STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675936	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PONDEROSA NURSING AND REHABILITATION CENTER	**12520 FM 1840 DE KALB, TX 75559**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure an infection prevention and control program designed to provide a safe environment and to help prevent the development and transmission of communicable diseases and infections related to COVID-19 (a contagious respiratory virus) was provided for the facility. The facility did not ensure staff wore a mask covering their nose and mouth at all times while in the facility. The facility did not quarantine Resident #s 1 and 5 for 14 days following a hospital admission and Resident #6 after his exposure to Resident #5, who had a COVID-19 unknown status. The facility did not sanitize telephones used by residents and staff after each use. The facility did not restrict all visitors from the facility. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 7/8/2020. While the IJ was removed on 7/9/2020, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for being exposed to COVID-19, health complications, and death. Findings included: 1. During an observation on 7/7/2020 at 9:00 a.m., CNA C opened the front door of the facility to allow surveyors entrance. She wore her mask under her chin, not covering her nose and mouth. During an interview on 7/7/2020 at 11:40 a.m., CNA C said a mask covering the nose and mouth was to be worn at all times while in the facility. During an observation on 7/7/2020 at 9:01 a.m., LVN D was sitting behind the nursing station without a mask, while handing the telephone to a resident in a wheelchair at the nursing station. During an interview on 7/7/2020 at 11:45 a.m., LVN D said a mask was to be worn at all times while in the facility. LVN D said she should have been wearing a mask During an observation on 7/7/2020 at 9:15 a.m., dietary aide E was walking past the nursing station and down a resident hall toward the kitchen and was not wearing a mask. During an interview on 7/7/2020 at 9:40 a.m., COTA N said staff in the facility did not wear a facemask at all times. She said she saw staff in the hallways without a mask. During an observation and interview on 7/7/2020 at 9:45 a.m., CNA F had her mask pulled under her chin, not covering her mouth or nose, while bending over speaking to a resident in a wheelchair. She said she had her mask under her chin because the resident could not understand what she was saying with it on. She said facility policy was to wear a mask covering the mouth and nose at all times. During an observation and interview on 7/7/2020 at 9:48 a.m., CNA G had her mask pulled down under her chin, not covering her mouth and nose, while sitting at the nursing station. She said facility policy was to wear a mask at all times. She said it was not policy to have the mask pulled under the chin. During an observation on 7/7/2020 at 9:50 a.m., 2 cooks in the kitchen were observed wearing masks pulled under their chin, not covering their nose and mouth. During an interview on 7/7/2020 at 9:50 a.m., the dietary supervisor said it was facility policy to wear a mask covering the nose and mouth at all times while in the facility. During an observation and interview on 7/7/2020 at 9:51 a.m., dietary aide E was walking down the hallway without a mask. She said it was facility policy to wear a mask at all times. During an interview on 7/7/2020 at 9:52 a.m., the dietary supervisor said the dietary aide should wear a mask when walking in the hallways. During an observation and interview on 7/7/2020 at 11:55 a.m., CNA H was leaving a resident's room with her mask under her chin, not covering her mouth and nose. She said it was the facilities policy to wear a mask in the facility with no exceptions unless eating lunch. CNA H said she had her mask pulled down because the resident could not understand what she was saying when she had it covering her mouth. During an observation and interview on 7/7/2020 at 3:00 p.m., dietary aide J was in the kitchen with her mask under her chin, not covering her nose and mouth. She said it was facility policy to wear a mask at all times while in the kitchen. She said she pulled the mask down while checking to see if the green beans were done. During an observation and interview on 7/7/2020 at 3:00 p.m., dietary aide K was in the kitchen with her mask over her mouth, but not covering her nose. She said her mask should cover both her nose and mouth. During an observation on 7/7/2020 at 3:10 p.m., RN M was in her office not wearing a mask while being interviewed by the surveyor. During an interview on 7/7/2020 at 9:55 a.m., Resident #1 said staff did not wear a mask at all times, especially the nurses. She said nurses cared for her at times while not wearing a mask. During an interview on 7/7/2020 at 10:30 a.m., Resident # 2's granddaughter said she brought a check to the facility in May of this year and the staff member who came to door was not wearing a mask. She said she did not know who the staff person was. During an interview on 7/7/2020 at 1:20 p.m., Resident #3 said staff sometimes wore masks in the facility. During an interview on 7/7/2020 at 3:05 p.m., Resident #4 said staff did not wear a mask at all times. During an interview on 7/7/2020 at 2:10 p.m., the ADON said staff were supposed to wear a mask at all times while in the facility. During an interview on 7/7/2020 at 9:10 a.m., the administrator said it was facility policy to wear a mask at all times, but he took his off in his office while he was alone. During an interview on 7/7/2020 at 9:15 a.m., The DON said all staff were to wear a mask covering their nose and mouth at all times while in the facility. An undated Policy Statement for Infection Disease -COVID-19 provided by the facility indicated: . all staff and any visitors that enter the building must always wear a mask. The policy indicated the mask must cover the entire mouth and nose . The website https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html updated on 6/25/20 and accessed on 7/19/20 indicated: .HCP (health care personnel) should wear a facemask at all times while they are in the facility . 2. A face sheet dated 7/8/2020 indicated Resident #1 was [AGE] years old, readmitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] indicated Resident #1 made herself understood and understood others and had no cognitive impairment. The MDS indicated Resident #1 rejected care 1 to 3 days of the 7 day look back period. The MDS indicated Resident #1 was independent moving to and returning from off unit locations such as from the dining area, activities or treatments. A nursing note dated 6/28/2020 indicated Resident #1 returned from the hospital with a [DIAGNOSES REDACTED]. The care plan dated 7/2/2020 indicated Resident #1 returned from a hospital stay and refused to be put on isolation following COVID-19 guidelines. The care plan indicated the resident was educated about the risk of spreading COVID-19 to other residents if she was positive and did not know it. The care plan indicated it was her right to not remain on isolation. During an observation on 7/7/2020 at 9:55 a.m., Resident #1 was in her power chair in a cold (COVID-19 negative) hallway. Resident #1 said she was going to smoke. During and observation on 7/7/2020 at 3:45 p.m., Resident #1 was outside smoking with other residents. During an observation on 7/8/2020 at 9:50 a.m., Resident #1 was in her room on the warm hall. During an observation and interview on 7/7/2020 at 4:18 p.m., Resident #1 was at the communal phone station near the front door of the facility and next to a nursing station with her mask under her chin. She said she didn't think she was on isolation anymore. She said she had been instructed about isolation because she had gone to the hospital, but she wanted to smoke and did not want to stay in her room all the time. During an interview on 7/7/2020 at 3:55 p.m., LVN D said Resident #1 was not on isolation any longer. She said Resident #1 was on the warm (COVID-19 unknown) hall because of a sprinkler malfunction in the facility. During an interview on 7/7/2020 at 4:00 p.m., the DON said Resident #1 was supposed to be in isolation on the warm (COVID-19 unknown) hall due to a recent hospitalization . She said the resident had been educated regarding staying in her room for 14 days, but she refused. A face sheet dated 7/8/2020 indicated Resident #5 was a [AGE] year-old male, readmitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The most recent MDS dated [DATE], indicated Resident #5 made himself understood and understood others. The MDS indicated Resident #5 had a behavior

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) of rejection of evaluation or care that occurred 1 to 3 days during the 7 day look back period. The MDS indicated Resident #5 required extensive assistance with bed mobility, dressing and personal hygiene and was totally dependent with transfers and toileting. The MDS indicated Resident #5 needed supervision to move between locations in his room. A care plan dated 4/28/2020 indicated Resident #5 refused to remain in isolation for 14 days after a return from the hospital on [DATE]. The care plan indicated 5/21/2020 Resident #5 continued to refuse to remain in isolation. The care plan indicated Resident #5 had another hospitalization and returned to the facility on [DATE] and refused isolation. The care plan indicated Resident #5 would be monitored for signs and symptoms of COVID-19, educated on consequences of not remaining on isolation and the risk to other residents related to COVID-19 and would be instructed to wear a mask when out of his room. A waiver of treatment or intervention signed on 4/24/2020 indicated Resident #5 refused isolation for 14 days and was instructed of the risks including being COVID-19 positive, sore throat, cough, temperature, respiratory issues, possible death, putting others at risk for COVID-19. The document indicated Resident #5 was educated he should isolate himself as much as possible, wear a mask, stay in his room, distance himself 6 feet from others and do hand hygiene. A waiver of treatment or intervention signed on 7/3/20 indicated Resident #5 refused isolation for 14 days and was instructed of the risks including being COVID-19 positive, sore throat, cough, temperature, respiratory issues, possible death, putting others at risk for COVID-19. The document indicated Resident #5 was educated he should isolate himself as much as possible, wear a mask, stay in his room, distance himself 6 feet from others and do hand hygiene. During an observation on 7/7/2020 at 11:21 a.m., Resident #5 was driving his powerchair through the communal dining room. He was wearing a surgical mask. During an observation on 7/7/2020 at 3:40 p.m., an isolation cart was outside of Resident #5's room on the cold hallway. During an observation on 7/7/2020 at 3:45 p.m., Resident #5 was outside smoking in the designated smoking area with Resident #6 and were not wearing masks. During an observation on 7/7/2020 at 4:15 p.m., Resident #5 was driving his power wheelchair down the cold hall back to his room. He was wearing a mask covering his mouth and nose. During an interview on 7/7/2020 at 4:15 p.m., Resident #5 said he did not want to be in his room for 14 days. He said he wanted to get out of his room and be able to go smoke. Resident #5 said he had been instructed on isolation precautions and that he was instructed to wear a mask when he left his room. During an interview on 7/7/2020 at 3:45 p.m., LVN P said Resident #5 was in the hospital from 6/28/2020 through 7/3/2020 and was on isolation precautions. LVN P said Resident #5 was supposed to be in his room and she had reported Resident #5 did not stay in his room to management. LVN P said the staff could not keep him in his room and he had refused to move to the warm hallway. During an interview on 7/7/2020 at 4:00 p.m., the DON said Resident #5 refused to move out of his room on the cold hall to a room on the warm hall and refused to stay isolated in is room on the cold hall. She said Resident #5 was a smoker and spent a lot of the day outside in the smoking area. She said Resident #5 was roommates with Resident #6 who was not currently on quarantine, but both had refused to move to another room. The DON said both residents had signed a waiver of refusal and both were educated on the risks to themselves and others, COVID-19 signs and symptoms, wearing a mask, and on isolation following a hospital stay. The DON said they had not contacted the ombudsman for assistance with the situation. A face sheet dated 7/8/2020 indicated Resident #6 was [AGE] years old and readmitted to the facility 8/5/2019 and had [DIAGNOSES REDACTED]. The physician orders [REDACTED].#6 could use his electric wheelchair for mobility and would wear a mask when out of his room. A care plan dated 7/8/2020 indicated Resident #6 was at risk for alteration in psychosocial wellbeing related to restriction on visitation due to COVID-19. The care plan indicated Resident #6's roommate returned from the hospital on [DATE] and the resident and roommate refused to be moved and refused isolation. The care plan said Resident #6 signed a waiver in April 2020 and again in July 2020 indicating he knew the risks of staying in the room with his roommate. The care plan indicated the resident was educated regarding COVID-19 and risks of spreading to other residents if they were positive and did not know it. A waiver of treatment or intervention signed by Resident #6 on 4/24/2020, indicated Resident #6 refused to isolate from his roommate for 14 days. The waiver indicated by refusing to isolate from his roommate the following risks were likely to occur testing positive for COVID-19 symptoms including sore throat, cough, temperature, respiratory issues, and possible death. A Waiver of treatment or intervention signed by Resident #6 on 7/3/2020 indicated Resident #6 refused to move rooms and refused 14-day isolation. The waiver indicated by refusing to move rooms and refusing isolation the following risks were likely to occur: COVID-19 +, sore throat, cough, temperature, respiratory issues, possible death, and would put others at risk for COVID 19. The waiver indicated Resident #6 was educated to isolate himself as much as possible, wear a mask, stay in the room, distance 6 feet from others and to perform hand hygiene. During an observation and interview on 7/7/2020 at 11:12 a.m., Resident #6 was in the cold hallway returning from the common area with a mask covering his nose and mouth. Resident #6 said he was told his roommate had refused isolation after his hospital stay and he had been offered a room change but he did not want to move to another room. Resident #6 said he did not smoke but liked to go out to the smoking area to visit other residents including Resident #5 while they were outside smoking. During an observation on 7/7/2020 at 3:45 p.m., Resident #6 was outside in the smoking area with Resident #5. During an interview on 7/7/2020 at 4:00 p.m., the DON said Resident #6 was the roommate of Resident #5. The DON said Resident #6 was not on isolation precautions and also refused to move out of his room with Resident #5. The DON said both residents signed waivers refusing to move rooms and refusing isolation. The DON said both residents were educated regarding COVID-19, wearing masks, and isolation following a hospital stay but the facility was unable to force them to move rooms or remain in isolation per policy. The DON said it was the facility policy for residents to be quarantined for 14 days when readmitted to the facility after a hospital stay. During an interview on 7/7/2020 at 4:45 p.m., the administrator said they encouraged residents to stay in their rooms for isolation after a hospital stay. He said the facility had many residents with behaviors of rejecting care. He said he knew Resident #5 on B-hall (cold hall) refused to move to the warm hall and his roommate (Resident #6) also refused to move out of the room and a waiver had been signed for both residents. The website https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html updated 6/25/20 and accessed 7/19/20 indicated: .create a plan for managing new admissions and readmissions whose COVID-19 status is unknown .this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19 .residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission . The website https://www.hhs.gov/answers/public-health-and-safety/what-is-the-difference-between-isolation-and-quarantine/index.html accessed 7/19/20 indicated: .Isolation separates sick people with a contagious disease from people who are not sick .quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease buy do not show symptoms . 3. During an observation on 7/7/2020 at 9:00 a.m., LVN D was using the nursing station phone and was not wearing a mask. LVN D handed the phone to a resident without cleaning and disinfecting the phone. An unknown resident was using a communal phone that was located near the nursing station. During an interview on 7/7/2020 at 1:40 p.m., LVN D said she cleaned the phone at the nursing station with wipes throughout the day but was unsure of when the communal phone for the residents was cleaned. During an interview on 7/7/2020 at 4:25 p.m., the administrator said he was unaware of how often the communal phone was being cleaned. 7/7/2020 at 4:30 p.m., the housekeeping supervisor said all phones in the facility were cleaned daily. https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Fdisinfecting-building-facility.html accessed 7/19/20 indicated: .Surfaces and objects in public places .should be cleaned and disinfected before each use .High touch surfaces include: .phones . https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf accessed 7/19/20 indicated: .Properly clean, disinfect and limit sharing of medical equipment between residents .provide additional work supplies to avoid sharing and disinfect workplace areas (.phones .). 4. During an observation on 7/7/2020 at 1:30 p.m., 2 males were sitting together inside the smoking area and were not wearing a mask (later determined to be an employee's husband and facility HR personnel) During an observation and interview on 7/7/2020 at 1:35 p.m., a resident was sitting under the gazebo smoking and a male visitor was sitting inside the fenced in area, smoking. The visitor said he was the spouse of an employee of the facility and he stopped by occasionally to visit with the residents and staff as they came outside to smoke. He said the facility had not told him about restricting visitors and he never went to the front of the building to be screened. During an interview on 7/7/2020 at 1:43 p.m., an unidentified resident said all visitors were being restricted from coming in the facility. The resident said he saw an employee's husband out at the smoking area quite often visiting with staff members while smoking. During an interview on 7/7/2020 at 1:55 p.m., human resource employee A said there were no visitors allowed at the facility except through the window for residents or an end of life situation. He said he was outside smoking in the fenced in area with an employee's husband a few minutes ago. He said he could not recall the employees name. He said they remained 6 feet

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) apart but were not wearing a mask because they were smoking. He said the man came by the facility about once a week and visited with staff members outside. He said he never saw the man visit with residents or under the gazebo area. He said he thought administration was aware of the visits. During an interview on 7/7/2020 at 2:10 p.m., the ADON said the facility was to have zero visitors at this time unless it was an end of life situation. During an interview on 7/7/2020 at 1:45 p.m., the DON and administrator said absolutely no visitors were allowed inside or outside of the facility for staff or residents unless there was an end of lift situation or the family was visiting a resident at the window. The DON and administrator said family of employees were not allowed in the facility and were prohibited from visiting with the employee outside at this time. An undated Policy statement for Infections Disease-COVID 19 provided by the facility indicated: .no visitors allowed within the building or outside around any residents or staff . https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf accessed 7/19/20 indicated: .Guidance for limiting the transmission of COVID-19 Nursing Homes. For ALL facilities nationwide: Facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain [MEDICATION NAME] care situation, such as end of life . The administrator was notified on 7/8/2020 at 9:20 a.m. that an IJ situation was identified due to the above failures. The administrator was provided the IJ template on 7/8/2020 at 9:38 a.m. The facility's Plan of Removal was accepted on 7/8/2020 at 11:06 p.m. and included: #1. Mask: In-service initiated on 07-07-2020 by the DON on wearing mask while in the building to cover entire mouth and nose at all times. If mask is not worn correctly disciplinary actions will take place. All staff in all departments will be in-serviced on this and it will be ongoing. Education will also be placed within new hire orientation to include Policy on wearing mask at all times while in facility. In-service to be completed on 07/09/2020 and ongoing. *** Phones will be disinfected by staff/nurse at the nurses' station prior to and after resident using phone. In-service to be initiated on 07/08/2020 by DON and to be completed by 07/10/2020 and then ongoing to include instructions on cleaning/disinfecting phones. Signs will be posted by phones at nurses' stations to educate on cleaning/disinfecting from person to person contact. ***Phones not in nurses' station (for resident use on wall) will be disinfected after each use by the Door screener as well as during regular right traffic area cleaning by the housekeeping department. In-service to be initiated by the Administrator on 07/08/2020, to be completed on 07/10/2020 to include Nursing department, Head departments, and Housekeeping Departments and will continue to be ongoing. #2. 2 residents not on Warm Hall isolation: **Both residents (were placed on the Warm Hall/isolation hall-with only isolated residents present on 07/08/2020) by Maintenance Director and Housekeeping Supervisor. **The resident roomed on the cold hall with one of the 2 residents) was moved to Warm Hall/isolation hall with the other resident on 07/08/2020, waiver signed by both residents with risk factors and education provided. **Any new admissions/ Re-admissions will be placed only on the Warm Hall that occupies only isolated residents. **Plastic Barrier put in place on 07/08/2020 to limit staff and resident exposure to Warm Hall area. Completed by maintenance director and housekeeping supervisor. Plastic Barrier contains zipper that keeps barrier in place and others from freely entering and exiting Warm Hall. Clear window area cut in plastic barrier to allow easier visualization throughout the hall. **Supply room moved to conjoin with medication supply room [ROOM NUMBER]/07/2020, therapy department moved to activity room [ROOM NUMBER]/08/2020, and staff conference room relocated to another room on 07/08/2020 to keep non-needed staff and residents from entering and exiting the Warm Hall area. Completed by the Maintenance Director, House Keeping Supervisor, and DON/ADON. In-service initiated to include these changes on 07/08/2020, to be completed by 07/09/2020 and ongoing by Administrator and Activity Director. **Laundry department will bring in and out barrels of linen from the Cold Halls through the activity room door, front door, or through a door on the Cold Hall. They will no longer bring barrels in and out of the facility throughout the Warm Hall area. In-Service initiated to all Nursing and Laundry department on 07/08/2020, to be completed by 07/09/2020 by the Activity Director and Administrator and ongoing. **Dietary to send all meals to Warm Hall on paper products that can be discarded into the biohazard trash. No meal carts will be transferred from Warm Hall back to the dietary department. In-Service initiated to all Dietary and Nursing department on 07/08/2020, to be completed by 07/09/2020 by the administrator and activity director and ongoing. **Smoking area sectioned off to maintain distance between isolated residents and non-isolated residents. In-service will be initiated on 07/08/2020 to educate all staff on reminding and educating residents on social distancing and keeping at least 6 feet apart by DON, to be completed by 07/09/2020 and will be ongoing. Isolated residents will exit Warm Hall door (this leads straight outside and does not allow the resident to travel throughout the facility) to smoke in the designated area for isolated residents. #3 NO Visitors In-service initiated on No Visitors started 07/08/2020 by DON, will be completed by 07/09/2020 and will be ongoing to all staff. a.Revealed who visitor was----(A staff members husband). Staff members Husband was immediately asked to leave on 07/07/2020 by the Administrator. Record of Concern as well as in-servicing this staff member on NO visitors was initiated on 07/07/2020 by DON. All staff In-serviced on NO visitors initiated on 07/08/2020 by DON, to be completed by 07/09/2020 and will be ongoing. On 7/9/2020 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Six LVN's (on all shifts 6 a.m.-2 p.m., 2 p.m.-10 p.m., 10 p.m. to 6 a.m.), 4 RNs (on all shifts), 19 CNA's (on all shifts), 4 dietary personnel (on all shifts), 2 housekeepers, one human resource staff, 1 social worker and 1 maintenance staff member said they were in serviced regarding wearing a mask in the facility at all times covering the mouth and nose, restriction of all visitors in and outside of the facility including resident and staff family members or friends, disinfecting the phones prior to and after a resident using the phone and isolation procedures including a 14 day quarantine following all hospital stays. All staff interviewed said: *they were to wear mask at all times when in the building and the mask should always cover their nose and mouth. *staff could not have visitors inside or outside the facility and if they saw a visitor they would report to administration. *all phones should be cleaned and disinfected between each use. *residents returning from the hospital should be quarantined and have restricted movement in the facility for 14 days following re-admission. During an observation on 7/9/2020 at 12:10 p.m. Resident #1 was in her room on the warm hallway. During an observation on 7/9/2020 at 12:10 p.m., Resident #5 was in his room on the warm hallway. During all observations on 7/9/2020 from 9:45 a.m. through 3:45 p.m. all staff wore masks covering their nose and mouth. On 7/9/2020 at 3:00 p.m., the administrator was informed the IJ was removed; however, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.