STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. Building B. Wing	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Mooresville	752 E Center Avenue Mooresville, NC 28115

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on observations, record review, resident, and staff interview the facility failed to treat Resident #40 in a dignified manner when she turned her call light on for assistance and three staff members entered her room without asking Resident #40 what she needed and turned her call light off without meeting Resident #40's need which made her feel sad and worthless like the staff did not care about her or her needs. The facility also failed to treat Resident #15 in a dignified manner when a Cook at the facility spoke loudly to Resident #15. This affected 2 of 4 residents reviewed for dignity. The findings included: 1. Resident #40 was admitted to the facility on [DATE] with diagnoses that included diabetes, cerebral vascular accident (CVA), chronic kidney disease, and congestive heart failure (CHF). The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #40 was cognitively intact with the ability to make her needs known and needed extensive to total care for her activities of daily living (ADL) to include transfers, bed mobility, and toileting. It further indicated Resident #40 was always incontinent of bowel and bladder and had no behavioral issues such as rejection of care. Resident #40 had a fall care plan dated 05/14/20 which indicated she was to have her call light in reach at all times and encouraged her to use it. (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	A continuous observation and interview with Resident #40 on 06/21/21 beginning at 3:23 PM and ending at 4:00 PM in Resident #40's room revealed she was sitting up in her wheelchair facing the bed with the call light on. The signage on the door indicated Resident #40 was on Enhanced Droplet Isolation Precautions. Resident #40 mentioned she had her call light on to request assistance from staff and she felt staff were reluctant to answer her call light because they had to garb up (don full personal protective equipment-PPE) just to provide her pain medications or assist her to the toilet. Resident #40 continued to say staff did not answer her call light recently when she slid from her wheelchair and another resident went to obtain help after she had hollered for a while. She stated when there were substantial delays in answering her call light almost daily and staff not addressing her needs when they did enter her room, it made her feel sad, worthless, and as though staff did not care about her or what her needs were. Resident #40 mentioned she had complained in the past (although she could not recall an exact date) to the former Director of Nursing about staff not answering lights timely and was told they would monitor this, but while being on the quarantine unit it was taking longer again. At approximately 3:35 PM, the facility Administrator opened the door without knocking and looked in the room and made eye contact with the surveyor in the room, did not address Resident #40's needs, and turned and shut the door. Shortly following that at 3:47 PM, Laundry Worker (LW) #1 and Nurse Aide (NA) #2 entered the room to return a mesh bag of laundry belonging to Resident #40. NA #2 then turned off Resident #40's call light without asking how she could address her needs and turned and left the room with LW #1. During the 37- minute continuous observation, Resident #40's needs were not addressed by a staff member. An interview on 06/21/21 at 4:05 PM with NA #2 revealed she was assigned to work with Resident #40 on that shift. She acknowledged she had entered the room to return the laundry provided by LW #1 and had turned the call light off without thinking about asking what Resident #40 may have needed. NA #2 indicated she was aware she had sustained multiple falls and was a high fall risk and required assistance with her ADL. NA #2 stated she had been taught to answer all call lights timely and address the request of the resident. She indicated she was not to turn off the call light unless she was able to address the need of the resident, but all staff were to answer resident call lights. NA #2 stated she would try to do a better job in addressing her needs timely. An interview on 06/24/21 at 2:00 PM with the Director of Nursing (DON) revealed all staff had been trained to answer and address call lights timely. She acknowledged Resident #40's call light should have been addressed before she waited over 30 minutes with the light on and NA #2 should not have turned the call light off without helping Resident #40. The DON was unaware Resident #40 felt as though staff did not care about her or her needs, but indicated it was unacceptable to not assist a resident or get the appropriate person to help before turning a call light off. An interview on 06/25/21 at 2:46 PM with the Administrator revealed he did not recall opening the door to Resident #40's room without knocking or addressing her needs on 06/21/21. He elaborated he expected all staff to address call lights timely and treat all residents with dignity and respect. 35789 2. Resident #15 was readmitted to the facility on [DATE] with diagnoses that included diabetes, heart failure, osteoarthritis, and others. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Review of a comprehensive Minimum Data Set (MDS) dated [DATE] revealed that Resident #15 was cognitively intact for daily decision making and required extensive assistance with activities of daily living. An interview was conducted with Resident #15 on 06/21/21 at 12:50 PM. Resident #15 stated that on April 05, 2021 Cook #1 was in the hallway and she stated to him that he had prepared a salad a few days prior that was not acceptable. Resident #15 explained that it was a chef salad that did not have any meat on it and the lettuce was wilted. She stated that Cook #1 began to speak very loudly and rudely and began to argue with her and stated that she was the reason he was going to quit. Resident #15 also stated that Cook #1 stated that he was not going to do anything else to accommodate Resident #15 before leaving the hallway directly in front of her room. She added that the Director of Nursing (DON) was in her office next door to Resident #15 and overheard the verbal exchange. Resident #15 stated that she was fearful of eating anything he served and when he was cooking, she generally would order outside food. An interview was conducted with Cook #1 on 06/23/21 at 12:15 PM. Cook #1 stated that a few days prior to April 05, 2021 he was preparing salads for the evening meal and was running low on salad mix and had to split it up between all the residents that ordered salads that night. Cook #1 stated that Resident #15 got the skimpy one and was not up to Resident #15's standards. Cook #1 continued to say that on April 05, 2021 he was in the hallway and Resident #15 began to complain about her salad that she received a few days prior and he took it very personal and raised my voice with Resident #15. Cook #1 stated that he could not recall the exact words that were used but stated there were no curse words but the way he spoke to Resident #15 was inappropriate. He added that he prepared Resident #15's meal just as he did all the other residents and he had taken it personal that she did not enjoy the salad he had prepared for her despite it being skimpy. An interview was conducted with the DON on 06/24/21 at 3:06 PM. The DON stated that on April 05, 2021 she was in her office with the door open which was next door to Resident #15's room. The DON stated that she heard Cook #1 very loudly say, I am not going to do anything extra for you anymore. The DON stated that it shocked her because no staff member should be that loud in the hallway while speaking to a resident. The DON stated she got up and went to the hallway and Cook #1 had already reached the nurses station and was on his way back to the kitchen. She stated she went into Resident #15's room and she was very upset and stated that she did not want Cook #1 preparing her meals anymore. The DON stated she never spoke to Cook #1 about the incident but did report it to the previous Administrator. The DON stated she did not want the staff speaking to the residents in the manner and tone that Cook #1 spoke to Resident #15 in on that day. An interview was conducted with the Administrator on 06/25/21 at 2:46 PM. The Administrator stated that he expected the staff to treat the resident with respect and dignity and it was not appropriate to speak to Resident #15 in a loud/rude tone.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on observations, record review, staff and resident interviews the facility failed to provide access to the call light system for 1 of 58 residents (Resident #33) reviewed for accommodation of needs and failed to provide the appropriate sized incontinent product for 1 of 10 dependent residents (Resident #7) reviewed for activities of daily living. The finding included: Resident #33 was admitted to the facility on [DATE] with diagnoses that included cerebral vascular accident (CVA). The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33's cognition was moderately impaired and required supervision assistance of one staff for all her activities of daily living. The MDS also indicated Resident #33's balance was not steady, and she was occasionally incontinent of bladder. A review of Resident #33's care plan dated 05/12/21 revealed she was at risk for falls related to a recent CVA with the goal that she would be free from falls through the next review date. The interventions utilized to obtain the goal included: ensuring the call light was within reach and encourage Resident #33 to use it as well as having a workable and reachable call light. On 06/23/21 at 2:25 PM an observation and interview with Resident #33 was conducted. The observation revealed there was no call light cord available for the Resident to ring for staff assistance. The Resident stated she did not have a call light cord and when she needed something she had to walk to the door and get someone's attention. The Resident's roommate Resident #45 who was cognitively intact explained she and Resident #33 moved into the room on the same day and Resident #33 has had no call light cord attached to her call light since that day. An observation on 06/24/21 at 2:30 PM revealed there was no call light cord attached to Resident #33's call light to ring for assistance. An observation on 06/25/21 at 8:35 AM revealed there was no call light cord attached to Resident #33's call light to ring for assistance. A review of the Nurse Call System call light audit provided by the facility conducted 06/15/21 and completed by the Maintenance Assistant indicated 100 Hall passed inspection. On 06/25/21 at 9:06 AM an interview was conducted with the Maintenance Supervisor (MS) who explained that he made walking rounds throughout the facility about twice a week to identify issues that needed to be addressed by the maintenance department. The MS continued to explain that when staff other than the maintenance department discovered issues that needed to be addressed, they would either verbally relay the concern to him or fill out a request through the computer system for maintenance repairs. The MS explained that he had one assistant for the maintenance department who was responsible for conducting the call light audit which was completed two weeks ago. He stated he was not aware of a concern regarding Resident #33's call light cord. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempts were made to interview the Maintenance Assistant but were unsuccessful. During an interview with the Administrator on 06/25/21 at 11:28 AM he expressed that he was unaware that Resident #33 did not have a call light available to her and that it was unacceptable. The Administrator stated that the missing call light cord should have been identified on maintenance rounds during the last audit. 42090 2. Resident #7 was admitted to the facility on [DATE] with diagnoses that included diabetes. A self-care deficit care plan dated 03/22/21 revealed Resident #7 was dependent for bed mobility, dressing, toileting, hygiene, and bathing and required 1-2 staff assistance. A bowel and bladder care plan dated 3/22/21 indicated Resident #7 was incontinent of bowel and bladder with interventions to clean peri-area with each incontinent episode. A recent quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #7 was rarely or never understood and extensive to total dependent for all ADL care. The MDS further indicated Resident #7 was always incontinent of bowel and bladder. An observation of wound care provided by Nurse #8 on 06/24/21 at 3:20 PM revealed Resident #7 in bed. Nurse #8 entered the room to perform wound care therapy to her Stage II pressure ulcer to her sacrum. Nurse #8 pulled back the sheet that was partially draped over Resident #7 and realized Resident #7 needed incontinence care because her blue brief was soiled. Nurse #8 was unable to locate a brief in Resident #7's room and exited the room and returned with a white brief which she wrapped around Resident #7 twice due to the brief being oversized, then covered Resident #7 with her sheet. An interview on 06/24/21 at 3:38 PM with Nurse #8 revealed she had entered the room to perform pressure ulcer care she found Resident #7 in need of incontinence care. Nurse #8 stated when she was unable to locate a brief for Resident #7 in her room, she quickly exited the room and retrieved the first available brief instead of a smaller brief for time sake. Nurse #8 stated the facility did not have a brief to fit Resident #7 due to her size and therefore they typically used the smallest brief the facility carried which was a small. She believed the brief applied on 06/24/21 to be a medium or large. An interview on 06/24/21 at 4:36 PM with the Director of Nursing revealed she the appropriately sized brief applied each time. She stated she was aware the facility had not previously had the ability to order a pediatric sized brief until they had switched to a different incontinence product company and the DON explained she would be requesting the pediatric size be ordered in the future for Resident #7.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on observations, record review, and facility staff interviews, the facility failed to notify a resident's family of the development of a pressure ulcer (Resident #210) for 1 of 2 resident's reviewed for pressure ulcers. Findings Included: Resident #210 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, diabetes mellitus with complication, muscle weakness, and Alzheimer's disease. Review of Resident #210's care plan dated 10/30/20 revealed a care plan for Resident #210 has potential for pressure ulcer development related to impaired mobility, incontinence, Alzheimer's, anemia, diabetes, and kidney failure. Deep tissue injury to left heel 12/1/20. Interventions included administer treatments as ordered and monitor for effectiveness; assess and document status of wound perimeter, wound bed, and healing progress. A physician's order was written on 12/02/20 for Resident #210's left heel to be cleaned with wound cleanser, pat dry, apply a moisturizer cream and wrap with roll gauze daily on day shift. Resident #210's wound physician notes revealed a note dated 12/08/20 for an initial exam of a left heel deep tissue injury. Per the note, the wound was 100% closed and measured 7 centimeters (cm) X 5 cm X 0 cm. A review of Resident #210's discharge Minimum Data Set, dated dated dated [DATE] revealed Resident #210 to be cognitively impaired for daily decision making. Resident #210 was coded as having one or more unhealed pressure ulcers or injuries. The wound was coded as one unstageable pressure injury that presented as a deep tissue injury. Resident #210's electronic progress notes for December 2020 revealed no documentation of the facility notifying Resident #210's representative of the development of the pressure wounds to Resident #210's heels. Interviews with nurses scheduled to have worked with Resident #210 during her admission were unsuccessful. An interview with the Director of Nursing (DON) on 06/25/21 at 1:00PM revealed it was the responsibility of the hall nursing staff to notify a resident's representative of a change in the resident's condition. She stated the development of a pressure ulcer would warrant notification to the representative via telephone call. She stated after the telephone call was completed, a progress note should be placed in the resident's electronic medical record. The DON reported if there was not a progress note in the electronic medical record, then the notification must not have occurred. The DON reported it was her expectation that the family of Resident #210 should have been notified of the development of a pressure wound to Resident #210's left heel when it was first observed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 06/25/21 at 2:45PM, he reported it was his expectation that a resident's power of attorney or representative be made aware of the development of pressure ulcers and documentation be placed in the electronic medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on observations, record reviews, staff and Resident interviews the facility failed to clean and sanitize the doorframes, label and store residents' personal care items and failed to label and store residents' personal care items in 2 of 8 bathrooms (shared bathroom of rooms #107-109,#202-204, and #204-#206) and failed to ensure walls and doors were free from holes and scratches for 2 of 8 bathrooms (shared bathroom of rooms #107-109 and #202-204). The facility also failed to ensure 2 of 3 community shower rooms (500 hall and the 200 hall male shower rooms) were free of clutter, clean, sanitized and in good repair for areas reviewed for environment. The findings include: 1. Resident #45 was admitted to the facility on [DATE] with diagnoses that included lung cancer. The admission Minimum Data (MDS) set assessment dated [DATE] revealed Resident #45 was cognitively intact and required supervision with personal hygiene. During an interview with Nurse Aide (NA) #1 on 06/23/21 at 12:21 PM the NA explained that Resident #45 liked to take a partial bath every morning in her bathroom and she would provide the Resident with a washcloth and towel and would remove them after the Resident was finished with them. The NA continued to explain that Resident #45 was independent with stand by assist with bathing. a. On 06/23/21 at 2:25 PM an interview was conducted with Resident #45 who explained that the sanitary conditions of her bathroom were not acceptable with her in that there had been fecal matter on the doorframe of the adjoining room for days and that when she called it to the attention of the (unidentified) housekeeper several days prior, the housekeeper cleaned some of the fecal matter off but left some on the doorframe. The Resident stated she was not accustomed to living in a mess like the shape her bathroom was in. An observation was made of the shared bathroom between rooms #107-109 on 06/23/21 at 2:25 PM. The observation revealed a brown substance approximately 3 inches long and 1 inch at the widest point on the right side of the doorframe on room [ROOM NUMBER] side of the bathroom. The brown matter had an odor of feces. A subsequent observation of the shared bathroom of #107-109 on 06/24/21 at 8:59 AM remained unchanged. An interview was conducted with Housekeeper #1 on 06/24/21 at 11:18 AM. The Housekeeper reported he began employment on 06/03/21 but had worked in housekeeping for several years and was responsible for 100 hall. He explained that every resident room and bathroom was cleaned every day that involved dusting, disinfecting, sweeping, mopping and changing the trash in every resident room and their bathrooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Nurse Aide (NA) #5 on 06/24/21 at 1:45 PM. The NA explained that Resident #45 liked to take a sponge bath ever morning in her bathroom and had asked the NA several times if she would clean her bathroom because it was dirty. The NA stated she did not notice the brown substance on the doorframe or she would have cleaned it herself. A subsequent observation of the shared bathroom of rooms #107-109 on 06/24/21 at 4:07 PM revealed the bathroom remained as noted above. A subsequent observation of the shared bathroom of rooms #107-109 on 06/25/21 at 8:34 AM revealed the bathroom remained as noted above. An interview and observation were made of the shared bathroom between rooms #107-109 with Housekeeper #1 on 06/25/21 at 8:49 AM. The Housekeeper confirmed he cleaned room [ROOM NUMBER] and the adjoining bathroom. He stated he did not notice the brown stain on the doorframe or he would have cleaned it off then proceeded to wash the brown substance off the doorframe. An interview was conducted with the Housekeeping Supervisor (HKS) on 06/25/21 at 9:17 AM. The HKS explained the housekeepers were responsible for cleaning the residents' bathrooms every day which included sweeping, mopping and disinfecting the commonly touched areas. The HKS stated the housekeepers should be more vigilant to the commonly touched areas because it was unacceptable for the brown substance to have been on the doorframe for days. During an interview with the Director of Nursing (DON) on 06/25/21 at 10:30 AM she explained that keeping the bathrooms in a clean sanitary condition should be a joint effort by both nursing and housekeeping and both departments should be accustomed to making sure they done that. b. On 06/23/21 at 2:25 PM an interview was conducted with Resident #45 who explained that the sanitary conditions of her bathroom were not acceptable with her in that there was a wash basin in the floor next to the commode (left side) with several dirty wet washcloths (brown substance on washcloths) that had been there for days. Resident #45 continued to explain that on the left side of the small sink was a clear plastic cup and open bottles of mouthwash and body wash and on the right side was a clear plastic cup that contained a toothbrush and toothpaste and an open bottle of body wash setting next to the cup. The Resident stated there was a towel and used washcloth hanging on the towel bar mounted on the right wall beside the sink all of which the Resident stated were not her personal toiletries. The Resident stated she was not accustomed to living in a mess like the shape her bathroom was in. On 06/23/21 at 2:25 PM an observation was made of Resident #45's bathroom [ROOM NUMBER]. There was an unlabeled wash basin that contained several dirty (brown substance) wet washcloths stored on the floor on the right side of the commode. Setting on the left side of the small sink was a clear plastic cup and open bottles of mouthwash and body wash. On the right side of the sink was a clear plastic cup that contained a toothbrush and toothpaste and setting next to the cup was an open bottle of body wash. All of which were unlabeled and not belonging to Resident #45. On the mounted towel rack on the right side of the wall was a towel and used washcloth that also did not belong to the Resident. The Resident stated she was not accustomed to living in a mess like the shape her bathroom was in. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A subsequent observation of the shared bathroom of #107-109 on 06/24/21 at 8:59 AM remained unchanged. An interview was conducted with Nurse Aide (NA) #5 on 06/24/21 at 1:45 PM who confirmed she cared for Resident #45. An observation was made of Resident #45's bathroom [ROOM NUMBER] during the time of the interview. The observations remained the same as described in the previous observation. The NA explained that the residents' personal toiletries should be in a bag and labeled with their [NAME] and stored in their drawers. She continued to explain that she did not know who the unlabeled wash basin belonged to but that it should not be stored on the floor. A subsequent observation of the shared bathroom of rooms #107-109 on 06/24/21 at 4:07 PM revealed the bathroom remained as noted above. A subsequent observation of the shared bathroom of rooms #107-109 on 06/25/21 at 8:34 AM revealed the bathroom remained as noted above. During an interview with the Director of Nursing (DON) on 06/25/21 at 10:30 AM she explained that the residents' personal toiletries should be labeled with their names and stored in a bag or at their bedside. She continued to explain that the nurse aides should clean the bathrooms after they have assisted the residents and that they should take their toiletries back to the residents' bedside. The DON stated that keeping the bathrooms in a clean sanitary condition should be a joint effort by both nursing and housekeeping. c. On 06/23/21 at 2:25 PM an interview was conducted with Resident #45 who explained that the sanitary conditions of her bathroom were not acceptable with her in that there had been a grab bar lying underneath the sink since she was transferred into the room (06/09/21) and holes in the wall on the right side of the commode where the grab bar was apparently once mounted. Resident #45 stated there were multiple scratch marks on both inside bathroom doors and black marks on the walls and doorframes. The Resident stated she was not accustomed to living in a mess like the shape her bathroom was in. An observation was made on 06/23/21 at 2:25 PM of Resident #45's shared bathroom between rooms #107 and 109 revealed a grab bar lying on the floor underneath the sink and holes in the wall on the right side of the commode. There were also multiple scratch marks on the inside doors as well as multiple black scratch marks on the walls and doorframes. A subsequent observation of the shared bathroom of rooms #107-109 on 06/24/21 at 8:59 AM remained unchanged. A subsequent observation of the shared bathroom of rooms #107-109 on 06/24/21 at 4:07 PM revealed the bathroom remained as noted above. An observation of the shared bathroom of rooms #107-109 on 06/25/21 at 8:34 AM revealed the bathroom remained as noted above. (continued on next page)

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Accordius Health at Mooresville	752 E Center Avenue Mooresville, NC 28115

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation of the shared bathroom between rooms #107-109 with the Maintenance Supervisor (MS) on 06/25/21 at 9:06 AM the MS stated he made walking rounds of resident rooms, bathrooms and common areas about once a month but had not made one this month. He explained the facility had no major projects in progress at the current time. The MS stated that when the staff noticed a repair that needed to be made they were supposed to put the request into the computer TELs system and he would get it or they would verbally inform him of what needed to be done. The MS stated he was not made aware of the grab bar underneath the sink on the floor but that it was not there about 2 weeks ago. The MS also remarked that the holes in the wall and the black scratch marks on the walls, doors and doorframes needed to be repaired. An interview was conducted with the Administrator on 06/25/21 at 11:28 AM. The Administrator explained that the residents' personal toiletry items should be labeled and stored in their rooms because of the limited space in the bathrooms. He indicated that all departments should be vigilant in identifying issues that need to be repaired and fill out the work orders to correct those issues. 2. On 06/24/21 at 3:18 PM during an observation of the 500 hall shower room was made. The room was noted to be cluttered and in disarray. Stored in the spa tub was an empty jar of zinc oxide cream and 3 wet wash cloths. The first privacy curtain had 5 hooks disconnected from the curtain, limiting complete privacy. On the floor in front of the spa tub was an unlabeled wash basin, gloves, toothbrush and discarded toilet paper. On the floor behind the commode was a silver pipe and above the commode the vent on the ceiling had one side of the door hanging open. In the shower area was an opened bottle of unlabeled body wash, a toothbrush, washcloth, toilet paper and plastic shower cap on the floor as well as two brown substances that appeared to be fecal material. Stored in the cabinet were multiple used and unlabeled toiletry items of deodorants, lotions, toothbrushes, toothpastes, body washes, razors, shaving creams, combs and hairbrushes. Toiletry items were both facility and residents' personal property. An interview was conducted with Nurse Aide (NA) #7 on 06/24/21 at 3:48 PM who confirmed she was scheduled for 500 hall at that time. The NA explained that the 500 hall shower room was used by the residents' on 500 hall as well as other residents in the facility and she did not know what nurse aide used the shower room last. Regardless, the NA explained that the shower room should be kept neat and orderly for the residents and everyone should pick up after themselves after giving the residents their showers. The NA continued to explain that the toiletry items should have the residents' names on them and they should not be stored in the cabinet but that they could keep extra unopened items stored in the cabinet to keep the staff from having to walk down the hall to get them. The NA added the staff should pt the resident's name on the item when the item was used for the resident. The NA also stated the spa should not be a storage place for the lifts, sheets etc. that were in the spa tub. NA #7 reported that the housekeeper on the hall was supposed to have cleaned the shower room at the end of their shift. During an interview and observation of the 500 hall shower room with the Maintenance Supervisor (MS) on 06/25/21 at 9:06 AM he explained the staff were supposed to report the needed repairs that he did not identify on his walking rounds which were about once a month but that he had not made them this month. The MS stated he was not aware of the vent door hanging down above the commode nor the pipe on the floor behind the commode. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/25/21 at 9:17 AM an interview and observation were made of the 500 hall shower room with the Housekeeping Supervisor (HKS) who explained the housekeepers were supposed to sweep, mop and disinfect the showers at the end of the shift. The HKS noted the brown substance on the shower staff floor and stated it should have been cleaned up the day before. 3. An observation and interview conducted with Nurse Aide (NA) #7 of the 200 hall male shower room on 06/24/21 at 4:23 PM was conducted. The shower room had multiple areas on all four walls of crackling and peeling of paint, and the fluorescent light above the spa tub had one side of the light cover hanging loose. The NA explained that the shower room was renovated about 2 year ago and the paint started peeling shortly after that. The NA was not aware of the condition of the light cover above the spa tub but stated someone should have noticed it and put in a work order to maintenance. An interview and observation of the 200 hall male shower room was conducted with Nurse Aide (NA) #4 on 06/24/21 at 6:30 PM. The NA explained she will occasionally bring a resident into the shower room but she didn't like to because of the condition of the room. The NA stated she was not aware of the light cover hanging down over the spa tub because she does not go on that side of the room where the spa tub was stationed because she does not use it. On 06/25/21 at 9:06 AM an interview and observation were made of the 200 hall male shower room with the Maintenance Supervisor (MS). The MS noted the condition of the paint peeling off the walls and the light cover hanging down over the spa tub. The MS stated he had not made a round in the shower room for a while and did not know the peeling paint was that bad and that the light cover needed to be fixed. An interview was conducted with the Administrator on 06/25/21 at 11:28 AM who explained he had not been in the 200 hall or 500 hall shower rooms for a while but was aware of the peeling paint on the wall in the 200 hall shower room but not the light fixture hanging down above the spa tub. The Administrator continued to explain that he was not aware of the vent door hanging down above the commode in the 500 hall shower room. The Administrator indicated that all staff should be active in filling out repair requisitions when the issues were discovered so they could be repaired. 42090 4. Observation on 06/24/21 at 11:10 AM revealed a bathroom joining rooms [ROOM NUMBERS] which included: a. A strong stale urine odor b. A dark brown substance smeared on the exterior toilet base and on the wall, which appeared to be feces was located to the left side of the commode under the handrail c. A urinal which contained a dark yellowish-brown crusty substance around the rim and on the sides was located on the floor behind the commode d. Two additional urinals were hanging from the handrail which contained a similar crusty substance. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Two used washed basins were sitting in the floor of the bathroom- one of the basins contained a soiled wash rag that was dried and stiff in texture and the other was empty. f. A soiled bed pan which hung from a hook above the toilet. The urinals, bed pans, and wash basins were observed with no identifiable labeling included. g. One approximately 5-foot unidentifiable piece of thin white plastic which appeared to be a form of molding leaned up against the wall behind the commode During the observation, Nurse Aide (NA) #11 entered the bathroom to empty a urinal for Resident #17. NA #11 was interviewed about the items in the bathroom being heavily soiled and none of the items being labeled, she responded saying she was not sure who the items belonged to or why they were heavily soiled with a reddish-brown crusty substance on the interior and exterior surfaces. NA #11 emptied the urinal into the commode and returned it to Resident #17 before returning to the bathroom to discard all unlabeled items, doff her gloves, and wash her hands. NA #11 stated she had been taught that items should include the residents' name for easily identifying the items and to avoid cross-contamination between residents. She indicated housekeeping staff cleaned the bathrooms daily and she was not sure why there was a dark brown substance on the toilet or the wall which she identified to likely be feces and stated she would ask the housekeeper to clean it. An interview on 06/24/21 at 11:15 AM with Resident #17 revealed he used a urinal most of the time and the toilet for bowel elimination. He stated housekeeping comes in to clean the bathroom daily and stated he had only had one urinal provided to him. He indicated it would be nice to get a new one occasionally, but he managed with the one he currently had and although heavily soiled did not like causing any problems, so he had not asked for another one. An interview on 06/25/21 at 8:30 AM with the Director of Nursing revealed she expected all hygiene items such as bed pans, urinals, and wash basins to be labeled and stored properly in separate bags and discarded when heavily soiled. An interview on 06/25/21 at 9:23 AM with the Housekeeping Director revealed he expected bathrooms to be cleaned daily to include sweeping, mopping, and disinfecting surfaces. He stated the bathroom should be free of feces, urine odor, and items should be discarded from the room when a resident was discharged . He was unsure why there would be feces on the toilet and the wall in a resident's bathroom but felt it to be unacceptable. The Housekeeping Director stated it was the NA's responsibility to provide urinals, bed pans, and wash basins to residents and label them for ease of identification, but it was a joint effort between housekeeping and nursing department to discard the items when soiled. An interview on 06/25/21 at 2:46 PM with the Administrator revealed he expected bathrooms to be cleaned and sanitized daily to include sweeping, mopping, and disinfecting surfaces. He indicated if the toilet or walls became soiled, housekeeping should clean and disinfect the areas. He indicated nursing staff was to label items and store them in bags properly after each use.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on observations, record review, resident and staff interview the facility failed to perform routine incontinent care (Resident #7) and failed to provide scheduled showers (Resident #24, Resident #37, Resident #17, and Resident #45) for 5 of 10 residents reviewed for activities of daily living. Findings included: 1. Resident #7 was admitted to the facility on [DATE] with diagnoses that included diabetes. A self-care deficit care plan dated 03/22/21 revealed Resident #7 was dependent for bed mobility, dressing, toileting, hygiene, and bathing and required 1-2 staff assistance. A bowel and bladder care plan dated 3/22/21 indicated Resident #7 was incontinent of bowel and bladder with interventions to clean peri-area with each incontinent episode. A recent quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #7 was rarely or never understood and extensive to total dependent for all ADL care. The MDS further indicated Resident #7 was always incontinent of bowel and bladder and a Stage II pressure ulcer that was not present on admission. An observation of wound care provided by Nurse #8 on 06/24/21 at 3:20 PM revealed Resident #7 in bed. Nurse #8 entered the room to perform wound care therapy to her Stage II pressure ulcer to her sacrum. Nurse #8 pulled back the sheet that was partially draped over Resident #7 and realized Resident #7 needed incontinence care because her blue brief was soiled. There was no stool present in the brief; however, it was heavily saturated with urine. As the heavily soiled brief was removed by Nurse #8, it was observed to contain a dark yellow color inside, a strong odor, and the inside of the brief showed the inside lining to have visible cotton shedding of the liner inside. As the brief was removed, the skin below revealed a soiled dressing labeled 6/24 at 9:23 AM covering a Stage II pressure ulcer. After the incontinence care was provided, she applied a clean brief which she wrapped around Resident #7 twice due to the brief being oversized, then covered Resident #7 with her sheet. An interview on 06/24/21 at 3:38 PM with Nurse #8 revealed she was assigned to provide treatments to Resident #7 and had first completed them around 9:00AM. Nurse #8 stated when she applied the treatment to Resident #7's sacrum that morning, she did not require incontinence care and therefore applied the dressing and requested NA #7 get Resident #7 up to her chair. Nurse #8 stated she had not returned to Resident #7's room until 3:20 PM when she was told the sacral dressing had become soiled and needed a PRN dressing change applied and found Resident #7 to be heavily saturated with urine. Nurse #8 stated the NA assigned to the resident typically performed routine incontinence care for the residents; however, she would provide it if needed when she did wound care; however, she had not provided incontinence care prior to performing the pressure ulcer treatment during the observation. An interview on 06/24/21 at 3:46 PM with NA #3 revealed she was not assigned to Resident #7 and had not provided incontinence care to her during the day shift on 06/24/21. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 06/24/21 at 3:49 PM with NA #7 revealed she was assigned to care for Resident #7 on 06/24/21 during day shift. She indicated she had not performed incontinence care on Resident #7 during her shift. NA #7 indicated 3rd shift had reported she had incontinent care shortly before 7 AM on 06/24/21 and NA #7 had gotten Resident #7 up to her chair. Shortly after breakfast, Nurse #8 approached NA #7 and said she needed to perform Resident #7's ulcer bandages and needed her put back to bed. NA #7 reported she put Resident #7 back to bed and thought Nurse #8 would perform incontinence care while performing the treatment, so she did not include her on the routine incontinence round checks after that time. She stated she gotten busy after putting Resident #7 to bed and did not realize how long had passed since Resident #7 had been changed. NA #7 said she had been taught to check residents for toileting and incontinence needs every 2 hours. An interview on 06/24/21 at 3:51 PM with NA #11 revealed she was not assigned to work with Resident #7 and had not provided incontinence care to her during day shift on 06/24/21. An interview on 06/24/21 at 4:36 PM with the Director of Nursing revealed she expected each resident to be checked for the need of toileting or incontinence care every 2 hours. She stated NA #7 and Nurse #8 should have communicated clearly about who would provide incontinence care to Resident #7's during wound care and throughout the remainder of the shift. The DON explained it was unacceptable for a resident to not be checked from 9:23 AM to 3:20 PM and be required to sit in a heavily urine saturated brief. An interview on 06/25/21 at 2:46 PM with the facility Administrator revealed he expected staff to perform rounds frequent enough to ensure all residents were clean and dry. 35789 2. Resident #24 was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included end stage renal disease, chronic obstructive pulmonary disease, heart failure, weakness, and others. The facility's shower schedule revealed that Resident #24 was scheduled for a shower every Wednesday evening. Review of Resident #24's bathing record dated May 2021 indicated that on Wednesday 05/05/21 Resident #24 received a partial bed bath from Nurse Aide (NA) #6, on Wednesday 05/12/21 Resident #24 received a partial bed bath from NA #6, on Wednesday 05/19/21 Resident #24 received a partial bed bath from NA #6 and on Wednesday 05/26/21 no shower or bed bath was provided by NA #2. The quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #24 was cognitively intact and required total assistance from staff with bathing. The MDS further indicated no rejection of care during the assessment reference period. Review of Resident #24's bathing record dated June 2021 indicated that Wednesday 06/02/21 no bathing activity was provided in the evening by Nurse Aide (NA) #7, on Wednesday 06/09/21 no bathing activity was recorded in the evening at all, on Wednesday 06/16/21 a partial bed bath was provided in the evening by NA #6, and on Wednesday 06/23/21 no bathing activity was recorded at all. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with NA #7 on 06/24/21 at 12:29 PM. NA #7 confirmed that she cared for Resident #24 at times and was familiar with her care. NA #7 stated that when she arrived for her shift, she would check the shower book at the nurse's station and see who was scheduled for showers that day. NA #2 stated that on the evening shift there were only 3 NAs and that did not leave enough staff to complete the showers. She explained if there were 4 or more staff that did allow for some showers to be given but not all of them. She stated that she had told the Director of Nursing (DON) on numerous occasions that there was not enough staff to get all the showers done. NA #2 stated that when there were 3 NAs working on the evening shift all they had time to do was feed the residents the evening meal, dry them once or twice and turn them. An interview was conducted with the DON of 06/24/21 at 3:58 PM. The DON stated that the UM had went around and spoke to the residents about their bathing preferences but was not sure what she had done with the information she collected because the facility was in the process of switching to 12 hour shifts. The DON stated that whatever the resident decided about their showers was what she expected to happen. The DON explained that 90-95% of the staff they had was agency and that sometimes staffing was hit or miss because at times the agency staff would confirm their assignment but then just not show up. The DON stated that they scheduled enough staff, but we don't always end up with enough staff. 3. Resident #37 was readmitted to the facility on [DATE] with diagnoses that included: weakness, hypertension, polyneuropathy, hyperlipidemia, and others. The quarterly Minimum Data Set (MDS) dated [DATE] indicated that Resident #37 was cognitively intact for daily decision making and required extensive assistance with bathing. The MDS also revealed no rejection of care during the assessment reference period. The facility's shower schedule revealed that Resident #37 was scheduled for a shower every Tuesday, Thursday, and Saturday in the morning. Resident #37's bathing record dated June 2021 revealed that on Tuesday 06/01/21 Resident #37 received a shower, on Thursday 06/03/21 Resident #37 received a shower, on Saturday 06/05/21 no shower or bath was recorded, on Tuesday 06/08/21 no shower or bath was recorded, on Thursday 06/10/21 no shower or bath was recorded, on Saturday 06/12/21 no shower or bath was recorded, on Tuesday 06/15/21 a shower was recorded, on Thursday 06/17/21 no shower or bath was recorded, on Saturday 06/19/21 no shower or bath was recorded, and on Tuesday 06/22/21 no shower or bath was recorded. An interview was conducted with Resident #37 on 06/21/21 at 10:32 AM. Resident #37 stated that she had agreed upon with the staff to receive a shower three times a week and they were scheduled on Tuesday/Thursday/Saturdays in the morning. She stated that sometimes she would get them during the week but rarely to never got her showers that were scheduled on the weekends. Resident #37 stated that in the past she had been able to complete her showers independently with supervision from the staff for safety but that was not the case now, she physically needed help with washing her body and hair. She explained that most of the time the staff would tell her they did not have enough staff to do her showers or did not have the time to take her to the shower because there was not enough staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #17's care plan dated 04/26/21 revealed a care plan area for [Resident #17] has an Activities of Daily Living (ADL) self-care performance deficit related to stroke with hemiplegia, impaired mobility, and weakness. Interventions included AM routine: prefers breakfast in bed and dressing/grooming routine in AM and prefers showers 2 times per week on day shift A review of Resident #17's bathing sheet for the month of June, 2021 revealed he had received 3 showers for the month. A shower was documented as given on 06/01/21, 06/15/21, and 06/19/21. During an interview with Resident #17 on 06/22/21 at 9:33 AM, he reported he had not received a shower on his scheduled weekend day in the past 7 weeks. He stated he was scheduled to get his showers on Tuesdays and Saturdays. Observation of Resident #17 revealed him to have unkempt hair with a greasy appearance. During an interview with Nurse Aide (NA) #10 on 06/24/21 at 1:42PM, she reported Resident #17 required extensive assistance with bathing due to his limited mobility. NA #10 stated she worked every weekend and that there were times when showers would not be completed due to lack of staffing in the facility. She reported she tried to make sure that showers were done but that with the amount of staff the facility scheduled all she really had time to do was assist residents with eating, changing incontinent residents and turning the dependent residents. She reported when showers could not be completed due to the workload, she at least gave a bed bath or partial shower. During an interview with NA #7 on 06/24/21 at 12:58, she reported she was familiar with Resident #17 and that he was dependent on staff for completion of his showers. She reported she could not remember if she had been able to give Resident #17 a shower or not when she was working but stated there were times when there were only 2 NAs and 2 Nurses scheduled in the building and when that occurred, showers were not provided because all she could complete was turning dependent residents, changing incontinent residents, and provide assistance with feeding. During an interview with the Director of Nursing on 06/25/21 at 11:55AM, she reported she expected residents to receive showers as scheduled unless they refused. She stated if a resident refused a shower, then it should be appropriately documented. She stated Resident #17 should have received his showers on Tuesdays and Saturdays, in the morning as per his preference. During an interview with the Administrator on 06/25/21 at 2:45PM, he reported he was in the midst of changing his staffing to 12 hour shifts for the NAs and was implementing a dedicated shower team whose sole responsibility would be to provide showers to residents on their assigned days. He reported he expected his staff to provide resident showers as they were scheduled. 37280 5. Resident #45 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) and lung cancer. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 was cognitively intact and required physical help in part of bathing activity with the assistance of one staff. The MDS also indicated Resident #45 was oxygen dependent. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #45's care plan dated 05/24/21 revealed she had a self care deficit performance related to the diagnoses of lung cancer and COPD. The goal for the Resident to remain at her current level of functioning in her activities of daily living through the next review would be attained by utilizing interventions that included set up supplies for bathing and transfer assistance of one staff. A review of the 100 Hall shower list revealed Resident #45's room number was not on the shower list. A review of Resident #45's bathing record from 06/09/21 through 06/21/21 revealed only one shower was documented as given on 06/18/21. An interview was conducted with Resident #45 on 06/21/21 at 4:40 PM. The Resident explained that she had only received one shower since she transferred to her current room on 06/09/21. The Resident continued to explain that she had been getting two showers a week on Tuesday and Friday evenings but after 06/09/21 when she transferred to her current room she had only received one shower. Resident #45 stated she was okay with two showers a week but really needed her showers because her hair was oily (Resident pointed to her hair that did appear oily and matted to her head) when it was not washed regularly. The Resident stated that when she asked the nurse aides to assist her with her showers their responses were that they did not have the time, or that she was not on the shower list. An interview was conducted with Nurse Aide (NA) #2 on 06/23/21 at 4:06 PM. The NA confirmed that she worked on Resident #45's hall on 06/15/21 evening shift but did not have time to assist her with her shower due to the workload on the hall. During an interview with Nurse Aide (NA) #8 on 06/23/21 at 5:40 PM she confirmed she assisted Resident #45 with her shower on the evening of 06/18/21. The NA explained that the Resident approached her and asked her if she would let her shower and the NA stated she made time for her. On 06/24/21 at 6:30 PM an interview with Nurse Aide (NA) #4 revealed she remembered Resident #45 asked her to give the Resident a shower one evening (could not remember the evening) but Resident #45 was not on the shower schedule to receive a shower that shift. The NA stated she told Resident #45 that her shower days may have changed since she was moved to a new hall and that the NA did not know what the new shower days would be. Attempts were made to interview the NA who worked on 06/11/21 evening shift but were unsuccessful. An interview was conducted with the Director of Nursing (DON) on 06/25/21 at 10:30 AM. The DON explained that she had identified that there was no system in place maintaining the shower schedules and management was in the process of updating the shower schedules on 06/21/21 but the audit had to be put off for the time being. Regardless of that the DON stated Resident #45 should have been given a shower when she requested no matter if she was scheduled for one or not. On 06/25/21 at 11:26 AM during an interview with the Administrator he explained that Resident #45 should have received her two showers a week and more if she requested them.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on observations, record review, resident and staff interviews, the facility failed to provide pressure ulcer care according to the physician's order during a pressure ulcer observation for 2 of 2 residents sampled for pressure ulcers (Resident #7 and Resident #210). Findings included: 1. Resident #7 was admitted to the facility on [DATE] with diagnoses that included ischemic foot and diabetes. A skin care plan dated 5/5/21 included a Stage II pressure ulcer with interventions of administer treatments as ordered. A wound provider note dated 06/11/21 revealed a Stage II pressure ulcer measuring 1.5 centimeter (cm) x 1. 5 cm x 0.1 cm with moderate serosanguineous exudate with a sacral treatment order of the following: wound cleaning spray, silver alginate (a wound dressing with an antimicrobial agent to decrease wound infection and collect exudate) , and cover daily. A recent quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #7 was rarely or never understood and extensive to total dependent for all ADL care. The MDS further indicated Resident #7 had a Stage II pressure ulcer that was not present on admission. An observation of pressure ulcer care on 06/24/21 at 3:20 PM revealed Resident #7 laying on her back in bed with her legs bent back and clinching a triangular wedge towards her buttocks. Nurse #8 entered the room and told Resident #7 she needed to perform wound care therapy to her Stage II pressure ulcer to her sacrum. From the treatment cart outside Resident #7's room, Nurse #8 sat the following supplies on an overbed table: a cloth towel drape, a bottle of cleaning spray, a wooden tongue depressor, 4 x 4 gauze, a bordered gauze dressing, and 2 plastic cups containing 2 substances Nurse #8 had squeezed from two different tubes labeled with Resident #7's name. Nurse #8 labeled the bordered gauze with the date and time of 6/24 3:22 PM and applied clear plastic gloves on each hand and entered the room pushing the bedside table to the bed. Nurse #8 pulled back the sheet that was partially draped over Resident #7's small frame and Nurse #8 then performed PRN pressure ulcer care. She removed a dressing labeled 6/24 9:23 AM. She picked up a cup of cream from the overbed table and applied a thick layer of cream to Resident #7's entire backside. Nurse #8 identified the cream to be an incontinence barrier cream. She then picked up another cup of cream of which she identified as Debriding Ointment #1 (an ointment used to remove impaired tissue) which she used the wooden tongue depressor stick to apply a thick layer of Ointment #1 to the inside of the sacral wound then put the wooden stick back into Ointment #1 and obtained additional ointment and applied it to the intact skin on the outside of the sacrum area of Resident #7. She covered the pressure ulcer with a bordered gauze dressing. She then covered Resident #7 with the sheet on Resident #7's bed and discarded the soiled dressing in the trash before exiting the room. Nurse #8 was not observed to obtain or apply the ordered alginate wound dressing (a dressing used to collect drainage) before applying the bordered gauze outer dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/24/21 at 3:38 PM with Nurse #8 revealed she was assigned to complete Resident #7's treatments for the day shift. She indicated she had already changed it earlier in the shift, but staff notified her the pressure ulcer dressing to the sacrum was soiled and needed a PRN (as needed) dressing change. She acknowledged she was nervous while being observed. Nurse #8 said she gathered the supplies by memory and acknowledged she failed to apply the alginate dressing (wound dressing for collection of drainage) ordered to be applied directly over the debriding ointment but she had been trained to follow physician's orders as written and normally would have verified the order from the Treatment Administration Record (TAR) before performing the treatment. Nurse #8 explained she didn't think about the likelihood of the debriding ointment being applied to healthy tissue could cause additional skin breakdown and didn't recall the alginate dressing as part of the order when she gathered the supplies from the treatment cart. An interview on 06/25/21 at 8:30 AM with the Director of Nursing (DON) revealed she expected each staff member to follow a resident's treatment orders as written. She indicated she was unsure if Ointment #1, being a debriding agent, applied to the good intact tissue would harm the skin, how it might effect the wound if the exudate collecting portion of the dressing was not applied, and Nurse #8 should have known to only wear one pair of gloves on at a time and perform hand hygiene when gloves were changed. The DON acknowledged the bordered gauze dressing would not stay in place due to the incontinence barrier cream applied to Resident #7's entire bottom. An interview on 06/25/21 at 9:24 AM with the Nurse Practitioner revealed he felt if the debriding agent was applied to the healthy tissue, it could cause further skin breakdown to the pressure ulcer. He further revealed the wound dressing portion used to collect exudate was needed to aid Ointment #1 stay in place and assist with debriding of the wound bed and was needed to prevent further skin breakdown. 38515 2. Resident #210 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, diabetes mellitus with complication, muscle weakness, and Alzheimer's disease. Resident was subsequently discharged on [DATE]. Review of Resident #210's care plan dated 10/30/20 revealed a care plan for Resident #210 has potential for pressure ulcer development related to impaired mobility, incontinence, Alzheimer's, anemia, diabetes, and kidney failure. Deep tissue injury to left heel 12/1/20. Interventions included administer treatments as ordered and monitor for effectiveness; assess and document status of wound perimeter, wound bed, and healing progress. Resident #210's physician orders revealed an order dated 12/02/21 for left heel clean with wound cleanser, pat dry, apply dimethicone (a skin moisturizer), and wrap with kerlix daily and as needed until healed. Every day-shift for wound. On 12/25/20, that order was changed to left heel clean with wound cleanser, pat dry, apply silver alginate and cover with dry gauze daily and as needed until healed. Every day-shift for wound. Review of wound physician note dated 12/08/20 revealed Resident #210 was initially seen due to the development of a deep tissue injury to her left heel that measured 7 centimeters (cm) x 5 cm x 0 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an additional wound physician note dated 12/17/20 revealed Resident #210's left heel wound with measurements of 3.5 cm x 1.6 cm x 0.1 cm depth. The wound had a discharge of blood and blood serum with no odor. Resident #210's electronic treatment administration record (TAR) logs from December 2020 revealed no signatures on the TAR for the dates of December 4th-7th, 10th, 13th and 14th, 17th and 18th, 20th, and the 24th for the physician order for daily wound treatment to Resident #210's left heel. Interviews with nurses assigned to Resident #210 on the dates the treatments were not initialed as completed were attempted but unsuccessful. During an interview with the Wound Nurse on 06/25/21 at 10:32AM, she reported she was not working in the facility at the time of Resident #210's admission. She reported she would be unable to determine if wound care was provided based on the TAR record. She reported her understanding was if the TAR was not initialed, then the wound care would not have been completed. An interview with the Director of Nursing on 06/25/21 at 12:35PM revealed although she was not working at the facility at the time of Resident #210's admission she expected wound care to be completed as ordered and signed off on as being completed. She reported based on her review of Resident #210's TAR, she would assume that the pressure ulcer treatments were not completed. An interview with the Administrator on 06/25/21 at 2:45PM, he reported it was his expectation that a resident's pressure ulcer treatments be completed according to the physician order and documented as completed in on the Treatment Administration Record.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35789 Based on observations, record review, resident, and staff interview this facility failed to provide sufficient nursing staff to honor a resident choice of getting out of bed every day, to provide incontinent care and showers as scheduled, and to answer call lights in a timely manner for 7 of 11 residents reviewed for staffing. The findings included: This tag is cross referred to: 1. F561: Based on staff and Resident interviews, the facility failed to honor Resident #13's choice of getting out of bed every day for 1 of 7 residents reviewed for choices. 2. F677: Based on observations, record review, resident and staff interview the facility failed to perform routine incontinent care (Resident #7) and failed to provide scheduled showers (Resident #24, Resident #37, Resident #17, and Resident #45) for 5 of 10 residents reviewed for activities of daily living. 3. F689: Based on observations, record review, and facility staff and resident interviews, the facility failed to respond to a resident's call light (Resident #23) and after waiting for an hour, the resident got up and ambulated to the bathroom and on the way back to her bed fell , striking her face on the floor and sustaining a hematoma to the left side of her face for 1 of 3 residents reviewed for falls. The facility also failed to safely secure a propane tank on an outdoor grill that was located approximately 3-5 feet of the resident smoking area and was left unlocked and accessible to residents for 1 of 1 smoking areas reviewed, and failed to secure a resident's smoking materials (Resident #31) specifically a lighter, for 1 of 4 residents reviewed that were smokers. An interview was conducted with Nurse #2 on 06/22/21 at 7:30 AM. Nurse #2 stated that during the day shift they may have enough staff to do incontinence rounds 3 times and even understaffed they did try to complete the scheduled showers except for on the weekends and there was not enough staff to do them. Nurse #6 was interviewed on 06/22/21 at 7:35 AM. Nurse #6 stated that she had worked at the facility for 2 months and staffing was a huge concern because most of the days she worked there were only 3 Nurse Aides (NA) on day shift for 50-60 residents and most resident were provided incontinence care only one time per shift and rarely received their showers as scheduled. NA #9 was interviewed on 06/22/21 at 7:45 AM. NA #9 stated that she worked 4 days a week from a local staffing agency. She stated that staffing was rough because most of the time the only thing that the staff had time to do was provide incontinent care to the resident and get them out of bed before the end of her shift. If the staff were lucky, they would have enough time to do another incontinent round around lunch time but most days not everyone got changed before lunch and they had no time to complete their scheduled showers. NA #9 stated that sometime the food was cold by the time they got around to serving it to the residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NA #4 was interviewed on 06/23/21 at 11:10 AM. NA #4 stated that the only thing she had time to do when she came to work for her scheduled shift which was usually second shift was to pass out the supper trays, pick them up and then put the residents to bed. She stated that at times no one would be assigned to a unit in the facility and she would help answer call lights on that unit during the time that no one was assigned to that unit. A resident council meeting was held with 12 residents on 06/23/21 at 1:30 PM. The council expressed concerns with call bells not being answered in a timely manner because there was not enough staff to help provide the care. The Director of Nursing (DON) was interviewed on 06/24/21 at 2:00 PM. The DON stated that she was aware of the staffing challenges. She stated she tired to schedule 4 NAs as directed by the facility. She explained the facility believed that for a census of 58 4 NAs were sufficient staff. The DON stated she did not feel like that was always enough staff to meet the care needs of all the residents every day. An interview was conducted with the Scheduler on 06/24/21 at 2:33 PM. The Scheduler stated that 90% of the staff in the facility were agency staff and that a big problem with that was that she would confirm with the agency that the staff member was going to come for a scheduled shift and then that employee would not show up. The Scheduler stated that she was taught that on first shift the Nurse Aides (NA) should have no more then 12 residents to care for, second shift NAs should have no more than 15 residents to care for and third shift NAs should have no more then 25 residents to care for. She explained she would take the amount of staff and divide that by the census and that would tell her how many staff members she needed to schedule. The Scheduler further explained that the second shift was the biggest concern and the facility was moving to 12 hour shifts to eliminate the second shift gap and continue to rotate weekends which was another issue because she had one weekend that was over staffed and one weekend that was very short staffed and she had asked some of the staff to switch weekends but they did not want too. She stated that if the staff were aware that they were going to be short on a particular shift they would call out just to avoid having to work with a higher patient load. The Scheduler stated that if an agency employee called out two times then they were not allowed to return to the facility but again she was so dependent on agency staff that she really could not be picky because she was short approximately 8 nurses and approximately 8-10 NAs. She explained in a 24-hour period she may have 6 staff members that were employed by the facility and the rest were agency. Applications were printed off by the Administrator and given to the Scheduler to conduct interviews and make hiring selections but a lot of interviews that are set up the potential employee won ' t show up. She stated that on a daily basis she begs the staff to stay over and work longer hours and to come in on their days off and they get tired of it and want a break but we have to have staff. She added that sometimes the Administrative staff would help pass meal trays and if they were also NAs they would help on the floor when they could. The Administrator was interviewed on 06/25/21 at 3:41 PM. The Administrator stated that his expectation was the ratio of resident to staff was 8-12 residents to 1 NA and they facility tried to schedule that. He stated that we had too much staff at night, but the evening shift was lacking so he indicated he eliminated the evening shift and was going to 12 hours shifts. He indicated that he built a schedule for a census up to 70 residents and we are actively trying to fill those spots. He added that he had reached out to the corporation and let them know that the local agencies were not giving us the number of staff we needed. The Administrator stated that we have done the best we could to bring staff in, an effort was made but we did best we could.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, test tray, record review and resident and staff interviews the facility failed to provide palatable food that was appetizing in appearance, taste, and temperature for 6 of 6 residents reviewed with food concerns (Resident #09, Resident #10, Resident #15, Resident #20, Resident #24, and Resident #40). The findings included: 1 a. Resident #9 was readmitted to the facility on [DATE] with diagnoses that included anemia, hypertension, diabetes, and depression. The quarterly Minimum Data Set (MDS) dated [DATE] indicated that Resident #9 was cognitively intact for daily decision making and required set up assistance with eating. An observation and interview were conducted with Resident #9 on 06/25/21 at 12:43 PM. Resident #9 stated that the dietary department had served him a baked potato with no butter and he asked the staff to bring him some butter and by the time the staff brought the butter the baked potato was cold and would not melt the butter. Resident #9 stated that the mixed vegetables had no seasoning on them and were bland and added that they continued to send him tea despite telling them numerous time he did not drink tea. Resident #9's lunch tray remained sitting on his bedside table with only a few bites gone from the meal along with cup of tea. 1 b. Resident #10 was admitted to the facility on [DATE] with diagnoses that included anemia, hypertension, peripheral vascular disease, and hyperlipidemia. The quarterly Minimum Data Set (MDS) dated [DATE] indicated that Resident #10 was cognitively intact for daily decision making and required set up assistance for eating. An observation and interview were conducted with Resident #10 on 06/25/21 at 12:57 PM. Resident #10 stated that on a scale of 1 to 10 he would give lunch a 3. He stated that he was served a fish square with no tarter sauce and a baked potato with no butter and he asked the staff to bring him tarter sauce and butter and by the time they got back with the tartar sauce and butter his food was stone cold. Resident #10's lunch tray remained sitting on his bedside table and was untouched. 1 c. Resident #15 was readmitted to the facility on [DATE] with diagnoses that included asthma, diabetes, vitamin D deficiency, gout, and others. The comprehensive Minimum Data Set (MDS) dated [DATE] indicated that Resident #15 was cognitively intact for daily decision making and required set up assistance with eating. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview were conducted with Resident #15 on 06/25/21 at 1:01 PM. Resident #15 was resting in bed and was eating some meat that her family had brought into the facility. The lunch tray that was served to Resident #15 was sitting beside her bed. Resident #15 stated that when her meal tray arrived from the kitchen it was not hot and they had sent the fish with no tartar sauce and no butter for her baked potato and by the time the tarter sauce and butter arrived the food was too cold to eat. She stated that the mixed vegetables were mushy and bland, and the fish square was just too cold to eat. 1 d. Resident #20 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, severe protein calorie malnutrition, and anemia. The comprehensive Minimum Data Set (MDS) dated [DATE] for Resident #20 indicated that he was cognitively intact for daily decision making and required one-person assistance with eating. An observation and interview were conducted with Resident #20 on 06/25/21 at 1:55 PM. Resident #20's lunch tray sat on his bedside table and was noted to have only a few bites missing from it. Resident #20 stated that he did not eat fish and the mixed vegetables were mushy and he could not eat it. 1 e. Resident #24 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, chronic obstructive pulmonary disease, heart failure and others. The quarterly Minimum Data Set (MDS) dated [DATE] indicated that Resident #24 was cognitively intact for daily decision making and required set up assistance with eating. An observation and interview were conducted with Resident #24 on 06/25/21 at 1:10 PM. Resident #24 was sitting in her wheelchair with her meal tray in front of her. She stated that when she received the meal tray the fish square was cold and mushy not crunchy at all and the mixed vegetables were bland with no seasoning. She stated she had requested a sandwich of some kind but had not yet gotten it. 1 f. Resident #40 was admitted on [DATE] with diagnoses that included stroke, diabetes, anemia, and hypertension. The comprehensive Minimum Data Set (MDS) dated [DATE] for Resident #40 indicate that she was cognitively intact for daily decision making and required one-person assistance with eating. Review of Resident #40 meal tray ticket on 06/25/21 revealed that her dislikes were grits. An observation and interview were conducted with Resident #40 on 06/25/21 at 8:51 AM. Resident #40 stated that she had told the staff numerous times that she did not eat grits and she was observed to have a bowl of grits on her tray. The grits were congealed and could be picked up as one blob of grits with the spoon. Resident #40 also received a piece of burnt black toast and stated her eggs were colder than room temperature and she could not eat that cold food. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Cook #2 on 06/25/21 at 10:39 AM. Cook #2 stated he had been cooking on and off for 9 months and usually cooked at breakfast and lunch. Cook #2 stated that this morning for breakfast he served grits, eggs, bacon or sausage and toast. He explained that the Dietary Aides (DA) would call out the likes and dislikes off the tray ticket and he would plate the meal based off the tray ticket. Cook #2 stated that another DA would place the drink and condiments on the tray and give it one final review to ensure it was accurate before sending it out to the residents. Cook #2 further explained that he checked the temperature of the food before it got plated so he knew that it was hot when it left the kitchen and stated that the food sat for long periods of time on the hallway and that was one reason why the food was cold when the residents received it. He added that he used a lot of Styrofoam containers to serve food in because he did not like the food to run together and acknowledged that the food did not stay as hot in styrofoam containers as it did on a hot plate with a lid. An interview was conducted with DA #1 on 06/25/21 at 10:44 AM. DA #1 confirmed that he worked the tray line and was usually the one calling out the likes and dislikes from the residents meal tickets and then doing the final check of the tray before it went out the floor to be served to the residents. DA #1 stated that he must have overlooked Resident #40's dislikes of grits and the burnt toast when he was doing the final check of her tray earlier on the shift. 2. An observation of the lunch tray line was conducted on 06/25/21 at 12:01 PM. A test tray was requested at this time as well. The menu included a fish square, half of a baked potato, and mixed vegetables. Temperature monitoring was conducted with Cook #2 on 06/25/21 at 12:05 PM and revealed the following: -Fish Square: 186-degree Fahrenheit (F) and when sampled it was 120-degree F. -Half of baked potato: 180-degree F and when sampled it was 120-degree F. -Mixed vegetables: 190 degrees F and when sampled it was 139-degree F. The test tray was plated at 12:15 PM and sampled at 12:30 PM with Cook #3. When the tray lid was removed from the tray there was no visible steam coming from the tray. The tray was served with no butter for the baked potato. Cook #3 stated that the fish was chewy and room temperature at best and the mixed vegetables were bland but tasted terrible she added that the mixed vegetables were the warmest item on the tray but were also the worse. Cook #3 stated that she preferred to have butter with her baked potato, and none was served with the test tray or with the resident's tray. The Dietary manager was unavailable for interview on 06/25/21 at 1:00 PM. (continued on next page)

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	345179	A. Building B. Wing	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Mooresville	752 E Center Avenue Mooresville, NC 28115

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator was conducted on 06/25/21 at 3:34 PM. The Administrator stated that he had received numerous grievances from residents about the food and indicated that they were quite legit. He stated that two weeks ago he met with the dietary department to go over all the concerns including food temperature. The Administrator stated that they began paging overheard to alert the direct care staff that the meals trays were on the unit and ready to be served. The Administrator stated that in the 8 weeks that he had been at the facility he had attempted to tackle the dietary concerns by simplifying the processes one by one. He continued to explain that on July 6, 2021 there was a new company taking over the dietary department and he was hopeful that would help with the number of food complaints. The Administrator added he expected the resident to receive a hot meal that appeared appetizing in appearance, taste, and temperature.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on record reviews and staff interviews, the facility failed to maintain a complete and accurate medical record when a staff member altered a resident's answers provided on the Brief Interview of Mental Status (BIMS) assessment to reflect the resident was cognitively intact for 1 of 1 residents sampled (Resident #9). Findings include: Resident #9 was originally admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses that included diabetes. The most recent quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #9 to be cognitively intact with the ability to make his needs known and understand others. Resident #9's care plan did not reveal his cognitive status or ability to make his needs known. A BIMS assessment, a standardized testing system comprised of structured questions to determine the cognition status on the MDS and remains a part of the permanent medical record, dated 6/22/21 revealed the assessment was opened and completed by Social Worker #1 on 6/22/21 with the question related to accuracy of the current year marked as missed by greater than 5 years. The assessment reflected it was edited by MDS Nurse #1 on 6/22/21 for the question related to the accuracy of the current year changed to correct. The assessment was later locked on 6/22/21 at 1:56 PM. An interview on 6/22/21 at 2:22 PM with Social Worker #1 (SW) revealed she had been the facilities Director of Social Services since March 2021 and was expected to conduct a BIMS interview on each resident to correlate with the frequency of the MDS assessment. SW #1 indicated she completed a BIMS assessment to assess Resident #9's cognitive status on the morning of 6/22/21 which reflected Resident #9 was moderately impaired for cognitive status related to Resident #9 identifying the current year as 2001. SW #1 stated shortly after completing the assessment, MDS Nurse #1 approached SW #1 and asked her to alter her documentation to reflect Resident #9 to be cognitively intact. SW #1 explained she refused to alter the documentation of the assessment she conducted and inaccurately transcribe Resident #9's answers to reflect differently than the answers provided by Resident #9. She reported MDS Nurse #1 said she would reconduct the BIMS assessment herself. After the MDS Nurse #1 conducted the assessment, SW #1 reported MDS Nurse #1 reapproached her and indicated Resident #9 had also indicated to her the year was 2001 but after prompting, Resident #9 was able to identify the accurate year to be 2021. SW #1 elaborated that MDS Nurse #1 told her she would modify SW #1's documentation on the original assessment to reflect Resident #9 answered the year as being correct because she believed Resident #9 to be cognitively intact despite, he provided an incorrect answer. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/22/21 at 2:56 PM with MDS Nurse #1 revealed SW #1 was responsible for ensuring BIMS assessments were completed and accurate in the medical record and she did not routinely have involvement in conducting the BIMS assessment for Resident #9 in the absence of SW #1 and further revealed the previous administrator had appointed the activity director to perform the BIMS assessment if SW #1 was unable to complete them. MDS Nurse #1 indicated after SW #1 documented Resident #9's change in cognition on the BIMS assessment conducted on 6/22/21 she asked SW #1 if she was aware of a change in cognition and reported SW #1 stated she was not sure, but Resident #1 had failed to accurately identify the correct year during the interview. MDS Nurse #1 explained Resident #9 was routinely cognitively intact and felt the BIMS should be repeated and stated she would conduct one herself. MDS Nurse #1 elaborated that when initially conducting the BIMS assessment herself, Resident #9 identified the current year to be 2001 and further elaborated she prompted Resident #9 what last year was and Resident #9 identified last year to be 2020 and she continued to ask Resident If last year was 2020, what does it make this year and she stated is 2001 your final answer? According to MDS Nurse #1, Resident #9 then stated 2021, you know I know what year it is; I just wasn't saying it right. MDS Nurse #1 further stated, she felt Resident #9 was cognitively intact and therefore modified SW #1's original documentation to reflect Resident #9 answered the current year accurately because he was able to state it after prompting. MDS Nurse #1 indicated she had not been trained to conduct the BIMS assessment to assess a resident's cognition and was not aware prompting Resident #9 was not allowed when asking the resident to identify the current year. An interview on 6/22/21 at 2:56 PM with the Regional MDS Nurse Consultant revealed she expected the BIMS assessment to be completed accurately and timely. The Regional MDS Nurse Consultant also indicated if MDS Nurse #1 questioned the accuracy of the original BIMS assessment completed on 6/22/21 by SW #1, MDS Nurse #1 should have opened an additional BIMS assessment and completed her own instead of modifying the one written by SW #1 and written a note to reflect the decision to repeat the assessment. The Regional MDS Nurse Consultant explained after the second BIMS assessment was completed by MDS Nurse #1 for validation and Resident #9 provided the answer to the question referencing the current year as 2001, MDS Nurse #1 should have documented that response as incorrect by greater than 5 years which would have reflected a lower BIMS assessment score. The Regional MDS Consultant stated she expected MDS Nurse #1 to follow the guidelines outlined in the Resident Assessment Instrument (RAI) manual which reads in part that prompts should not be provided when asking a resident the question, What year is it? An interview on 6/23/21 at 9:48 AM with the Administrator revealed he expected the BIMS assessment be completed accurately by a trained and qualified individual. He stated he was not aware MDS Nurse #1 had not been trained to complete a BIMS assessment. The Administrator explained when Resident #9 answered the question of the current year as 2001, MDS Nurse #1 should have documented the BIMS assessment to reflect that was answered incorrectly.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38515 Based on observations, record review, and facility staff interviews, the facility failed to maintain clean dryer drums free from build-up of melted and hardened substances in dryers for 3 of 3 dryers used to dry linens (dryers #1, #3, and #4). Findings Included: An observation of the facility's dryers completed on 06/21/21 at 11:44 AM revealed dried, multicolored hard substances throughout the entirety of the dryer drum completing a rainbow colored circle approximately 8-12 wide in dryers #1, #3, and #4. An interview with Laundry Aide #1 on 06/21/21 at 11:49 AM revealed the dryer drums have had the dried substances in them as long as she has worked in the building. She reported she did not know what the dried substance was nor was she able to determine if it had gotten worse. During the interview, Laundry Aide #1 tried to scrap off the substance without success. She reported 3 of the dryers had unidentified dried, hardened substances in them and verified that the dryers were used for drying resident laundry along with all the linen provided by the facility. During an interview with the Environmental Services Director on 06/21/21 at 11:53 AM, he reported he could not identify the dried, hardened substances that were located in the 3 dryers. He reported he would not want his personal clothing to be dried in the facility's dryers in the condition they were in. During a follow up interview with Laundry Aide #1 on 06/24/21 at 3:23 PM, she reported she had voiced her concern over the condition of the facility's clothes dryers to the previous administration numerous times but nothing was ever done. She reported it was difficult to do her job with the condition the dryers were in due to her feeling like the clothes were not clean after being dried in the dryers with the hardened substances in the drums. During an interview with Laundry Aide #2 on 06/24/21 at 5:19 PM, he reported he has worked at the facility in the laundry room for a year and stated the dryer drums have had that dried substance in it since he started working at the facility. He reported he had not notified anyone about the condition of the dryers because they get hot and dry clothes, so to me, they are working good. During an interview with the Administrator on 06/25/21 at 2:45 PM, he reported Accordius was responsible for the maintenance and the servicing of the facility's dryers. He reported his expectation was the dryers be clean, sanitary, and in good operating condition.