved. Rounds began on 6/3/21. (Exhibit L) -Any negative findings will be brought to the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. Findings were brought before our Quality Assurance Committee on June 24, 2021. (Exhibit D) Findings will continue to be reviewed in our Quality Assurance Performance Improvement Meeting in July and August.	

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F 677	Continued From page 2 On 05/6/2021 at 10:35 AM with CNA #1 revealed the aides do most of the nail care with bathing but I always ask the nurse before trimming nails. The nurse will let me know if I can trim nails. Record review of Resident #26's Admission Record revealed he was admitted to the facility on 09/20/2016 with diagnoses of Austitic Disorder and Unspecified Intellectual Disabilities. Record review of the Order Summary Report dated May 5, 2021, and the Treatment Administration Record (TAR) dated 4/1/2021 - 4/30/2021 revealed nail care was not listed as an order or treatment on either record. Record review of the Care Plan revealed, "Focus: I have a physical functioning deficit related to ...self care impairment...Date initiated 10/4/2016, revealed, Interventions:... RN to file/trim nails as ordered/needed, Date initiated 2/22/2017."	F 677		
F 689 SS=D	e Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review and facility policy review, the facility failed to ensure a safe environment as	F 689	-Resident #10, #5 and #330 were assessed for self-administration of medications, medication storage boxes	7/12/21

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F 689	Continued From page 3 evidenced by respiratory inhalers left at the resident's bedside for three (3) of 25 residents observed for respiratory inhaler use. Resident #5, #10, and #330 Findings include: Review of the faclity policy, titled, " Self-Administration of Medications", revealed the facility should document in the resident's care plan whether the resident or facility staff is responsible for the storage of the resident's medications. If the resident is responsible for the storage of his/her medicatons, the facility should provide a secured compartment for storage of such medications in accordance with Facilty policy, Applicable Law, the State Operations Manual, and as follows: 9.1 The medication storage compartments should be located in the resident's room so that another resident is not able to access the medications. 9.2 The storage compartment should be locked when not in use. 9.3 The resident should store the key or combination to the compartment securely at all times. On 05/03/21 at 10:26 AM, an observation, of Resident #10's overbed table revealed small open top plastic box containing two (2) respiratory inhalers, a Symbicort 160-4.5 mcg/act and an Albuterol 90mg inhaler. On 05/04/21 at 9:30 AM, Resident #10 continued to have her Symbicort and Albuterol Inhalers at the bedside. She stated the nurses let her keep them to use. She stated that she was competent and knows when and how to use them. She stated she feels safer with them because she has Chronic Obstructive Pulmonary Disease, and if	F 689	were placed in room with medications, and residents were educated on 5/4/21 by Director of Clinical of Education. (Exhibit M) Resident #10, #5 and #330□s care plan was updated on 5/4/2021 to reflect Self-Administration of Meds (Exhibit M2) -Residents who are capable of administering their own medications have the potential to be affected by this alleged deficient practice. Rounds were made on 5/5/21, 5/12/21, and 5/19/21 which was one (1) time a week for three (3) weeks by the Director of Nursing Services/Assistant Director of Nursing/Unit Managers/Charge Nurse to ensure that no medications are left at bedside. (Exhibit O) -On 5/10/21 all current residents were reviewed by our interdisciplinary team to identify any resident who were capable of self-administration of medications. (Exhibit O1) No other residents were identified during our review. An In-service was completed with all nursing staff on self-administration of medications, storage of these medications and resident education on 5/4/21 by our Director of Clinical Education. (Exhibit P) -Systemic changes starting 5/7/21 will be that the Clinical Health Status on all new admits will be reviewed during our morning clinical start up meeting Monday through Friday to determine if the residents wish and or capable of administrating their own medications by our Interdisciplinary Team. If any resident	

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F 689	Continued From page 4 she gets short of breath, she can't wait for the nurses to bring them. She stated that she feels like they are her life line. Resident #10 was able to verbalize appropriately all of the steps for administration of her inhalers and stated she takes them at 8 AM and 8 PM. She stated that she does not want the facility to take them. On 05/04/21 at 03:03 PM, an observation revealed an Albuterol 90 mcg inhaler on Resident #5's over bed table. Resident #5 stated that they (the staff) came and took her roommates inhaler and she wanted this surveyor to know that she had her rescue inhaler with her. She stated the nurses know she keeps it in her room so she can use it when she needs it. An interview, on 05/05/21 at 09:00 AM, with Licensed Practical Nurse (LPN) #2 revealed that the facility is a non-administering facility for the residents. She stated that the residents should not be taking medications themselves. LPN #2 confirmed that she was aware that Resident #10 had her inhalers at the bedside. LPN #2 stated that she had asked the resident about it and Resident #10 told her that they always let her keep them. LPN #2 stated that she guessed they were charting the inhalers based on what the resident said. LPN #2 stated that the resident could be at risk for overuse or nonuse of the medication. An interview, on 05/05/21 at 02:10 PM, with Registered Nurse (RN) #6, revealed she did not see any inhalers in Resident #5 and Resident #10's room when she administered medications yesterday but, the residents had their inhalers at their bedside when she was told by management to remove them from the resident's room.	F 689	wishes to administer their own medications, a Self-Administration of Medications Assessment will be completed and medication storage established and Resident educated. This Systemic change will be ongoing. (Exhibit Q) -Any negative findings will be brought to the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. Findings were brought before our Quality Assurance Committee on June 24, 2021. (Exhibit D) Findings will continue to be reviewed in our Quality Assurance Performance Improvement Meeting in July and August.	

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F 689	Continued From page 5	F 689		

A telephone interview, on 5/5/21 at 3:34 PM, with Licensed Practical Nurse (LPN) #3, revealed that she did not see any medications on the Resident #5 and Resident #10's overbed tables. She stated that she administered their inhalers from the medication cart. When asked if she thought it was possible for the pharmacy to send Resident #10 two (2) of the same inhalers at the same time, she stated that it probably was not.

An interview, on 05/06/21 at 9:00 AM, with the Director of Nursing (DON), revealed that the resident's should not have medications left at the bedside. She stated she did not know how the residents got those medications. The DON confirmed that Resident #10 only had one (1) Symbicort Inhaler and it was removed from her bedside. The DON stated that she did not know why the nurses were leaving medication with the residents. The DON stated they did not have any wanderers on the hall and the two (2) residents in this room did not get out of their room, especially since COVID-19.

Record review of the Minimum Data Set(MDS) with an Assessment Reference Date (ARD) 1/28/21 Section C revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 13 and the MDS with an ARD of 2/24/21 revealed Resident #10 had a BIMS score of 15, indicating both residents are cognitively intact.

Observation on 05/03/21 at 11:31 AM, in Resident #330's room revealed 2 inhalers laying on the resident's overbed table. Trelegy 100 micrograms

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F 689	Continued From page 6 (mcg)/25 mcg and Trelegy 100 mcg/62.5/25 mcg. Observation on 05/04/21 at 09:00 AM, in Resident #330's room revealed an Albuterol inhaler laying on the bedside table and the Trelegy inhalers not observed in the room. Observation and interview on 05/04/21 at 04:35 PM, in Resident #330's room revealed an Albuterol inhaler laying on the overbed table. Interview with Resident #330 revealed he stated this inhaler is one I had in my pocket that I brought from home and that it is empty. The State Agency (SA) asked him about the Trelegy inhalers that he had in his room yesterday and he stated that he is not sure why they took it out of his room because "I know how to use it because I am supposed to use it one time a day." An interview, on 05/05/21 at 09:00 AM, with Licensed Practical Nurse (LPN) #2 revealed that the facility is a non-administering facility for the residents. She stated that the residents should not be taking medications themselves. An interview, on 05/04/21 at 04:12 PM, with the Nurse Consultant, revealed she stated the facility was following the policy concerning self administration of medications. This surveyor asked if the facility had locked boxes in the rooms and the Nurse Consultant responded that they did not but, then added that they would tomorrow. She then confirmed that the facility was not following the policy for self-administration of medications.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		7/12/21

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F 693	Continued From page 7 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to label the enteral feeding bag and ensure the correct flow rate for a continuous tube feeding was consistent with the physician order for one (1) of four (4) residents reviewed for gastrostomy feedings. Resident #76 Findings include: Observation on 05/03/21 at 11:45 AM, revealed Resident #76 receiving a tube feeding of Jevity 1.2 cal (calorie) at 60 milliters (ml)/hour (hr). Observation on 05/04/21 at 10:15 AM, revealed	F 693	-Resident #76□s enteral feeding bag was removed and replaced with a bag that was labeled by the Unit Manager with the correct flow rate for a continuous tube feeding that is consistent with the physician□s order on 5/3/2021. Residents that are fed with enteral feeding have the potential to be affected by this alleged deficient practice. -An audit was conducted on 5/4/2021 by a Licensed Nurse on all residents that are fed with enteral feeding to ensure that all enteral feeding bags were labeled with the correct flow rate that is consistent with	

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F 693	Continued From page 8 Resident #76's tube feeding rate was at 60ml/hr. Interview and observation on 05/04/21 at 02:50 PM, with Licensed Practical Nurse (LPN) #1, when asked had she used Resident #76's Percutaneous Endoscopic Gastrostomy (PEG) tube today, she stated that she had given her medications in the tube at 9 AM and 1 PM today. When asked what the order was for Resident #76's tube feeding, she looked on the Medication Administration Record (MAR) and stated she has an order for Jevity 1.2cal at 55ml/hr. When asked had she checked the feeding rate today, she admitted that she had not looked at the rate. Observation in Resident #76's room, LPN#1 looked at the feeding pump and stated the rate is set on 60ml/hr. She used a marker and wrote Jevity 1.2 at 55ml/hr on the feeding bag and when asked her how she knew what was in the feeding bag, she stated that she did not know for certain and that she is going to discard the feeding bag and tubing because she could not say for certain what was in the bag. LPN#1 changed the rate on the feeding pump to 55ml/hr. When asked LPN #1 what the wrong rate could do to the resident, she stated it could cause an upset stomach and the physician order was not followed. Interview on 5/4/21 at 3:30 PM, with the Director of Nursing (DON) and Nurse Consultant, they confirmed that the facility had no specific policy and procedure on gastrostomy feedings. Record review of the MAR revealed Jevity 1.2 cal at 55ml/hr and is initialed on 5/4/21 by LPN #1. Interview on 05/05/21 at 08:30 AM, with LPN #2, when asked when she would assess her residents and she stated that she would assess	F 693	the physician□s order. (Exhibit R) Audits were conducted 5/4/21, 5/5/21, 5/6/21, 5/10/21, 5/11/21, 5/13/21, 5/17/21, 5/19/21 and 5/21/21 which was three (3) times a week for three (3) weeks by the Director of Nursing Services/Unit Managers to ensure all enteral feeding bags are labeled with the correct flow rate that is consistent with the physician□s order. (Exhibit S) -An in-service was conducted on 5/5/2021 by the Director of Clinical Education with all licensed nurses concerning the expectation of labeling of enteral feeding bags with the correct flow rate that is consistent with the physician□s order. (Exhibit T) -Systemic changes will include rounds that began on 5/24/21 by Director of Nursing Services/Assistant Director of Nursing/Unit Managers/Charge Nurse to ensure that all feeding bags are labeled with the correct flow rate that is consistent with the physician□s order on all residents that are fed with enteral feeding one (1) time a week for twelve (12) weeks or until sustained compliance can be reached. (Exhibit U) -Any negative findings will be brought to the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. Findings were brought before our Quality Assurance Committee on June 24, 2021. (Exhibit D) Findings will continue to be reviewed in our Quality	

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F 693	Continued From page 9 them when she goes from room to room administering her morning medications. When asked what she would assess on a resident with a PEG tube feeding and she stated that she would check the formula and flush rate and compare to the orders. Record review of a Physician Orderdated 4/21/21 revealed an order for Jevity 1.2 cal at 55ml/hr continuous. Record review of the Care plan revealed a care plan with a revision date of 4/30/21 revealed an intervention "Enteral Feed order every shift.Juvity 1.2 cal...55 ml/hr continuous...." Record review of the Admission Record revealed Resident #76 was admitted to the facility on 4/14/21. Record review of the Diagnosis Information revealed Traumatic Subarachnoid with loss of consciousness of unspecified duration, subsequent encounter, Dysphagia unspecified, Hydrocephalus unspecified, Hemiplegia and Hemiparesis following Cerebral infarction affecting right dominant side, Anorexia, Unspecified Severe Protein-Calorie Malnutrition. Record review of the Minimum Data Set (MDS) dated 4/21/21 revealed a Brief Interview for Mental Status (BIMS) score of 99 which revealed Resident #76 is cognitively impaired and unable to complete the interview. Interview on 05/05/21 at 03:23 PM, with DON, when asked what the consequences could be if the rate of a tube feeding was not correct, and she stated it could cause them to be too full and they could aspirate.	F 693	Assurance Performance Improvement Meeting in July and August.	

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F 693	Continued From page 10 Interview on 5/6/21 at 12:18 PM, with Registered nurse (RN) #4, she stated they do not have any in-services on feeding tube flow rate and that the nurses are supposed to follow the physician orders for this.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, the facility failed to ensure the oxygen (O2) flow rate for a resident was consistent with the physician order for one (1) of six (6) residents reviewed for oxygen administration. Resident #330 Resident #330 Findings include: Observation on 05/03/21 at 11:31 AM, revealed Resident #330 receiving oxygen at a flow rate of 5 liters. Observation on 05/04/21 at 09:20 AM, revealed Resident #330 receiving oxygen at a flow rate of 2 liters.	F 695	-Resident #330□s Oxygen flow was set at the correct rate immediately upon discovery by the Unit Manager on 5/3/21. On 5/3/2021 resident #330 was encouraged to adhere to the correct flow of Oxygen as ordered by his Physician by the Director of Clinical Education. (Exhibit V) Residents who have orders for oxygen have the potential to be affected by this alleged deficient practice. -An audit was conducted by the Unit Managers on 5/4/21 on all residents who had orders for oxygen to ensure that their O2 flow rate was consistent with the physician order. (Exhibit W). -An audit was conducted on all residents	7/12/21

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F 695	Continued From page 11 Observation on 05/04/21 at 03:00 PM, revealed Resident #330 receiving oxygen at a flow rate of 2 liters. Observation and interview on 05/04/21 at 04:30 PM, with Resident #330, revealed the resident sitting in his room in the wheelchair with an oxygen flow rate at 2 liters with no shortness of breath noted. Resident #330 revealed he does not adjust his oxygen. An Interview and observation on 05/04/21 at 04:35 PM, with Registered Nurse (RN) #1 revealed she had not assessed Resident #330. She stated she had not made rounds on him yet because he had been doing therapy. When making her rounds, she stated she would check his oxygen for the correct rate. RN #1 confirmed Resident #330 currently had an oxygen flow rate of 2 liters. RN #1 confirmed the physician order and the Medication Administration Record (MAR) for Resident #330 revealed the oxygen order was for 6 liters. When asked she reported the consequence of the wrong oxygen rate could be the oxygen would not do what it should do. She stated she was going to check his oxygen saturation and set the rate to 6 liters. An interview on 05/04/21 at 04:58 PM, with Assistant Director of Nursing (ADON) revealed there were no new orders written today on Resident #330 for a change in his oxygen rate. An interview on 05/05/21 at 03:23 PM, with the Director of Nursing (DON), revealed the potential consequences of not having the correct flow rate per the physician order, could result in the resident having a low oxygen level, and could lead to seizures or a stroke.	F 695	who have orders for oxygen on 5/3/21, 5/6/21, 5/7/21,5/10/21,5/11/21, 5/12/21, 5/19/21, 5/20/21, and 5/21/21 which was three (3) times a week for three (3) weeks by the Director of Nursing Services/Unit Managers to ensure the O2 flow rate is consistent with the physician orders. (Exhibit X) -An in-service was conducted on 5/5/2021 by our Director of Clinical Education with licensed nurses concerning the expectation of resident□s O2 set at the correct flow rate that is consistent with the physician□s order. (Exhibit K) -Systemic changes will include rounds that began on 5/24/21 by Director of Nursing Services/Assistant Director of Nursing/Unit Managers/Charge Nurses to ensure O2 flow rates are consistent with the physicians order on all residents who have orders for Oxygen one (1) time a week for twelve (12) weeks or until sustained compliance can be reached. (Exhibit Z) -Any negative findings will be brought to the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. Findings were brought before our Quality Assurance Committee on June 24, 2021. (Exhibit D)Findings will continue to be reviewed in our Quality Assurance Performance Improvement Meeting in July and August.	

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F 695	Continued From page 12 An interview on 05/05/21 at 04:06 PM, with the DON, revealed the facility does not have a policy and procedure for Oxygen Flow Rate and that they use Care Delivery Procedures from Perry and Potter. Record review of the Care Delivery procedure revealed under Delegation and Collaboration the skill of applying a nasal cannula or oxygen mask can be delegated to Nursing Assistive Personnel (NAP). The nurse is responsible for assessing patient's respiratory system, response to oxygen therapy, and setup of oxygen therapy, including adjustments of oxygen flow rate. An interview on 5/6/21 at 12:18 PM, with RN #4, revealed the facility does not have any in-services on oxygen flow rate and that the nurses are supposed to follow the physician orders. Record review of Resident #330's Order Summary Report dated 4/28/21 revealed an order for Humidified Oxygen at 6 liters by nasal cannual (BNC) continuous. Record review of Resident #330's care plan "Focus-Potential for Shortness of Breath (SOB) related to Chronic Obstructive Pulmonary Disease (COPD)" dated 4/28/21 revealed an intervention "Humidified O2 at 6L BNC Continous" Record review of Resident #330's the MAR revealed Humidified oxygen at 6 liter BNC continuous and is initialed on 5/4/21 by Licensed Practical Nurse (LPN) #1.	F 695		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/12/21

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F 880	Continued From page 13 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 14 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to store nebulizer masks to prevent the likelihood of infection for one (1) of seven (7) residents observed with nebulizer at bedside. Resident #330. Findings include: In an interview on 5/6/21 at 10:00 AM, the Director of nursing stated that the facility does not have a policy for cleaning Nebulizer machines.	F 880	-Resident #330□s nebulizer machine was properly cleaned and resident□s mask was replaced, dated and stored properly according to the manufacturers guidelines on 5/6/21 by the Unit Manager immediately upon discovery to prevent the likelihood of infection. -Residents who have orders for use of Nebulizer have the potential to be affected by this alleged deficient practice.	

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F 880	Continued From page 15 Observation on 05/03/21 at 11:31 AM, in Resident #330's room the nebulizer mask was laying on the nebulizer machine and was not bagged. Observation on 05/04/21 at 09:20 AM, in Resident #330's room the nebulizer mask was laying on the machine and was not bagged. Observation on 05/04/21 at 03:00 PM, in Resident #330's room the Nebulizer mask was laying on the nebulizer machine and was not bagged. On 05/05/21 at 9:00 AM, in an interview with Registered Nurse (RN) #4, Infection Control Preventionist, revealed the nebulizers are deep cleaned before and after they are assigned to the resident. She reports they should be cleaned with the weekly tubing changes. The tubing and mask should be kept in a zip lock bag at bedside. On 05/06/2021 at 10:00 AM, an interview with the Director of Nurses (DON), revealed the facility does not have a policy for cleaning nebulizer machine at this time. They follow Physicians orders. The nebulizer tubing and masks are scheduled to be changed on Sunday nights on the 7PM to 7AM shifts for the nurses. When asked where the nurses document the cleaning, she reported we are working on that. Interview on 5/6/21 at 10:45 AM, with LPN #2 revealed the nebulizer tubing and mask and oxygen tubing and water bottle are changed out on 11/7 shift each Sunday. Stated they should be dated should and the mask should be stored in a	F 880	-An audit was conducted on 5/6/21 by the Unit Managers on all residents who had orders for nebulizer treatments to ensure nebulizer machine were properly cleaned and resident□s mask was dated and stored properly according to the manufacturers guidelines to prevent the likelihood of infection. (Exhibit AA) -An audit was conducted by the Director of Nursing Services/Unit Managers on 5/11/21, 5/12/21, 5/13/21, 5/17/21, 5/18/21,5/19/21,5/26/21, 5/27/21, and 5/28/21 which was three (3) times a week for three (3) weeks on all residents who have physician orders for nebulizer treatments to ensure that their nebulizer machines were properly cleaned and resident□s masks were dated and stored properly according to the manufacturers guidelines to prevent the likelihood of infection. (Exhibit BB) -Root Cause Analysis The center leadership has identified an OFI (Opportunity for Improvement) regarding the established practice standards that govern Infection Prevention and Control related to the process for cleaning, storage and labeling of nebulizer mask, tubing and machines. Licensed Nurses failed to follow established practice standards that govern the administration of nebulizer treatments as evidenced by the identification of the nurses□ failure to ensure proper cleaning, storage and	

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F 880	Continued From page 16 ziplock bag. Stated if we do not have a ziplock bag that she will use the plastic bag the mask came in. Record review of the Care Plan revealed Potential for episodes of Shortness of Breath (SOB) related to Chronic Obstructed Pulmonary Disease(COPD) that includes interventions of Albuterol Sulfate Nebulization Solution 0.083%, 3ml inhale orally every 2 hours as needed for SOB. Record review of Resident #330's Medication Administration Record (MAR) revealed an order dated 4/26/21 for Albuterol Sulfate Nebulizer 2.5 mg / 3 ml inhale orally every 2 hours as needed for shortness of breath.	F 880	labeling of mask, tubing and machine after completion of prescribed treatment. The Interdisciplinary Team has identified impacting factors associated with improper cleaning, storage and labeling of nebulizer mask, tubing and machine to include: -The opportunity for the center to establish a defined process for cleaning of respirator equipment -Opportunities to increase the licensed nurses knowledge base regarding the established process for cleaning and storage of respiratory equipment secondary to hiring of new licensed nurses -Goal for System Compliance: The staff will deliver care and services in accordance with the established practice standards and regulatory guidelines that govern Infection Prevention and Control as it relates to the proper cleaning, storage and labeling of respiratory equipment. The center will achieve a 100% system compliance rate by 7/16/21 and demonstrate a sustainability rate of 100% system compliance over the next 90 days. -An in-service was conducted on 5/6/2021 by the Director of Clinical Education/Infection Control Preventionist and Director of Clinical Services with all licensed nursing staff on the proper storage and labeling of nebulizer mask as well as cleaning guidelines for nebulizer	

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F 880	Continued From page 17	F 880	mask and nebulizer machines to prevent the likely hood of infections. (Exhibit CC) -Education included the cleaning process per Vix One Manufacturer guidelines. Education also included competency validation per the Infection Control Quality Consultant and the Center□s Infection Preventionist. (Exhibit DD1) Initial education began on 5/6/2021. Education with validation of competency will be completed by 7/16/2021. Nurses who have not had the opportunity to complete education by 7/16/2021 will not be scheduled to work until in-service and competency validation has been completed. -Systematic changes will include rounds that began on 6/1/21 which is one (1) time a week for twelve (12) weeks or until sustained compliance can be reached by the Director of Nursing Services/Assistant Director of Nursing/Unit Managers/Charge Nurses to ensure the proper storage and labeling of nebulizers, as well as, cleaning guidelines for nebulizer masks and nebulizer machines to prevent the likely hood of infections. (Exhibit DD) On 7/7/2021 the Nebulizer Cleaning Competency was added to our general orientation process for all new employees (LPN, RN). (Exhibit DD1) -Any negative findings will be brought to the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. Findings were brought before our Quality Assurance	

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F 880	Continued From page 18	F 880	Committee on June 24, 2021. (Exhibit D) Findings will continue to be reviewed in our Quality Assurance Performance Improvement Meeting in July and August.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure a safe environment as evidenced by a staff nurse vaping at the nurses desk for one (1) of 16 nursing staff working on the floor during the 7 to 3 shift on 05/03/21. Findings include: Record review of facility policy titled, "Health and Safety", dated November 2020, revealed the facility is a "smoke-free environment. To maintain a safe and comfortable working environment and to ensure compliance with applicable laws, smoking is prohibited in all of (proper name) centers and office buildings. Smoking, including electronic smoking devices, is allowed only in designated areas outside of the building. If you choose to smoke, including electronic cigarettes (e-cigarettes), you may only do so on approved breaks and meal periods." Observation on 5/3/2021 at 12:45 PM, at the	F 921	-RN #2 was disciplined and in-serviced on 5/6/2021 by the Director of Nursing Services on the facility□s smoking policy that includes vaping, as well as, maintaining a safe and comfortable working environment. (Exhibit EE) -All residents have the potential to be affected by this alleged deficient practice. -An in-service was held on 5/6/21 by the Director of Clinical Education with all staff members on the facility□s smoking policy that includes vaping, as well as, maintaining a safe and comfortable working environment. (Exhibit B) The Maintenance Supervisor/Nursing Home Administrator/Director of Nursing/Assistant Director of Nursing made rounds in the building to ensure that staff members are adhering to the facility□s smoking policy that includes vaping on 5/6/21, 5/7/21,5/10/21, 5/11/21, 5/12/21, 5/19/21, 5/20/21, 5/21/21,	7/12/21

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F 921	Continued From page 19 Nurses Station on the C/D Hall revealed a huge puff of vapor smoke noted around Registered Nurse (RN) #2's head and face. Observed RN pull a vaping device from her mouth and placed it into her left pants pocket. The State Agency (SA) was standing approximately 8 feet from the Nurses Station Entrance. No other employees or residents were in the immediate area. Interview on 5/3/2021 at 12:45, with RN #2, stated "Oh, no, no, we don't vape in the building." She stated "vaping is not allowed in the building and I would not do that." When asked about the observation of the puff of vapor and the device being placed into her pocket, RN #2 stated, "Oh, I am so sorry. I should never have vaped. I don't ever vape in the building, but I am just stressed out. I really am so sorry. I know I shouldn't be vaping in the building and I will never do this again. I know it is dangerous and I know it's against the facility policy to be doing vaping in the building." She stated she has been in-serviced and instructed on facility policy on smoking and vaping and she is aware she should not have done this. Interview with the Director of Nursing (DON) on 5/3/2021 at 3:00 PM, revealed the facility is a smoke free facility for the staff. She stated the residents are allowed to smoke at the designated times and in the designated areas. She stated the facility considers the electronic smoking devices as smoking devices and are prohibited for staff use on facility grounds. She stated she is unaware of any employees using a vaping device on facility property and if it did occur, a disciplinary action would be taken. Interview with the Assistant Director of Nursing	F 921	5/24/21, 5/26/21, and 5/28/21 which was three (3) times a week for three (3) weeks. (Exhibit FF) -Systematic changes will include rounds which began on 5/31/21 by Nursing Home Administrator/Director of Nursing Services/Assistant Director of Nursing/Unit Managers/Charge Nurses to ensure that the facilities smoking policy, that includes vaping is followed by all staff members one (1) time a week for twelve (12) weeks or until sustained compliance can be reached. (Exhibit GG) Any negative findings will be brought to the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. Findings were brought before our Quality Assurance Committee on June 24, 2021. (Exhibit D)Findings will continue to be reviewed in our Quality Assurance Performance Improvement Meeting in July and August.	

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F 921	Continued From page 20	F 921		

(ADON) on 5/6/2021 at 9:15 AM, revealed the facility is a smoke free facility except for the residents during their scheduled smoking times. Stated the employees cannot smoke or use smoking products on facility grounds. Stated some employees smoke at the road, but there is also a place on adjoining property that allows the facillity staff to use.

Interview with the Director of Nursing (DON) on 5/6/2021 at 11:55 AM, revealed the employees are not allowed to smoke or use smoking devices on facility property. Informed of the observation and interview with RN #2. DON asked if SA actually witnessed this occurring. Informed this was witnessed by SA and informed the DON of the exact observation and interview that occurred. DON stated the employees have been in-serviced of the facility's policy concerning smoking and electronic devices. The DON confirmed that someone vaping can cause personal risks to that individual. Also, confirmed that inhaling this mist could be a hazardous to other staff members and to the residents. DON stated it might be a fire hazard, depending on the vaping device being used. The DON confirmed that if residents witnessed this, they would be angry that the staff can do this and the residents can not and this could cause discontentment among the residents. The DON confirmed the facility failed to maintain a safe and smoke-free environment for the residents.