STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015397	A. BUILDING _____ B. WING _____	05/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	4411 MCALLISTER DRIVE HUNTSVILLE, AL 35805

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F 000	INITIAL COMMENTS A recertification survey was conducted by Ascellon Corporation on behalf of the State of Alabama, Department of Public Health (State Survey Agency) on 4/14/2021. Windsor House is not in compliance with applicable requirements of 42 CFR Part 483, Health Standard Requirements for Long Term Care Facilities. After a retrospective Quality Assurance Review and at the direction of the Centers for Medicare & Medicaid Services (CMS) Atlanta Regional Office, a survey team re-entered the facility from 5/25/2021 to 5/29/2021, to gather more evidence to determine the facility's compliance with Federal regulations, in addition to the investigation of a new complaint/report, AL00041387, received on 5/24/2021. The Statement of Deficiencies (FORM CMS-2567) was amended to reflect the facility's compliance status. Windsor House is not in compliance with applicable requirements of 42 CFR Part 483, Health Standard Requirements for Long Term Care Facilities.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		7/2/21

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

Electronically Signed | 06/23/2021

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F 580	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of a facility policy titled "Weight Loss	F 580	"This plan of correction constitutes a written allegation of substantial	

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F 580	Continued From page 2 Interventions", the facility failed to notify Resident Identifier (RI) #36's responsible party when RI #36, a resident with a history of weight loss, lost a severe amount of weight from October 2020 through March 2021. RI #36 went from 169.9 pounds to 132.0 pounds without the family being made aware of the continued weight loss. This deficient practice affected RI #36; one of three residents sampled for weight loss. Findings include: The facility's policy titled "Weight Loss Interventions", with an effective date of 3/16/2021, documented "PURPOSE To ensure adequate nutrition for those at risk for weight loss, etc. ... PROCEDURE ... 6. If weight has not stabilized or if the resident has lost 5% in one month ... the ... responsible party shall be notified ... 8. The ... responsible party shall be notified if weight loss continues ... ." RI #36 was admitted to the facility on 9/4/2019 with an admitting diagnosis of Dementia. The resident has a medical history to include a diagnosis of: Dysphasia, Oropharyngeal Phase. A review of RI #36's weights over a six-month period revealed the following: On 10/14/2020, RI #36 weighed 169.9 pounds On 11/25/2020, RI #36 weighed 157.4 pounds, a severe loss of 7.3% in one month On 12/17/2020, RI #36 weighed 149 pounds, a severe loss of 5.3% in one month On 1/18/2021, RI #36 weighed 137.9 pounds, a severe loss of 7.4% in one month On 2/10/2021, RI #36 weighed 134 pounds, a loss of 2.8% in one month On 3/15/2021, RI #36 weighed 132 pounds, a	F 580	compliance with Federal Medicare and Medicaid requirements." The submission of this response to the statement of deficiencies by the undersigned doe snot constitute an admission that the deficiencies existed or were correctly cited or require correction. F 580 1. RI # 36 current weight, historical weights, nutritional interventions and nutritional status was reviewed with Responsible Party on 5-28-2021 and 6-18-2021 by regional Nurse. 2. We acknowledge residents identified with significant weight loss have the potential to be affected by deficient practice. DON/Designee to conduct an audit of any significant weight loss over the past 30 days to ensure proper notification of the Responsible Party has been completed and is documented in the medical record. Any additional Responsible parties identified to not have documentation of notification in the medical record will be contacted and informed with review of intervention to address. Audit completed 6-18-2021 by regional Nurse. 3. DON/Designee to provide education to licensed nurses on expectation pf notification of change with significant weight loss or gain to the responsible party and documentation of notification to	

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F 580	Continued From page 3 loss of 1.9% in one month In an interview on 5/26/2021 at 5:56 PM, Employee Identifier (EI) #1, the Director of Nursing (DON) was asked who notifies the family of a resident's weight loss. EI #1 stated nursing. EI #1 said if the family was notified it should be in the nurses or dietary notes. A review of RI #36's nurses and dietary notes revealed no documentation of RI #36's responsible party being notified of the resident's weight loss. In a follow-up interview on 5/27/2021 at 11:00 AM, EI #1 said she was not sure if RI #36's family had been notified of the resident's weight lost but they should have been. During a telephone interview on 5/27/2021 at 11:51 AM, RI #36's responsible party stated she had never been notified of RI #36's weight losses.	F 580	be reflected in the electronic medical record. Education to be started on 6-21-2021 and completed no later than 7-2-2021. 4. DON/Designee to review weights monthly x 3 months or until sustained compliance can be reached to ensure any significant weight loss is reported to the responsible party and documented in the patient/resident electronic medical record. DON/Designee to report findings monthly x 3 months to center Quality Assurance Performance committee.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		7/2/21

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F 584	Continued From page 4 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of Resident Identifier (RI) #28's medical record, the facility failed to maintain the ceiling in RI #28's room. RI #28's ceiling was observed with different color paint and water spots. This deficient practice affected RI #28, one of 39 sampled residents. Findings include: RI #28 was admitted to the facility on 10/15/2019.	F 584	F584 1. RI # 28 ceiling was painted by Maintenance director on 5-7-21. 2. All patient/resident rooms (walls and ceilings) were inspected on 5/19/21. Any identified walls/ceilings in need of repair/painting were placed on repair/paint schedule to be addressed.	

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F 584	Continued From page 5 RI #28's Quarterly Minimum Data Set with an assessment reference date of 2/17/2021 indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. On 4/11/2021 at 3:48 PM, RI #28 stated he/she would like the ceiling painted. An observation of the ceiling in RI #28's room revealed the ceiling had two colors of paint and spots over the resident's bed that resembled water spots. RI #28 stated he/she had spoken to the facility's Administrator about the ceiling, but nothing had been done about painting it. On 4/12/2021 at 9:03 AM, Employee Identifier (EI) #17, the Maintenance Director stated he observed RI #28's ceiling and it needed to be painted. During an interview on 4/12/2021 at 9:54 AM, EI #18, the Administrator stated she didn't remember being calling to look at RI #28's ceiling. EI #18 stated she will look at it and have it painted.	F 584	3. Maintenance Director was in-serviced by Administrator on 5/6/2021 related to repair painting and repair schedule to identify all walls and ceilings in patient/resident room sin need of repair or painting. Maintenance Director/designee will conduct compliance rounds beginning 6-21-2021 to identify any needed repairs/maintenance issues in centerand place on repair/painting schedule and submit to Administrator for audit beginning week of June 21, weekly x 4 weeks, every 2 weeks x 2 then monthly thereafter. All routinely scheduled tasks are tracked in electronic system (TELS). Administrator monitors system weekly for compliance and completion of routine center maintenance tasks. 4. Administrator/designee will bring audit findings to the center monthly Quality Assurance committee meeting x 3 months or until sustained compliance is achieved.	
F 625 SS=F	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if	F 625		7/2/21

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F 625	Continued From page 6 any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a notice of bed-hold to the resident and/or their representative when Resident Identifier (RI) #59 and RI #78 were transferred to the local hospital. This deficient practice affected RI #59 and RI #78, two of three sampled residents reviewed for hospitalization, with the potential to affect all residents that are transferred to the hospital. Findings include: RI #59 was admitted to the facility on 4/6/2017. A review of RI #59's medical record indicated the resident was transferred to the local hospital on 12/1/2020, 1/30/2021 and 3/28/2021. RI #78 was admitted to the facility on 6/21/2011.	F 625	F 625 1. RI# 59 returned to center on 3-30-21 after a 2 day stay at the hospital. Bed was not released and resident was able to return to room upon readmission. RI #78 returned to center on 4-9-21 after a 2 day stay at the hospital. Bed was not released and resident was able to return to room upon readmission. 2. All residents transferred from the center to the hospital have the potential to be affected. Administrator and Business Office Manager will audit records from the past 3	

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F 625	Continued From page 7 A review of RI #78's medical record indicated the resident was transferred to the local hospital on 3/24/2021, 4/1/2021, and 4/7/2021. In an interview on 5/26/2021 at 5:36 PM, Employee Identifier (EI) #18, the facility's Administrator stated the facility does not issue a notice of bed-hold when a resident is transferred to the hospital. According to EI #18, the only time a notice of bed-hold was discussed was during the admission process.	F 625	months to determine other residents who were discharged without receipt of the center bed hold policy upon discharge. 3. Director of Clinical Operations provided education to the Administrator related to Bed Hold Policy and procedure for notification on 4-16-2021. Administrator provided education to Business Office Manager on 4-16-2021 related to sending Bed Hold Policy to responsible Party via mail within 24 hours of patient/resident discharge to hospital. Bed Hold Policy will be given to resident and/or family upon discharge to the hospital. Business Office Manager will report patients/residents who discharge to the hospital during Daily Connect meeting and will document on form F625 Bed Hold and submit to Administrator weekly beginning 5/17/2021 showing that bed hold information was mailed to responsible party. 4. Administrator/Designee will audit reports submitted (Form F625) by Business Office Manager to ensure all bed hold notices are emailed to responsible parties of all patients/residents discharged to the hospital from center x 4 weeks, monthly x 2 months, or until sustained compliance is achieved. Administrator/Designee will report audit findings to the center Quality Assurance meeting x 3 months.	

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure Resident Identifier (RI) #77's Quarterly Minimum Data Set (MDS) with an assessment reference date of 10/21/2020, accurately reflected the stage of RI #77's pressure ulcer. This deficient practice affected RI #77; one of 14 residents whose MDS assessments were reviewed. Findings include: RI #77 was originally admitted to the facility on 7/13/2020. RI #77's Admission MDS with an assessment reference date of 7/21/2020, revealed RI #77 had a Stage II pressure ulcer during this assessment period. RI #77's Quarterly MDS with an assessment reference date of 10/21/2020, revealed RI #77 had a Stage IV pressure ulcer during this assessment period. On 1/18/2021, RI #77 was transferred to a local hospital for evaluation. RI #77 returned to the facility on 1/26/2021, with a diagnosis of Pressure Ulcer of Sacral Region, Stage IV, with an onset date of 1/26/2021. RI #77's readmit "BODY AUDIT" sheet, dated	F 641	F 641 1. RI # 77 Quarterly MDS with ARD 10/21/20 amended/corrected by Registered Nurse Assessment coordinator on 6/18/21 to correctly reflect pressure ulcer as a stage 3. 2. We acknowledge residents with pressure ulcers have the potential to be affected by identified deficient practice. registered Nurse Assessment Coordinator/Designee to audit most recently completed MDS assessments for current residents identified to have pressure ulcers to ensure staging is accurately reflected on the assessment. Any additional inaccuracies identifies will be immediately corrected to reflect the actual stage. Audit completed 6-18-2021. 3. Director of Clinical Operations/Designee to provide education to MDS staff regarding the expectation of accuracy of assessments to reflect actual current status at time the assessment is complete specifically addressing the expectation of Pressure Ulcer staging to accurately reflect the most recent wound assessment completed within that assessment look back period. Education completed on 6-21-21.	7/2/21

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F 641	Continued From page 9 1/27/2021, revealed RI #77 had a State IV pressure ulcer to the sacral area. In an interview on 5/29/2021 at 8:50 AM, Employee Identifier (EI) #6, the Treatment Nurse said on RI #77's first admission to the facility, the resident had a Stage II pressure ulcer. When asked when did the pressure ulcer progress to Stage IV, EI #6 said when RI #77 returned from the hospital on 01/26/21, the Stage IV pressure ulcer was present. When asked why RI #77's 10/21/2020 Quarterly MDS assessment coded RI #77 as having a Stage IV pressure ulcer if the Stage IV was not identified until 1/26/2021, EI #6 said it looked like a coding error had occurred. EI #6 said from the facility's investigation, RI #77's pressure ulcer was identified as a Stage IV when the resident was readmitted on 1/26/2021. During an interview on 5/29/2021 at 10:19 AM, EI #7, the Registered Nurse MDS Coordinator was asked did she complete the Skin Section, Section M of RI #77's Quarterly MDS dated 10/21/2020. EI #7 said yes. When asked where she got the information RI #77 had a Stage IV pressure ulcer, EI #7 said from the documentation of the Physician's Progress notes and from EI #2, the Assistant Director of Nursing (ADON). EI #7 said the Physician's Progress notes made it sound like a Stage IV pressure ulcer, but the stage of the pressure ulcer was never documented. EI #7 said she received a verbal statement from EI #2 about the stage of RI #77's pressure ulcer. EI #7 said she never saw any documentation of the pressure ulcer being Stage IV. A review of RI #77's wound care orders dated 10/10/2020 and RI #77's Physician's Progress Notes dated 10/16/2020, did not reveal the wound	F 641	Registered Nurse Assessment Coordinator and Interdisciplinary team will discuss the MDS and appropriate documentation of wounds for residents during ARD period to assure accuracy. DON/Designee to audit 100% of resident with pressure ulcers MDS assessments completed monthly x 3 months or until sustained compliance can be reached to ensure MDS accurately reflects current staging of wounds. 4. DON/Designee to report audit findings monthly x 3 months to the monthly Quality Assurance Performance Committee.	

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F 641	Continued From page 10 had been staged as a Stage IV pressure ulcer. On 5/29/2021 at 11:08 AM, EI #2, the ADON was asked before RI #77's readmission to the facility on 1/26/2021, was RI #77 ever identified to have a Stage IV pressure ulcer to his/her sacral area. EI #2 said no. EI #2 said she never informed EI #7 that RI #77 had a Stage IV pressure ulcer to his/her sacrum. EI #2 said RI #77 only had the Stage IV pressure ulcer when the resident was readmitted back to the facility on 1/26/2021.	F 641		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on an observation, interviews, record review, and review of "FUNDAMENTALS OF NURSING", the facility failed to ensure a dressing remained on Resident Identifier (RI) #77's Stage IV sacral pressure ulcer as ordered by the physician. This deficient practice affected RI #77; one of two residents observed for wound care.	F 686	F 686 1. RI # 77 dressing was replaced by Charge Nurse 2. All residents with pressure ulcer have potential to be affected by this deficient practice.	7/2/21

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F 686	Continued From page 11 Findings include: Page 1209 of Chapter 48 titled "Skin Integrity and Wound Care" of "FUNDAMENTALS OF NURSING" with a copyright date of 2017, documented "... Purposes of Dressings ... When the skin is broken, a dressing helps reduce exposure to micro-organisms ... ." RI #77 was readmitted on 1/26/2021, with a diagnosis of Pressure Ulcer of Sacral Region, Stage IV. RI #77's Quarterly Minimum Data Set with an assessment reference date of 4/20/2021, revealed RI #77 had a Stage IV pressure ulcer during this assessment period. RI #77's May 2021 physician's order revealed an order dated 4/14/2021 for "... CLEAN WOUND TO SACRUM WITH NORMAL SALINE. PACK WITH HYDROGEL IMPREGNATED GUAZE (GAUZE) THEM APPLY NON-ADHERENT FOAM DRESSING EACH DAY AND AS NEEDED ... ." On 5/25/2021 at 3:28 PM, RI #77 was observed lying in bed on his/her left side with a wedge to his/her back. On 5/25/2021 at 4:05 PM, Employee Identifier (EI) #1, the Director of Nursing (DON) and EI #10, a Nursing Assistant (NA) removed the wedge from 77's back and repositioned RI #77. There was no dressing observed to the Stage IV pressure ulcer on RI #77's sacral area at this time. In an interview on 5/28/2021 at 9:30 AM, EI #10,	F 686	Skin sweep- center wide was conducted on 5-18-2021 with no new areas of concern identified, and wound dressings noted to be cleaned/dry/intact upon inspection. All patient/residents with wounds inspected by regional Treatment Nurse on 6-14-2021 and wound dressings were found to be present, clean/dry/intact. 3. Education provided to floor staff (Nurses and CNAs) that if CNAs observe open wound or soiled dressing during ALD care, they are to report to nurse for replacement, and Nurses are to observe wounds every shift to ensure dressings are clean/dry/intact. If dressing soiled or removed, refer to PRN order, replace and document PRN order administered. Education started on 6--3-21, to be completed by or before 7-2-21. Licensed Nurses are to check patients/residents with wounds and document on MAR daily during shift beginning 6/25/2021 that wound dressings have been observed to be clean/dry/intact. 4. DON/Designee to audit records of all patients/residents with wounds during Clinical Start-up meeting to ensure licensed nurses are checking wound dressing for clean/dry/intact weekly x 4 weeks. Any omissions will be identified and retraining provided by DON/Designee related to documentation of monitoring.	

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F 686	Continued From page 12 a NA said she had no idea why RI #77 did not have a dressing to his/her sacral area but there definitely should have been one there. During an interview on 5/28/2021 at 10:03 AM, EI #2, the Assistant Director of Nursing (ADON)/Infection Preventionist said when a resident has a pressure ulcer there should be a dressing covering the wound. When asked what the potential was for when wounds are not covered, EI #2 said infection. EI #2 said she was not made aware RI #77 did not have a dressing on his/her Stage IV pressure ulcer until a little after 5:00 PM on 5/25/2021. EI #2 said when she became aware RI #77 did not have a dressing on his/her pressure ulcer she went and put one on it.	F 686	DON/Designee will spot check wounds for wound dressings clean/dry/intact. 1 resident 5 x week x 1 week, 2 residents 2 x week x 1 week, 2 residents weekly x 4 weeks, then 3 residents monthly x 2 months. DON/Designee will report wound audit findings to center monthly Quality Assurance Committee x 3 months.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		7/2/21

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F 690	Continued From page 13 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview, review of Resident Identifier (RI) #59's medical record and the facility's "Diversicare Restorative Guideline", the facility failed to assess RI #59, a resident having occasional incontinent episodes of bladder; and a history of falls when going to and from the bathroom, for a toileting program. This deficient practice affected RI #59; one of two residents reviewed for bowel and bladder incontinence. Findings include: RI #59 was admitted to the facility on 4/6/2017. RI #59's Admission Minimum Data Set with an assessment reference date of 4/13/2017, indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. RI #59 was assessed as being occasionally incontinent of bladder and not on a urinary toileting program during this assessment period.	F 690	F 690 1. RI # 81 discharged from center 5-22-2021, return not anticipated. EI # 4 (HIMC)was provided one on one education by the Director of Clinical Operations on 6-17-2021 regarding the expectation of Professional Standard of Practice regarding physician orders transcription accuracy. RI # 59 assessed by DON on 6-22-2021 for occasional incontinence and placed on a toileting plan with plan of care updated to reflect current status. 2. We acknowledge residents with physician orders for indwelling catheters and occasional incontinence have the potential to be affected by the identified deficient practice.	

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F 690	Continued From page 14 The facility's "Diversicare Restorative Guideline" dated June 2019, documented "Purpose Restorative services refers to nursing interventions to assist the resident in reaching his/her highest level and then maintain that function ... Restorative Considerations ... Bladder Training and Scheduled Toileting ... Key Elements: Residents will benefit from a restorative program in order to sustain function and/or to continue to progress toward functional goals after formalized therapy ... ." RI #59's Quarterly MDS with an assessment reference date of 9/14/2020, indicated the resident was cognitively intact with a BIMS of 13. RI #59 was assessed as being occasionally incontinent of bladder and not on a urinary toileting program during this assessment period. According to RI #59's medical record, the resident experienced a fall on 10/22/2020 when coming from the bathroom. RI #59's Quarterly MDS with an assessment reference date of 12/15/2020, indicated the resident was cognitively intact with a BIMS of 13. RI #59 was assessed as being occasionally incontinent of bladder and not on a urinary toileting program during this assessment period. According to RI #59's medical record, the resident experienced a fall on 2/20/2021 when coming from the bathroom. RI #59's Annual MDS with an assessment reference date of 3/11/2021, indicated the resident was cognitively intact with a BIMS of 14. RI #59 was assessed as being occasionally incontinent of bladder and not on a urinary	F 690	On 6-22-2021 an audit will be conducted to DNS/Designee of current residents with indwelling catheters to ensure MD orders in place for monitoring and changing are present in the current orders. No other current residents were found to be affected by the identified deficient practice. On 6-18-2021 thru 6-22-2021 an audit of residents coded to have occasional incontinence was completed by the DON/Designee to determine if a toileting plan is appropriate. If found to be appropriate a toileting plan will be developed and care plan updated to reflect the plan. 3. DON/Designee to provide education to licensed nurses regarding Professional Standards of Practice regarding physician order transcription and the expectation of accurate transcription of newly received physician orders. Education started on 6-22-2021 to be completed no later than 7-2-2021. DON/Designee will provide education to MDS staff 6-22-2021 regarding the expectation of assessing for appropriate toileting plan with MDS assessments that reflect occasional incontinence - if found to be appropriate expected to implement the plan and update plan of care to reflect the plan. DON/HIMC/Designee to review new	

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F 690	Continued From page 15 toileting program during this assessment period. According to RI #59's medical record, the resident experienced a fall on 3/28/2021 and 4/8/2021 when going to the bathroom. On 5/28/2021 at 4:51 PM, the surveyor conducted an interview Employee Identifier (EI) #1, the Director of Nursing. When asked when residents are placed on a toileting program, EI #1 said when a pattern is needed to identify the times a resident usually voids. EI #1 said the resident is usually continent or frequently incontinent of bowel and bladder when a toileting program is initiated. EI #1 said the facility did not have any residents on a toileting program at the time. EI #1 said the reason for that was usually the incontinent residents are checked and changed every two hours and the continent residents are encouraged and assisted to the restroom approximately every two hours as the resident will allow. When asked how many of RI #59's falls occurred when the resident was going to or coming from the bathroom, EI #1 replied, four. When asked if the facility ever considered RI #59 would benefit from a toileting program, EI #1 said no because RI #59 was leaning on furniture when coming out of the bathroom. When asked what the one factor was of four of the falls, EI #1 said the use of the bathroom. EI #1 said to her knowledge RI #59 had not been considered for a toileting program. The surveyor asked EI #1 what would a toileting program do for the resident. EI #1 said it would help the staff and resident know the time a resident normally voids. When asked would RI #59 benefit from being placed on a toileting program, EI #1 said yes.	F 690	physician orders during morning clinical start-up meeting to verify accurate and complete transcription completed. Any identified transcription discrepancies to be addressed when identified and followed up with re-education with licensed nurse to have had the transcription error. DON/Designee to complete physician order audits of 100% of new physician orders received 5 x week x 4 weeks, then 3 x week x 4 weeks, then weekly or until sustained compliance can be reached to ensure physician orders are transcribed accurately by the licensed nurse. DON/Designee to audit 100% of completed MDs assessments monthly x 3 months or until sustained compliance can be reached to ensure coded with occasional incontinence to identify if appropriate candidates for a scheduled toileting plan and if deemed appropriate plan of care updated to reflect the toileting plan. 4. DON to report audit findings monthly x 3 months to the center monthly Quality Assurance Improvement Committee.	
F 692 SS=G	Nutrition/Hydration Status Maintenance	F 692		7/2/21

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F 692	Continued From page 16 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interviews, review of Resident Identifier (RI) #36's medical record, and the facility's policy titled "Weight Loss Interventions", the facility failed to ensure nutritional interventions were implemented when RI #36 experienced a severe weight loss from November 2020 to January 2021. Beginning 11/25/2020, RI #36 experienced a severe weight loss of 7.3% in one month. There were no nutritional interventions to address the resident's weight loss until 1/18/2021. This deficient practice affected RI #36; one of three residents reviewed for weight loss. Findings include:	F 692	F 692 1. RI # 36 Medical record reviewed by DNS/Designee on 6-22-21 and validated nutritional interventions have been implemented and are currently reflected on the plan of care. 2. Residents with dietary recommendations to address weight loss have the potential to be affected by the deficient practice. DON/Designee to review Dietary	

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F 692	Continued From page 17 RI #36 was admitted to the facility on 9/4/2019 with an admitting diagnosis of Dementia. The resident has a medical history to include a diagnosis of: Dysphasia, Oropharyngeal Phase. RI #36's care plan titled "I am at risk for altered nutritional status related to Dementia" with an initiated date of 9/30/2019, had an intervention of "Consult RD PRN (as needed) ... ." RI #36's Quarterly Minimum Data Set with an assessment reference date of 11/20/2020 indicated the resident was moderately impaired in cognitive skills with long- and short-term memory problems. The resident was assessed as requiring supervision with eating. A review of RI #36's weights over a six-month period revealed the following: On 10/14/2020, RI #36 weighed 169.9 pounds On 11/25/2020, RI #36 weighed 157.4 pounds, a severe loss of 7.3% in one month On 12/17/2020, RI #36 weighed 149 pounds, a severe loss of 5.3% in one month On 1/18/2021, RI #36 weighed 137.9 pounds, a severe loss of 7.4% in one month On 2/10/2021, RI #36 weighed 134 pounds, a loss of 2.8% in one month On 3/15/2021, RI #36 weighed 132 pounds, a loss of 1.9% in one month RI #36's Quarterly Minimum Data Set with an assessment reference date of 2/18/2021 indicated the resident was moderately impaired in cognitive skills with long- and short-term memory problems. The resident was assessed as requiring limited assistance with eating.	F 692	recommendations made within the last 30 days to validate recommendations have been implemented appropriately. No other residents were found to be affected by the deficient practice. Audit to be completed on 6-25-21. 3. Administrator will provide education to nursing administration on 6/22/21 regarding the expectation of completion of dietary consultant recommendations within 5 days of receipt. Any dietary recommendations will be reviewed at least weekly in clinical start up by the interdisciplinary team for follow up as needed. residents on the recommendation list will be reviewed weekly until weight improved and/or stabilized. Administrator/Designee to audit dietary recommendations weekly x 12 weeks or until sustained compliance can be reached to ensure recommendations have been implemented timely. 4. Administrator/Designee to report audit findings monthly x 3 months to the center monthly Quality Assurance committee meeting.	

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The facility's policy titled "Weight Loss Interventions", with an effective date of 3/16/2021, documented "PURPOSE To ensure adequate nutrition for those at risk for weight loss, etc. ... PROCEDURE ... When a resident loses 3% or more in one month ... the following steps shall be taken: ... 2. At the weekly Focus Meetings all possible causes for poor consumption shall be reviewed including: ... d) Need to review and update of the resident's personal food preferences ... 6. If weight has not stabilized or if the resident has lost 5% in one month ... the RD ... shall be notified and a revised plan shall be suggested, such as: A high calorie/protein snack, such as peanut butter, cheese, cottage cheese, etc. may be provided as an extra H.S. (bed time) snack ... 13. The RD will enter a progress note and will write monthly progress notes until the problem is resolved. They will enter documentation in the progress note describing the status of the residents condition related to nutritional therapy ... ."

A review of RI #36's dietary notes revealed there was no progress notes addressing nutritional interventions for RI #36's severe weight loss of 7.3% in one month on 11/25/2020, or the severe weight loss of 5.3% in one month on 12/17/2020.

During an interview on 5/27/2021 at 11:00 AM, Employee Identifier (EI) #1, the Director of Nursing was asked had RI #36 had any weight loss. EI #1 said yes. According to EI #1 on 10/14/2020, RI #36 weighed 169.9 pounds and RI #36's next month's weight on 11/25/2020, was 157.4 pounds. EI #1 said that was a 12.5-pound weight loss over a month. When asked was the RD, EI #8, consulted for the weight loss at that time, EI #1 said that would be something EI #9,

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the Dietary Manager (DM) does. EI #1 said she was not sure this was done. EI #1 said RI #36's next month's weight was 149 pounds on 12/17/2020. EI #1 said this was a loss of 8.4 pound over a month. When asked was this weight loss addressed by the RD, EI #1 said no but it should have been. EI #1 stated she attributes the resident's weight loss to COVID-19 and the constant walking he/she does. EI #1 explained the resident is constantly walking and that burns calories.

According to RI #1's diagnoses information, on 1/1/2021, the resident obtained a new diagnosis of personal history of COVID-19.

In a telephone interview with RI #36's emergency contact, she stated RI #36 usually body weight is between 130 and 140 pounds. While RI #36's emergency contact was not aware of the resident's weight loss, she had no concerns regarding the care the resident has received at the facility.

On 5/27/2021 at 3:52 PM, a telephone interview was conducted with EI #8, the Consulting RD. EI #8 was asked if she was familiar with RI 36 and she said yes. E #8 stated RI #36 had been in the facility since 2019 and when the resident was first admitted, the resident weighed 131 pounds. When asked how often residents are weighed at the facility, EI #8 replied on admission to establish his/her weight, then weekly or monthly. According to EI #8, RI #36's ideal body weight is between 117 and 143 pounds. When the RD Nutritional Assessment was done on 10/14/2020, this was the annual assessment and RI #36 weighed 169.9 pounds; the resident was above his/her ideal body weight. Then on 11/25/2020,

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RI #36's weight was listed as 157.4, which is a 7.4% weight loss from the previous month. EI #8 stated she didn't implement any interventions at this time because the resident was above his/her ideal body weight and the resident was a walker and that may have been a contributing factor. EI #8 stated then on 12/17/2020, the resident's weight was 149 pounds. EI #8 stated this was a 5.3% weight loss in one month; however, she was not aware of this weight. EI #8 stated while the resident was still within his/her ideal body weight, she would have recommended to review the resident's food preferences to see if the staff could get the resident to eat more of his/her meals. RI #36's next weight of 137.9 was recorded on 1/18/2021. This was a 7.4% weight loss in one month. When asked what interventions were implemented as the result of this weight loss, EI #8 stated fortified food. EI #8 was asked what could she attribute RI #36's weight loss to. EI #8 replied, it could have been from the resident's increased activity of walking. EI #8 stated she reviewed the resident's intake and it ranged from 25% to 100%. EI #8 stated she could not give a definitive reason/explanation for the resident's weight loss. Since the weight loss, appropriate interventions have been implemented and the resident has maintained his/her weight in the ideal body weight range.

In a follow-up telephone interview on 5/29/2021 at 6:06 PM, EI #8 stated again that she was not made aware of RI #36's weight of 157.4 pounds on 11/25/2020 but she should have been because it was a weight loss over 5% in one month. EI #8 stated had she been aware, she would have recommended some form of food preference or snack intervention. If the resident was not eating, she would have recommended a supplement. If

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F 692	Continued From page 21 the resident was eating, she would have recommended a snack. A telephone call/interview with the facility's Dietary Manager, EI #9, on 5/29/2021 was unsuccessful. From 5/25/2021 to 5/29/2021, RI #36 was observed for breakfast, lunch and dinner meals by the survey team. The resident was provided the correct, palatable diet with nutritional interventions. The staff provided verbal cues and assistance during each meal and the resident consumed 50% to 75% of each meal.	F 692		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		7/2/21

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F 761	Continued From page 22 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to discard the expired Lantus pen of Resident Identifer (RI) #67 and further failed to label and date the inhaler for RI #68. These deficient practices affected RI #67 and RI #68, and were oberved on one of two medication carts in the facility. Findings include: The facility's policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles," revised 10/28/2019, documented " ... This Policy ... sets for the procedures relating to the storage and expiration dates of medications, biologicals, syringes and needes ... PROCEDURE ... 4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; ... are stored separate from other medications until destroyed ... 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened ... ." During an observation of the medication cart on 4/11/2021 at 2:56 PM, RI #67's Lantus pen had an opened date of 2/27/2021. Employee	F 761	F 761 1. RI # 67 Lantus pen discarded by Nurse in medication destruction bin. RI # 68 inhaler was labeled and dated by Nurse and placed back in medication cart. 2. All residents receiving insulin or inhalers have the potential to be affected by the deficient practice. All of the medication carts were checked for expiration dates and labels on 6-22-2021 by licensed Nurse. any expired medications were destroyed. 3. Education/retraining will be provided by DON/Designee for licensed nursing staff related to observation for any expired medications on medication carts or in medication rooms, ensure medications are appropriately labeled with open dates/expiration dates. Education to begin 6-22-21 and will be completed by or before 7-2-21. All medication cart/medication rooms will be checked twice weekly x 4 weeks beginning 6-22-2021 by the DNS/Designee for any expired medications and to ensure all insulin pens and inhalers are labeled and dated. 4. DON/Designee to report audit findings	

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F 761	Continued From page 23 Identifier (EI) #19, a Licensed Practical Nurse (LPN) said the pen should be discarded 28 days after opening. Also observed on the medication cart was RI #68's Breo Ellipta inhaler; the inhaler and the packages did not have an opened date. The manufacture's information indicated " .... Discard BREO ELLIPTA 6 weeks after opening the foil traym ... ."	F 761	monthly x 3 months to the center monthly Quality Assurance Committee	
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and	F 790		7/2/21

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F 790	Continued From page 24 (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct an investigation when Resident Identifier (RI) #36, an ambulatory cognitively impaired resident brought an implant/bridge to a licensed nurse on 10/20/2020. The facility failed to conduct an investigation to determine whose implant/bridge this was. This deficient practice had the potential to affect one of the 82 residents who reside at the facility. Findings include: RI #36 was admitted to the facility's secured unit on 9/4/2019 with an admitting diagnosis of Dementia. RI #36's Quarterly Minimum Data Set with an assessment reference date of 2/18/2021 indicated the resident was moderately impaired in cognitive skills with long- and short-term memory problems. RI #36 was assessed as requiring supervision with walking in room and corridor and locomotion on and off the unit. RI #36's progress note dated 10/20/2020 10:44 PM written by Employee Identifier (EI) #14, a	F 790	F 790 1. RI # 36 was assessed by Dentist and found to have no issues in March. Dentist evaluated resident again 6/17/21. 2. We acknowledge residents with dental needs have the potential to be affected by the deficient practice. Dentist made rounds 6-17-21 for routine follow-up. DON/Designee will check residents for dental need on 6-23-21 for all patients/residents not seen by dentist 6-17-21 to ensure no current dental needs. If needs are identified, physician and Dentist will be notified for intervention. Oral assessments to be completed by or before 7-2-2021. 3. Oral care will be provided daily by nursing team. Any identified soreness or redness will be discussed with DNS/Designee who will follow up with physician. Social Service Director will assure and residents needing dental care	

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F 790	Continued From page 25 Licensed Practical Nurse (LPN) documented "At 3:15pm resident came to nurse and gave me (his/her) left front tooth implant/bridge (two connected teeth noted with a post extending from the root of one. Resident denies pain, no bleeding noted. Root of the left tooth is visible from the gumline. No complaints during the shift. Ate supper without difficulty. Will continue plan of care." During a telephone interview that began on 5/26/2021 at 4:26 PM, EI #14, a LPN was asked about the situation when RI #36 brought her an implant/bridge. EI #14 stated she was shocked when the resident brought it to her. EI #14 stated she looked in the resident's mouth and didn't see any bleeding or anything. EI #14 stated that evening for dinner she observed the resident and there were no problems with eating. When asked who did the implant/bridge belong to, EI #14 said RI #36. During an interview on 5/26/2021 at 5:56 PM, EI #1, the Director of Nursing stated she became aware on 10/21/2020 that RI #36's implant/bridge had come out via reading the nurses' notes and the facility's morning meeting. EI #1 stated on 10/21/2020, she went and assessed the resident's mouth and gum line. She stated there was no redness, swelling or bleeding and the resident did not voice or show signs of pain or discomfort. When asked if she had done an investigation to determine who the implant/bridge belonged to, EI #1 said no. In a telephone interview with RI #36's emergency contact on 5/27/2021 at 11:51 AM, she was asked did RI #36 have an implant/bridge when admitted to the facility. The emergency contact	F 790	will have dentist visit. Any issues with dentures will be discussed for a follow up at daily clinical start up by the interdisciplinary team for follow up. DON/Designee to audit 100% of new admissions monthly x 3 months for dental needs upon admission and ensure dental appointments are scheduled to address needs as identified. If any needs are identified Social Services Director will make needed dental appointments. 4. DON/Designee to report audit findings monthly x 3 months to center monthly Quality Assurance Committee.	

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F 790	Continued From page 26 said no, the resident only had his/her natural teeth. She stated RI #36 has never had an implant/bridge. RI #36's "Clinical Health Status Evaluation" dated 9/5/2019 indicated the resident has his/her own natural teeth. According to documentation within RI #36's medical record, the resident refused to be seen by the dentist on 2/12/2020. During the dental exam on 3/19/2021, the comprehensive oral evaluation was within normal limits; no concerns noted.	F 790		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		7/2/21

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F 842	Continued From page 27	F 842		

all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 28 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, review of Resident Identifier (RI) #36's medical record and the facility's policy titled "Weight Loss Interventions", the facility failed to consistently document the meal intake of RI #36, a resident with a history of weight loss. This deficient practice affected RI #36; one of three residents reviewed for weight loss. Findings include: RI #36 was admitted to the facility on 9/4/2019 with an admitting diagnosis of Dementia. The resident has a medical history to include a diagnosis of: Dysphasia, Oropharyngeal Phase. A review of RI #36's "Windsor House Documentation Survey Report v2 (Flow Sheet)", under the task of "Nutrition - Amount", revealed there was no documented percentage of RI #36's meal consumption for seven of 90 meals served during October 2020. A review of RI #36's "Windsor House Documentation Survey Report v2", under the task of "Nutrition - Amount", revealed there was no documented percentage of RI #36's meal consumption for 27 of 90 meals served during November 2020. A review of RI #36's "Windsor House Documentation Survey Report v2", under the task of "Nutrition - Amount", revealed there was no documented percentage of RI #36's meal	F 842	F 842 1. RI # 36 meal intake verified to be documented for all three meals 6-21-21. Current weight noted to be stable at %123 on 6-14-21. 2. We acknowledge residents who receive nutrition from dietary have the potential to be affected by the identified deficient practice. DON/Designee audited meal intake consumption documentation of 5-1-21 thru 5-31-21 and findings noted multiple omissions of intake percentages of meals. 3. DON/Designee to provide education to direct care staff regarding expectation of documentation of meal intake at he completion of each meal in the point of care to be reflected in the resident's electronic medical record. Education to begin 6-21-21 and will be completed by or before 7-2-21. DON/Designee to audit meal intake beginning during clinical start up meeting 6-21-21 daily x 1 week, then 5x week x 4 weeks, then weekly x 4 weeks or until sustained compliance can be reached. re-education to be provided for staff for any omissions identified through the audit	

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F 842	Continued From page 29 consumption for 68 of 90 meals served during December 2020. A review of RI #36's "Windsor House Documentation Survey Report v2", under the task of "Nutrition - Amount", revealed there was no documented percentage of RI #36's meal consumption for 24 of 90 meals served during January 2021. A review of RI #36's "Windsor House Documentation Survey Report v2", under the task of "Nutrition - Amount", revealed there was no documented percentage of RI #36's meal consumption for 34 of 84 meals served during February 2021. A review of RI #36's "Windsor House Documentation Survey Report v2", under the task of "Nutrition - Amount", revealed there was no documented percentage of RI #36's meal consumption for 35 of 90 meals served during March 2021. The facility's policy titled "Weight Loss Interventions", with an effective date of 3/16/2021, documented "PURPOSE To ensure adequate nutrition for those at risk for weight loss, etc. ... PROCEDURE ... 4. ... The CNA (Certified Nursing Assistant) will document on the Flow Sheet, the percentage of consumption of each meal ... ." During a telephone interview that began on 5/26/2021 at 4:26 PM, Employee Identifier (EI) #14, a Licensed Practical Nurse was asked where are RI #36's meal percentage charted. EI #14 said in the computer under RI #36's Activities of Daily Living portion of eating. When asked who	F 842	process. 4. DON/Designee to report audit findings monthly x 3 months to the center monthly Quality Assurance Committee.	

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F 842	Continued From page 30 was responsible for charting RI #36's meal percentage, EI #14 said the Certified Nursing Assistants. When asked why it was important for the meal percentage to be recorded, EI #14 said it showed how much the resident did or did not eat.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		7/2/21

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F 880	Continued From page 31 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure Employee Identifier (EI) #10, a Nursing Assistant (NA), changed her	F 880	F880 1. RI #77 assessed by licensed nurse on	

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F 880	Continued From page 32 contaminated gloves during the provision of incontinence care for Resident Identifier (RI) #77. This deficient practice affected RI #77; one of one resident observed for incontinence care. Findings include: RI #77 was originally admitted to the facility on 7/13/2020 with a principal diagnosis of Alzheimer's Disease. RI #77's Quarterly Minimum Data Set with an assessment reference date of 4/20/2021, revealed RI #77 was totally dependent on staff for toileting and personal hygiene and always incontinent of bowel and bladder. During the provision of incontinence care on 5/25/2021 at 4:05 PM, EI #10, a NA used Procare disposable large adult washcloth and wiped RI #77's groin area and labia using different wipes. There was a small amount of bowel noted in RI #77's inner buttocks; EI #10 wiped the bowel off four times, using different wipes. EI #10 picked up a clean adult brief, with the contaminated gloves still on, and positioned the brief to RI #77's back. With the contaminated gloves still on, EI #10 picked up the tube of skin barrier, squeezed the barrier on her contaminated gloves and rubbed the barrier cream onto RI #77's buttocks. With the same contaminated gloves still on, EI #10 rubbed skin barrier in RI #77's groin areas and fastened the right side of RI #77's adult brief. EI #10 pulled RI #77's gown down, touched the incontinent pad, helped to reposition RI #77 by placing a pillow under RI #77's left elbow, pulling the sheet over RI #77, and letting the head of bed of RI #77 up.	F 880	6-1-21 and found to be stable with no negative effects observed as a result of these observed deficient practice. EI # 10 provided one on one education by Regional Nurse on 6-11-21 regarding infection control practices including hand hygiene to be performed with incontinent care before donning gloves and after doffing gloves. Reviewed the required need to change gloves and perform hand hygiene each time they go from dirty prior to going back to clean. Incontinent care technique observed as well as infection control precautions/hand hygiene checkoff conducted. 2. We acknowledge residents dependent on staff for incontinent care that were assigned to RI #10 had the potential to be affected by the identified deficient practice. Residents checked DNS and no adverse effects noted from potential exposure to deficient practice identified. 3. Administrator/Interdisciplinary team to complete a Root cause Analysis under the guidance of the required Directed Plan of Care- Root Cause Analysis to be completed to determine solution and system changes to result in sustained compliance. RCA to be completed by 6-22-21. DON/Designee to provide all staff education regarding the facility Infection Control Program and all staff members to	

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WINDSOR HOUSE	4411 MCALLISTER DRIVE HUNTSVILLE, AL 35805

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F 880	Continued From page 33 On 5/27/1021 at 5:45 PM, the surveyor conducted an interview with EI #10. The surveyor read back the observed incontinence care observation and asked EI #10 what she failed to do. EI #10 said she did not change her gloves. When asked what it was considered when gloves are not changed when going from dirty to clean items, EI #10 said contamination. EI #10 said she was last in-serviced on infection control in orientation. EI #10 was asked when she was told she needed to change her gloves during incontinent care. EI #10 said she was told to be aware of her glove use and every time she went from dirty to clean to change her gloves. A review of EI #10's "Temporary Nurse Aide Skills Competency Checklist" revealed on 7/18/2020, EI #10 had been checked off on "Preventing Infection While Providing Personal Care." In an interview on 5/28/2021 at 10:03 AM, EI #2, the Infection Preventionist Nurse. was asked during incontinence care, when should gloves be changed. EI #2 said change gloves several times when going from one area to another, washing your hands or using hand sanitizer in-between. EI #2 said when not changed in this manner there was a potential for infection, Urinary Tract Infections, and yeast. EI #2 said CNAs are taught in orientation they are to change their gloves frequently. SYLVIA FOREMAN, REGISTERED NURSE SUSAN DANNELS, LAURA DEWAN, PATRICIA STEWARD, KIMBERLY SMITH, REGISTERED NURSE TONYA GREEN,	F 880	watch the mandated video by the CDC-"Clean Hands" All education and completion of staff watching the video will be completed by no later than 7-2-21. Administrator to initiate a letter on facility letter head that will be notarized which will summarize the circumstances that contributed to the identified deficient practice determined from RCA which contributed to the development of the education provided to all staff inclusive of Agency and Contract employee providing direct patient care in the facility. The letter along with a chart disclosing all staff who completed the educations name, department, title, and date video module observed. Attestation/Summary letter to be completed by no later than 7-2-21 and sent to the Bureau of Health Provider Standards Division of Health Care. DON/Designee will conduct incontinent care competency check offs for certified nursing assistants. Competency check will be completed by n later than 7-2-21. Hand hygiene audits to be conducted on 5 employees per week x 4 weeks, then 3 employees per week x 4 weeks, then 1 per week x 4 weeks or until sustained compliance can be reached. 4. DON/Designee to report competency checks and audit findings monthly x 3 months to the center monthly Quality Assurance Improvement Committee meeting.	