STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	C 05/10/2021

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted from 4/28/2021 through 5/10/2021. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 57K611.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey and complaint investigation survey was conducted from 04/28/2021 through 05/10/2021 at Event ID# 57K611. Seven out of 26 complaint allegations were substantiated resulting in deficiencies. One of 26 complaint allegations was substantiated without deficiency. An unannounced COVID-19 Focused Survey and complaint investigation survey was conducted from 04/28/2021 through 05/10/2021. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		5/31/21

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

Electronically Signed | 05/24/2021

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F 641	Continued From page 1 by: Based on record review and staff interview the facility failed to accurately code a minimum data set assessment for 1 (Resident #3) of 4 residents reviewed for accidents. Findings included: Resident #3 was admitted to the facility on 1/31/20 with cumulative diagnoses, one of which was Alzheimer's disease. A physician's order was initiated on 9/12/2020 for Resident #13 to have a wander or elopement alarm to the ankle and to have the placement checked every shift for monitoring. This order was documented as completed on the January and February 2021 treatment administration records (TAR). The most recent annual minimum data set (MDS) assessment dated 2/9/2021 coded Resident #3 as severely cognitively impaired and not using a wander or elopement alarm at the time of the assessment. An interview was conducted on 5/3/2021 at 11:20 AM with the Regional reimbursement specialist who completed the 2/9/2021 MDS assessment for Resident #3. The regional reimbursement specialist stated she made an error in coding the assessment for Resident #3 and the current MDS nurse would amend the MDS for Resident #3.	F 641	Address how corrective action will be accomplished for resident(s) found to have been affected: On 5/3/2021 the Minimum Data Set (MDS) Nurse amended the MDS for Resident #3 to capture accurate coding of wander or elopement alarm. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: On 5/3/2021 the Minimum Data Set (MDS) Nurse audited all wandering residents' assessments to ensure accurate coding. Based on findings of this audit, changes were implemented as indicated. Address what measures will be put in place and systematic changes made to ensure that the identified issue does not occur in the future: Starting the week of 5/16/2021, the Director of Nursing (DON) will complete an audit tool of Section P of the MDS assessment for all residents with wander or elopement alarm as part of the weekly Clinical Risk Meeting. Based on findings of this audit, changes will be implemented as indicated. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action	

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F 641	Continued From page 2	F 641	evaluated for its effectiveness: The Regional MDS/Reimbursement will review the audit tool weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month, of residents with wander or elopement alarm and will report audit findings monthly to the QAPI Team for review times 3 months. Documentation of the review will be kept by Administrator in the QAPI Book. Completion Date: 5/31/2021	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		5/31/21

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F 656	Continued From page 3 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, resident and family interview, the facility failed to consistently implement a care plan intervention for 1 (Resident #4) of 3 residents reviewed for interventions for potential accidents/falls. Findings included: Resident #4 was admitted to the facility on 4/21/2021 with a diagnosis of cerebral infraction with right sided hemiplegia. Review of a Brief Interview of Mental Status dated 4/21/2021 had a score of 15 indicating Resident #4 was assessed as being cognitively intact. Documentation in the nursing notes dated 4/24/2021 at 11:34 AM revealed Resident #4 had a fall from his bed on the 11:00 PM to 7:00 AM	F 656	Address how corrective action will be accomplished for resident(s) found to have been affected: On 5/6/2021 the Director of Nursing (DON) placed the fall mat on the right side of the bed and bed was put in the lowest position in order to consistently implement the care plan intervention for Resident #4. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: On 5/6/2021 current residents with fall mats as care plan interventions were reviewed by the Director of Nursing (DON) to ensure consistent implementation. If the fall mat was not in place, the Director of Nursing (DON) corrected immediately. On 5/6/2021, the Staff Development	

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F 656	Continued From page 4 shift on the morning of 4/24/2021. Documentation on a post fall review dated 4/24/2021 under the intervention recommendations stated, "Will place mat on right side of bed and bed in lowest position when in bed." The care plan for Resident #4 dated as initiated on 4/22/2021 had a focus area for a risk for falls relative to a new Cerebral Vascular accident with right sided hemiplegia, weakness, impaired gait, balance, strength, and mobility. The care plan focus area was updated on 4/24/2021 stating Resident #4 had a fall with no injury. One of the interventions on the care plan was for a fall mat to be placed to the right side of bed and the bed in a low position when in bed. An observation was made on 4/29/2021 at 10:00 AM of Resident #4 laying in bed. There was no fall mat on the floor to the right side of the bed. An observation was made on 4/30/2021 at 9:30 AM of Resident #4 laying in bed with his eyes closed resting. There was no fall mat on the floor to the right side of the bed. An observation was made on 5/6/2021 at 3:27 PM of Resident #4 laying in bed. A fall mat was located on the right side of the unoccupied bed located in the same room as Resident #4. Resident #4 did not have a fall mat located on the right side of his bed. Resident #4 was interviewed at the time of the observation and stated the fall mat was "sometimes" used next to his bed. An interview was conducted with Nurse #3 on 4/29/2021 at 2:02 PM. Nurse #3 was assigned to	F 656	Coordinator (SDC) started re-education to current staff regarding the consistent placement of the fall mat for those residents with the care plan intervention. Education will be completed on 5/20/2021. Address what measures will be put in place and systematic changes made to ensure that the identified issue does not occur in the future: Starting the week of the 5/16/2021, the Receptionist or designee will complete a weekly observation audit tool to ensure the consistent placement of the fall mat for those residents with the care plan intervention. Based on findings of this audit, changes will be implemented as indicated. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness: The Director of Nursing (DON) will review the observation audit tool weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month, of residents with the fall mat as a care plan intervention and will report audit findings monthly to the QAPI Team for review times 3 months. Documentation of the review will be kept by Administrator in the QAPI Book. Completion Date: 5/31/2021	

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care for Resident #4 on the 11:00 PM to 7:00 AM shift on 4/27/2021, 4/28/2021, and 4/29/2021. Nurse #3 stated she did not recall seeing a fall mat on the floor in the room of Resident #4 on the week of 4/27/2021 when she was assigned to care for the resident.

An interview was conducted with Nurse Aide (NA #8) on 4/30/2021 at 6:15 AM. NA #8 was assigned to the hall where Resident #4 resided on the 11:00 PM to 7:00 AM shift on 4/26/2021, 4/28/2021, and 4/30/2021. NA #8 revealed Resident #4 was still getting used to the smaller bed provided by the facility and frequently needed to be repositioned away from the edge of the bed. NA #8 also revealed Resident #4 did not have a mat on the floor next to his bed on the shift she was working while caring for the resident.

An interview was conducted with a family member of Resident #4 on 5/3/2021 at 12:55 PM. The family member stated she visited Resident #4 three times a day every day. The family member revealed a fall mat was not placed on the right side of the bed until the weekend of 5/1/2021 and 5/2/2021.

An interview was conducted with a Certified Medication Aide (CMA #2) on 5/4/2021 at 12:14 PM. CMA #2 was assigned to the hall where Resident #4 resided on 7:00 AM to 3:00 PM shift on 4/29/2021 and the 3:00 PM to 11:00 PM shift on 4/30/2021. CMA #2 stated she recalled going in the room to provide medications and answer a call light for Resident #4 on the days she was assigned to care for Resident #4. CMA #2 stated there was not a fall mat on the right side of the bed when Resident #4 was in the bed.

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F 656	Continued From page 6 An interview was conducted with the Director of Nursing (DON) on 5/3/2021 at 10:40 AM. The DON stated she personally put a fall mat on the floor next to the bed in the room of Resident #4 on 4/26/2021. The DON revealed the fall mat was still there on the floor in the same position as when she placed it there on 4/26/2021. The DON indicated she did not think the fall mat had been moved since she placed it there and expected the fall mat to be in place every time the resident was in bed.	F 656		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician interview, nurse practitioner interview, and family interview the facility failed to provide necessary services and medical equipment for treatment of pressure sores for 1 (Resident #13) of 3 residents reviewed for pressure sores. The facility failed to obtain replacement parts for a wound vac, provide an air mattress, provide	F 686	Address how corrective action will be accomplished for resident(s) found to have been affected: Resident #13 was discharged to the hospital on 5/1/2021. Address how corrective action will be accomplished for resident(s) having	5/31/21

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F 686	Continued From page 7	F 686		

wound treatments as ordered, and notify the physician of a decline in the wound for Resident #13, resulting in a deterioration of a stage 4 pressure wound with an increase in size and infection.

Findings included:

Resident #13 was admitted to the facility from the hospital on 3/3/2021 with diagnoses of diabetes, polyneuropathy, peripheral vascular disease, osteomyelitis of the sacrum.

The discharge summary from the hospital dated 3/3/2021 revealed Resident #13 was discharged to the facility with a wound vac to a Stage 4 pressure ulcer on the sacrum. A wound VAC is a vacuum-assisted closure of a wound as a type of therapy to help wounds heal. The discharge summary also indicated Resident #13 required a "low-pressure mattress."

The admission minimum data set assessment dated 3/6/2021 coded Resident #13 as having moderately impaired cognition with no behaviors or rejection of care. Resident #13 required extensive assistance of one person with bed mobility and did not walk or perform locomotion during the assessment period. The assessment coded Resident #13 as having a Stage 4 pressure sore and one unstageable pressure sore present on admission. The assessment additionally coded the resident as utilizing a pressure reducing device for the bed.

Review of the care plan for Resident #13 revealed a focus area initiated on 3/25/2021 for a pressure ulcer to the sacrum and unstageable to heel. The care plan indicated Resident #13 was

potential to be affected by the same issue needing to be addressed:
On 4/26/2021, the Treatment Nurse evaluated all residents with pressure ulcers to ensure they had an appropriate mattress and/or treatments in place according to their wound status. Based on findings of this audit, changes were implemented as indicated.
On 4/30/2021 the Staff Development Coordinator (SDC) started reeducation to current license nurses on documentation on the TAR at completion of the treatment and notification to physician regarding changes in pressure ulcer status.

Address what measures will be put in place and systematic changes made to ensure that the identified issue does not occur in the future:
Starting the week of 5/16/2021, the Treatment Nurse or designee, will be conducting a weekly audit tool of preventive mattress and/or treatments on all residents with pressure ulcers to ensure appropriate preventive mattress and/or treatments are in place. Based on findings of this audit, changes will be implemented as indicated.
Starting the week of 5/16/2021, Director of Nursing (DON) or designee will conduct a daily audit of the TARs of residents with pressure ulcers. Based on findings of this audit, changes will be implemented as indicated.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must

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F 686	Continued From page 8 at risk for further impaired skin integrity and/or worsening of current wounds relative to a urinary catheter, diabetes, peripheral vascular disease, morbid obesity, and activity of daily living self-care deficit. Some of the interventions were to administer treatments as ordered and monitor for effectiveness as well as the requirement of a pressure relieving (air mattress) on bed. Documentation in the medical record revealed Resident #13 was admitted to the facility with physician orders dated 3/3/2021 for a wound vac to the sacral pressure sore to be changed every Monday, Wednesday, and Friday and if the wound vac was not available a wet to dry dressing was to be applied every Monday, Wednesday, and Friday. An additional physician order dated as initiated 3/8/2021 for the inflation of a pressure redistribution mattress to be checked every shift for Resident #13. A physician admission progress note dated 3/8/2021, written by MD #1, noted Resident #13 was to be followed and treated at a wound clinic. Documentation on a follow-up progress note dated 4/6/2021, written by the wound care nurse practitioner (NP #1), revealed the recommendations for the treatment of the sacral pressure ulcer for Resident #13. The recommendations clarified the cleaning, packing, and sealing of the wound in addition to the wound VAC settings. Documentation in physician follow-up note dated 4/7/2021, written by MD #1, revealed the family of Resident #13 had requested the facility wound provider (NP #1) follow the patient. MD #1 documented he agreed because Resident #13	F 686	develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness: The Director of Nursing (DON) will review the audit tool weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month, to ensure the documentation on the TAR is complete and appropriate preventive mattress and/or treatments are in place. Findings will be reported monthly to the QAPI Team for review times 3 months. Documentation of the review will be kept by Administrator in the QAPI Book. Completion Date: 5/31/2021	

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was "making progress."

Documentation in a follow-up progress note dated 4/12/2021, written by NP #1, revealed under treatment recommendations instructions for the sacral pressure ulcer stated, "Wound VAC on hold due to malfunctioning, clean with dwc (wound cleanser), pack with calcium alginate, cover the abd (abdominal) pad, secure with tape. Change daily."

Documentation in a skin/wound progress note dated 4/12/2021 by treatment nurse #1 (TN #1), revealed NP #1 did an assessment of Resident #13. The progress note revealed the NP #1 recommended continuing the current treatment at that time. The progress notes also revealed the wound VAC for Resident #13 was on hold. TN #1 was not available for interview due to a medical leave of absence.

Review of the April treatment administration record (TAR) for Resident #13 revealed an order initiated on 4/13/2021 and discontinued on 4/15/2021, "Cleanse sacral wound with NS (normal saline). Apply NS moistened calcium alginate packing to wound bed. Cover with ABD pad. Secure with tape. Every day shift for wound healing for 8 days." This order was documented as administered on 4/13/2021 and 4/15/2021. The TAR was blank on for this treatment order on 4/14/2021.

Nurse #2, who was assigned to provide care for Resident #13 on the day shift on 4/14/2021, was interviewed on 5/7/2021 at 11:54 AM. Nurse #2 stated she did not recall if she did the sacral wound treatment for Resident #13 on 4/14/2021 and did not recall why she did not document the

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F 686	Continued From page 10	F 686		

sacral wound treatment. Nurse #2 stated she routinely did her treatments and routinely documented the treatments she completed.

Review of a nursing progress note dated 4/18/2021 at 8:24 AM revealed, "Resident alert and oriented able to voice needs during morning care resident rolled out of bed. CNA (certified nursing assistant) was at bedside holding onto resident. Resident was sitting on the floor left arm on the side rail left pinky toe open area cleansed dry dressing applied. [Responsible party] was made aware."

The Director of Nursing (DON) was interviewed on 5/7/2021 at 12:15 PM. The DON revealed she was made aware Resident #13 rolled out of bed on Saturday, 4/18/2021. The DON stated she decided Resident #13 was to be placed on a bariatric (larger) bed on Monday, 4/20/2021. The DON stated prior to the fall out of the bed, Resident #13 was on an air mattress. The DON indicated a company that made an air mattress for the bariatric bed had to be found. The DON recalled treatment nurse (TN #2) came to her and asked her if an air mattress for Resident #13 was ordered and she told her yes it was.

Documentation in a follow-up progress note dated 4/20/2021, written by NP #1, revealed under treatment recommendations, "Wound VAC on hold due to malfunctioning, clean with dwc, pack with hydrofera blue, cover with abd pad, secure with tape, change daily or as needed depending on if the foam turns white or if dressing becomes dirty from stool."

Documentation in a skin/wound progress note dated 4/20/2021, written by TN #2, revealed the

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sacral pressure ulcer was continuing to improve. The wound was described as measuring 3.5cm length x 3.8cm width x 0.9 cm depth with a small amount of serosanguinous drainage with no redness or warmth to surrounding tissue.

Review of the April TAR for Resident #13 revealed an order initiated on 4/16/2021 and discontinued on 4/26/2021 for "Sacrum cleanse with sterile water, apply sterile water moistened Hydrofera blue to wound bed, cover with dry dressing every day shift." This order was documented as completed from 4/16/2021 to 4/25/2021. The TAR was blank for this treatment order on 4/26/2021.

Nurse #12, who was assigned to provide care for Resident #13 on the day shift on 4/26/2021, was interviewed on 5/7/2021 at 2:21 PM. Nurse #12 stated maybe she forgot to click on the TAR indicating the treatment was completed on 4/26/2021 because there was a lot of orders to click on the TAR of Resident #13.

Review of a follow-up wound care progress note dated 4/26/2021 written by NP #1 stated in part, "Patient (Resident #13) with a Stage 4 wound to her sacrum with slight decline since changed to bariatric bed." The wound was assessed as 5 cm in length, 6 cm in width, and 4 cm in depth." It was noted, "dark appearing wound bed, no dressing on wound when assessed." The treatment recommendations were for Dakin's solution 0.125% on an abd pad, skin prep around perimeter of the wound, cover with a dry sterile dressing twice daily.

Review of the April TAR for Resident #13 revealed an order initiated on the evening shift on

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4/26/2021 for the sacrum to be cleansed with sterile water, apply Dakins soaked gauze, cover with dry dressing every day and evening shift. Documentation on the TAR revealed this order was documented as completed on as ordered except for the evening shift on 4/27/2021, which was left blank and the evening shift on 4/29/2021 when treatment was documented as refused.

Nurse #12, who was assigned to care for Resident #13 on 4/27/2021 on the evening shift, was interviewed on 5/7/2021 at 2:21 PM. Nurse #12 reiterated she might have performed the dressing change for Resident #13 on her sacrum but forgot to document she did so.

The facility Administrator was interviewed on 5/7/2021 at 10:35 AM and revealed the air mattress to fit the bariatric bed of Resident #13 was ordered on 4/27/2021.

Nurse #11, who was assigned to care for Resident #13 on 4/29/2021 on the evening shift, was interviewed on 5/7/2021 at 1:30 PM. Nurse #11 stated Resident #13 declined having the treatment performed on her sacrum on 4/29/2021 because she was in pain. Nurse #11 stated she gave Resident #13 pain medication and after she refused three times, documented the treatment was refused. Nurse #11 did not notify the physician of the resident's refusal of the treatment on 4/29/2021.

Nurse #1, who administered sacral dressing changes for Resident #13 on 4/29/2021 and 4/30/2021, was interviewed on 4/7/2021 at 1:40 PM. Nurse #1 stated the sacral wound looked, "horrible, huge and just awful" on 4/29/2021 and 4/30/2021. Nurse #1 indicated she had not

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performed wound care on Resident #13 on a regular basis and that was only the third dressing change she had ever performed for this resident. Nurse #1 stated she knew Resident #13 was being followed by a wound nurse practitioner every Monday so the resident would be assessed again within a couple of days.

Documentation in the nursing progress notes on 5/1/2021 at 11:40 AM stated, "During dressing change foul odor noted to wound no drainage noted." The nursing progress note further revealed MD #1 was called, orders for antibiotics, orders for laboratory tests, and orders for a follow up at the wound clinic received.

Documentation in the nursing progress notes on 5/1/2021 at 10:18 PM revealed Resident #13 had an altered mental status along with decreased oxygen saturation level of 88% on room air. MD #1 was called, and the resident was sent to the emergency room.

An interview was conducted with the responsible party (RP) for Resident #13 on 5/6/2021 at 2:50 PM. The RP revealed stated she called Resident #13 on 4/29/2021 and 4/30/2021 and she was not answering her phone, which was highly unusual. The RP stated she went to the facility on the morning of 5/1/2021 and discovered Resident #13 was not herself. The RP indicted the whole room just smelled rotten. The RP stated she gave Resident #13 a bath and saw the wound care performed by the nurse (Nurse #2). The RP revealed the wound looked awful to her and smelled horrible.

Nurse #2, who performed the dressing change and sent Resident #13 to the emergency room on

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5/1/2021, was interviewed on 5/7/2021 at 2:31 PM. Nurse #2 stated Resident #13 was not as alert and talkative on 5/1/2021. Nurse #2 revealed she noted the wound was bigger with a foul odor during wound care that day but had no drainage. Nurse #2 confirmed she called MD #1 and the family of Resident #13 were already at her bedside during the dressing change. Nurse #2 revealed Resident #13 later that evening had a temperature and MD #1 wanted her sent to the emergency room.

Documentation in the hospital emergency room described the pressure ulcer of Resident #13 as, "extraordinarily large cantaloupe sized [unstageable] sacral decubitus with very foul smelling [odor] obvious necrosis of tissue around the exterior edges of this ulcer and internally. Old records reviewed patient has had an ulcer like this before but unsure if is being followed by wound care or would need further evaluation [when] took down the dressing there was two small 4 X 4's inside the wound." Resident #13 was admitted to the hospital for further treatment for a urinary tract infection, treatment of her infected sacral decubitus, and a needed evaluation by wound care.

Documentation in the nursing progress notes on 5/2/2021 at 1:47 PM revealed Resident #13 was admitted to the hospital with diagnoses of sepsis and urinary tract infection.

Nurse aide (NA #2) was interviewed on 5/7/2021 at 1:05 PM. NA #2 confirmed she provided care for Resident #13 on the 7:00 AM to 3:00 PM shift when she was on the bariatric bed. NA #2 stated she was a cooperative resident who was turned and repositioned every two hours to three hours.

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NA #11 was interviewed on 5/7/2021 at 1:12 PM. NA #11 confirmed she provided care for Resident #13 on the 3:00 PM to 11:00 PM shift when she was on the bariatric bed. NA #11 stated Resident #13 never refused care and was repositioned every three hours.

TN#2 was interviewed on 5/7/2021 at 10:20 AM. TN #2 revealed that the previous treatment nurse (TN #1) was working in the facility when the wound VAC was malfunctioning, and TN #2 indicated she was unsure of what happened. TN #2 thought parts were ordered for the wound VAC, but they never seem to arrive. TN #2 stated NP #1 changed the treatment orders and the sacral wound on Resident #13 started to look a lot better, so NP #1 agreed to discontinue the wound VAC. TN #2 stated the air mattress was switched out for a bariatric bed at some point. TN #2 stated she was told by the Administrator the bariatric air mattress had been ordered. TN #2 attested to the fact she "pushed and pushed" for the resident to be put on an air mattress but was told by the DON the air mattress was on order. TN #2 reiterated she stressed the point to the DON an air mattress was necessary for this resident. TN #2 stated Resident #13 was doing so well with the new treatments without the wound VAC but as soon as the bariatric bed in placed the sacral wound started to decline. TN #2 felt like the nurse aides were doing the turning a repositioning that was necessary but the firm mattress with the weight and pressure caused the sacral wound to decline quickly.

NP #1 was interviewed on 5/6/2021 at 4:02 PM. NP #1 indicated the last time she did a wound care assessment on Resident #13 was

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4/26/2021. NP #1 explained Resident #13 was on a wound VAC, but it malfunctioned and for some reason another wound VAC was not obtainable. NP #1 explained she changed the treatment to a daily treatment to accommodate the loss of the wound VAC. NP #1 further explained that one day a nurse aide was turning Resident #13 and she fell out of bed. NP #1 stated the resident was taken off the air mattress and put on a bariatric bed. NP #1 stated the resident needed an air mattress for her wound and no body could clarify why a bariatric air mattress was not available. NP #1 revealed at the same time the treatment nurse went on leave and a new treatment nurse took her place. NP #1 stated on her assessment on 4/26/2021 she noticed the wound was increasing in size and was very dark, while prior to that the wound was healthy pink. NP #1 indicated it was her impression the wound was not getting enough circulation on the bariatric bed causing a very quick decline in the wound status. NP #1 emphasized she went to the Administrator and the DON to let them know the urgent priority of having Resident #13 not go another day without an air mattress on her bed. NP #1 stated there was no way the wound changed to the degree it did and nobody noticed.

MD #1 was interviewed on 5/5/2021 at 3:37 PM. MD #1 provided the following information regarding his professional opinion on the wound care and status of Resident #13. Resident #13 arrived at the facility with osteomyelitis of a sacral wound. At that time the resident was going to the wound clinic and had a wound VAC. The wound continued to improve so in April 2021 the family wanted the resident to see the facility wound care provider instead of going to the wound clinic. The nurse practitioner at the facility discontinued the

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wound VAC for the resident and changed the treatment orders to daily wound care. Resident #13 was admitted to the hospital on 5/1/2021 and the wound was observed at the hospital. MD #1 did not think the treatments were done at the facility and he did not know the treatment nurse (TN #1) at the facility had taken a 6 week leave of absence. MD #1 knew the facility took Resident #13 off the low air loss mattress and never got her a new one. MD #1 spoke with the DON who told him she usually looked at the wounds but did not look at the wounds in the facility the week prior to the hospitalization of Resident #13. MD #1 felt the care provided to Resident #13 was particularly distressing because he was a wound care specialist himself and he was the medical director at the facility.

The facility nurse consultant was interviewed on 5/7/2021 at 2:53 PM. The nurse consultant stated she felt several factors led the decline in the wound status of Resident #13. The nurse consultant stated the wound VAC was malfunctioning on 4/12/2021 and the wound care treatments were changed several times to compensate for the lack of a wound VAC. The nurse consultant indicated a wound VAC could have been obtained from a sister facility to optimize the wound care provided to Resident #13. The nurse consultant believed the wound VAC would have been the optimal treatment for Resident #13 because it was a more consistent process. The nurse consultant admitted the resident rolled out of bed on 4/18/2021 and was subsequently removed from the air mattress and put on a bariatric mattress. The nurse consultant did not think NP #1 or TN #2 effectively communicated the concerns they had about the bariatric air mattress to the DON and the

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F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, observations, and physician interview the facility failed to provide supervision to prevent a cognitively impaired resident who had been identified as a wandering risk from exiting the facility for one of two residents reviewed for supervision to prevent accidents. Resident #3, who was cognitively impaired, exited the facility without staff knowledge and was found approximately an hour later at a credit union adjacent to a 4-lane highway, 0.2 miles or 1,056 feet away from the facility. After Resident #3 was observed outside by a staff member, he was left unattended outside while confirmation and assistance was sought from other staff members. The findings included: Resident #3 was admitted to the facility on 1/31/2020 with multiple diagnoses, one of which included Alzheimer's disease. Review of a wandering assessment dated 1/31/2020 revealed Resident #3 was assessed as	F 689	Past noncompliance: no plan of correction required.	5/24/21

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a high risk for wandering.

A physician's order was initiated on 9/12/2020 for Resident #13 to have a wander or elopement alarm to the ankle and to have the placement checked every shift for monitoring.

Review of Resident #3's annual Minimum Data Set (MDS) assessment completed 2/9/2021 revealed he was coded as severely cognitively impaired. Resident #3 was coded as having no wandering behaviors, used a wheel chair for locomotion, and did not use a wandering/elopement alarm.

Review of Resident #3's care plan, completed 2/17/2021, revealed the resident had a focus area for being an elopement risk relative to having a diagnosis of Alzheimer's disease and confusion. The care plan goal specified the resident's safety was to be maintained through the next review date. Listed interventions included: checking placement and function of safety monitoring device on the right ankle every shift, seeking of placement for resident at a facility in a secure unit, and reorientation/validation/redirection of resident as needed.

There was no nursing progress note dated 4/10/2021 written by Nurse #1.

Review of the nursing progress notes revealed a note written by the Administrator on 4/10/2021 which indicated the Administrator spoke with the responsible party for Resident #3 and informed her of the elopement of Resident #3 from the facility and his safe return. The same progress note revealed the Administrator contacted the physician for Resident #3 and left a voice mail.

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A nursing progress note dated 4/10/2021 written by the Director of Nursing (DON) revealed, "Staff was notified by another staff member that resident was seen outside the building at 11:25 AM. Staff immediately responded, staff immediately assessed the resident with no injuries. Resident was assisted to the building by staff. Resident was placed on one on one supervision for additional precautions."

An interview was conducted with Nurse #1 on 4/30/2021 at 9:47 AM. Nurse #1 described and explained how on 4/10/2021 Resident #3 was thought to have exited the facility. Nurse #1 stated at approximately 10:30 AM Resident #5 was at the front door of the facility and shouted to her requesting for the door to be unlocked. Nurse #1 was behind the nurses' desk at the medication cart at the end of the front hallway with a view of the front door. Nurse #1 explained that Resident #5 had a medical appointment outside of the facility and could transport himself. Nurse #1 questioned Resident #5 if he had notified his nurse (CMA #1) he was leaving the facility to which he replied he had. Nurse #1 pushed the key pad at the nurses' station to remotely open the front door and returned to where she could visualize Resident #5 ambulate through the door. Nurse #1 revealed she did not see Resident #3 sitting to the side next to the front door. Nurse #1 revealed she saw Resident #5 leave through the front door. Nurse #1 indicated she did not see the door close or hear an alarm go off at the front door because she returned to her nursing duties. Nurse #1 stated she went to have lunch in her vehicle in the facilty parking lot at approximately 11:30 AM returning at approximately 12:00 PM and was notified at that time of the elopement of

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Resident #3. Nurse #1 confirmed she was the only nurse working in the facility on 4/10/2021, but was available by phone if she needed to return inside the building. Nurse #1 also confirmed she performed a physical assessment of Resident #3 for injuries upon her return to the facility, finding no injuries to the resident.

An interview was conducted on 4/29/2021 at 7:13 PM with dietary aide (DA #1) who observed Resident #3 outside of the building unaccompanied. DA #1 revealed on 4/10/2021 at approximately 11:24 AM, she came out a side door of the facility by the dumpster to take out garbage and to take care of an emergency phone call prior to the start of tray line service. DA #1 stated she was unable to address the phone call because she observed Resident #3 in a wheel chair near the credit union parking lot. DA #1 stated she called to Resident #3, but he did not respond. DA #1 stated she was unsure if this was a resident from the facility or not due to many older people frequently in the area of the facility. DA #1 indicated she went back into the facility to confirm with and notify the nursing staff of Resident #3 being outside the facility. DA #1 then went back to the facility kitchen because she was needed for the start of the tray line service.

An interview was conducted with HK #1 on 4/30/2021 at 11:29 AM. HK #1 explained her primary duties were in the laundry across from the kitchen. HK #1 stated on 4/10/2021 she was in the laundry room when DA #1 came through the outside door asking her if residents of the facility were "allowed to" go to the credit union on their own. HK #1 indicated DA #1 thought she saw a resident from the facility at the drive through of the credit union. HK #1 revealed DA #1

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described the resident to her, and she immediately was able to identify Resident #3 as the resident who was outside. HK #1 and DA #1 both agreed nursing staff should be alerted. HK #1 stated DA #1 went to alert the nursing staff while she stayed in the laundry. HK #1 stated soon after, NA #1 came running to the back door. HK #1 then went outside to assist NA #1 in the search for the resident. HK #1 revealed the four staff members, HK #1, NA #2, NA #1, and CMA #1 converged in the facility parking lot at the same time and observed Resident #3 stuck in the grass near the credit union. HK #1 revealed the four staff members went to Resident #3 through the muddy grass and asked him how he got outside. HK #1 stated the resident replied he was going to get his car. HK #1 stated she returned to the laundry room through the grass while CMA #1, NA #1, and NA #2 assisted Resident #3 in returning to the facility.

An interview was conducted with a Certified Medication Aide (CMA #1) on 4/29/2021 at 7:27 PM. CMA #1 recalled she gave medications to Resident #3 at approximately 9:30 AM on 4/10/2021 and watched him propel to the front lobby after telling her he was going to get his truck. CMA #1 revealed DA #1 came to the nurses' station at 11:30 AM, described Resident #3, and announced he was outside. CMA #1 stated two other nurse aides (NA #1 and NA #2), herself, and a housekeeper (HK #1) went outside to search for Resident #3. CMA #1 described how the Resident #3 was found stuck in the muddy median area next to the credit union drive through with his wheel chair wedged between a concrete "pass through." CMA #1 stated Resident #3 indicated he was uninjured but needed to get to the bank and then on to work. CMA #1 revealed

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the nurse aides (NA #1 and NA #2) helped her dislodge the wheelchair and propel Resident #3 along the highway back to the facility. CMA #1 confirmed Resident #3 was wearing a wander/elopement alarm which sounded when he was brought back into the facility through the front door.

An interview was conducted with NA #1 on 4/30/2021 at 10:35 AM. NA #1 confirmed she was assigned to monitor and provide care for Resident #3 on 4/10/2021 on the 7:00 AM to 3:00 PM shift. NA #1 relayed she set up the breakfast tray for Resident #3 at approximately 8:20 AM and gave him a bath after 9:00 AM. NA #1 stated at approximately 9:45 AM Resident #3 came out of his room and as was his usual practice propelled himself to the front lobby. NA #1 stated she went on her break at approximately 11:00 AM and upon her return a dietary employee (DA #1) came to the nurses' station and indicated Resident #3 was outside. NA #1 described the retrieval of Resident #3 with the assistance of CMA #1, HK #1, NA #2 and herself. NA #1 indicated she and HK #1 went out of the facility side door and CMA #1 and NA #2 went out the front door in search of Resident #3. NA #1 explained CMA #1, NA #2, HK #1, and herself all saw Resident #3 at the same time over at the credit union. NA #1 confirmed Resident #3 was found in his wheel chair stuck in the mud in a "walkway" next to the credit union. NA #1 stated it was thought that Resident #3 came through the front parking lot and crossed through the grassy area to get to the credit union as evidence by the wheel chair tracks in the muddy grass. NA #1 explained how Resident #3 was stood up and the wheel chair dislodged from the barrier and put in the road next to the credit union. NA #1 explained

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how Resident #3 was pushed in his wheel chair by CMA #1 through the parking lot and onto the highway with NA #1 and NA #2 waiving off traffic to return the resident to the facility.

An interview was conducted with NA #2 on 4/30/2021 at 11:14 AM, who confirmed the description of events on 4/10/2021 as described by NA #1.

A review of Resident #3's treatment administration record (TAR) from April 2021 revealed an order for a wander/elopement alarm on the ankle of Resident #3 was to have the placement checked every shift for monitoring. The April TAR revealed the placement of the wander/elopement alarm was checked every shift to include the night shift on 4/9/2021 and day shift on 4/10/2021 and was on Resident #3.

A review of the weather conditions, per Weather Underground web site, revealed the following data for Elizabeth City, North Carolina on 4/10/2021 at 10:30 AM were 65 degrees Fahrenheit (F) partly cloudy with no wind or precipitation. The conditions at 11:30 AM were 70 degrees F, with fair conditions.

An interview was conducted with the responsible party (RP) for Resident #3 on 4/30/2021 at 11:58 AM. The RP stated on 4/11/2021 she received a phone call from the DON and the Administrator letting her know Resident #3 "attempted to get out of the facility" but he was fine. The RP stated she visited Resident #3 on 4/12/2021 and was notified by the nursing staff Resident #3 was let out of the facility on 4/10/2021 by another resident leaving for a medical appointment and had propelled himself to the credit union. The RP

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stated she did not have any other information but was concerned Resident #3 could have been injured because the facility was located next to a highway.

The DON and the Administrator were interviewed, and observations of the nursing/ front door area was made on 4/29/2021 at 9:15 AM. A device to unlock the front door was observed to be to the left on the desk at the nurses' station. The device had a button to unlock the front door when pressed allowing the person at the front door to either push the door open or press the handicap button automatically opening the door. The Administrator explained the wander/elopement alarm on Resident #3 prevented the front door from opening and sounded an alarm as the resident approached the door. The Administrator clarified if the door was already open, then only an alarm would sound as the resident went to the door, allowing Resident #3 to exit if the alarm went unnoticed. It was observed at the time of the interview from the nurses desk the front door was visible down the front hallway but, the area to the left of the front door was not visible. The Administrator explained the facility investigation revealed it was likely Resident #3 was able to exit the facility while following Resident #5, for which the door was opened, so he could drive himself to a medical appointment. The Administrator explained Nurse #1 let Resident #5 out the door but was unable to visualize where Resident #3 was sitting to the left of the front door. The Administrator confirmed there was not a front desk receptionist sitting in the lobby on 4/10/2021 due to it being the weekend. The DON stated Resident #3 was coherent enough upon his return to the facility and he told her he left the building "behind the man who drove away."

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The physician for Resident #1 (MD #1) was interviewed on 4/30/2021 at 8:49 AM. MD #1 denied having any knowledge of Resident #3 eloping from the facility on 4/10/2021. MD #1 stated he thought Resident #3 was an "easy going guy" who sometimes spoke of wanting to go home. MD #1 stated to his knowledge the facility was checking the wander/elopement alarms on the residents every shift to include Resident #3.

Resident #3 was observed on 4/30/2021 at 11:29 AM propelling himself with his feet down the hallway. He had a wander/elopement alarm on his right ankle.

Observations were made on 4/30/2021 at 2:06 PM of the location and distance Resident #3 was from the facility when he was found on 4/10/2021. The credit union drive through where Resident #3 was found was observed to be 0.2 miles or 1,056 feet from the front entrance of the facility. Resident #3 had to propel himself across 3 parking lots and 2 grass medians adjacent to a 4-lane highway to get to the credit union drive through.

The maintenance supervisor was interviewed on 5/6/2021 at 11:14 AM. The maintenance supervisor revealed he was contacted on 4/10/2021 and notified a resident had eloped from the facility. The maintenance supervisor stated he checked the wander/elopement alarm system on 4/10/2021 after he was alerted Resident #3 had eloped from the facility and found it to be functioning properly. The maintenance supervisor additionally revealed a video tape surveillance tape of the facility lobby had revealed Resident #5

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had pushed the handicap door button for both front entrance doors and had exited the facility. The maintenance supervisor stated the video did not have any sound but Resident #3 was seen to be looking at the birds in the front lobby, turned himself around when the front door opened, hesitated, and then propelled himself out the front doors that remained open long enough for him to escape. The maintenance supervisor revealed the video tape surveillance was no longer available for viewing or for confirmation of the time of the elopement. The maintenance supervisor stated every Tuesday a maintenance assistant checked the functionality of the wander/elopement alarms on the residents and on the doors of the facility documenting this in a book at the nurse's station.

The corrective action provided by the facility was completed on 4/11/2021.

Problem Identified:

Resident #3 was admitted to The Citadel at Elizabeth City on 1/31/2020.

At 10:30 AM on 4/10/2021, Resident #3 exited the building via the front door. At 11:30 AM, the resident was observed by Dietary Aide #1/Dietary Staff Member #1 to be sitting in his wheelchair in the field between the facility and the State Employees Credit Union next door. The Dietary Aide #1/Dietary Staff Member #1 notified Nurse Aide NA #1. The Nurse Aide NA #1, Nurse Aide NA #2, Certified Medication Aide CMA #1, and Laundry Aide/Housekeeper #1 immediately responded and assisted Resident #3 back into the building.

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Our investigation on 4/10/2021 showed that prior to this event, Resident #3 was last seen by Housekeeper #2 in the front lobby watching the birds in the bird cage. The front door was locked and secured; it can only be unlocked by entering the code on the keypad at the door or by pushing the unlock button from the remote-control keypad at the nurse's station. Resident #5 approached the door to go out for his dialysis appointment. He yelled down the hallway and asked Nurse #1 who was at the nurse's station to unlock the door so he could go to his appointment. The Nurse #1 unlocked the door from the nurse's station using the remote-control keypad. Resident #5 pushed the handicap button to open the door. Nurse #1 saw the resident walk out but did not watch the door close. Nurse #1 went back down 200 Hall. Resident #3 then went out the door. The wander guard activated the door alarm sound, but none of the staff members heard it. Certified Medication Aide CMA #1 notified the Director of Nursing (DON) of the event on 4/10/2021 at approximately 11:45 AM.

Address how corrective action will be accomplished for resident(s) found to have been affected.

The Certified Medication Aide CMA #1, Nurse #1, Maintenance Director, Social Worker, Minimum Data Set (MDS) Nurse, Staff Development Coordinator (SDC), Director of Nursing (DON), and Administrator responded immediately on 4/10/2021.

The Nurse #1 completed a head-to-toe assessment on Resident #3 with no injury noted. An updated wandering assessment was

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completed by the Director of Nursing (DON). The care plan for Resident #3 was reviewed and updated by the Director of Nursing (DON) to include reviewing the current interventions and the use of a wander guard.

The Nurse #1 and Certified Medication Aide CMA #1 initiated increased supervision for Resident #3 to include constant knowledge of whereabouts through hall monitoring as well as every 15-minute checks. This was documented on safety check sheets which are located in the resident's medical record.

Post event at approximately 11:45 AM, a head count of all residents in the facility was conducted by Certified Medication Aide CMA #1. All residents were present and accounted for.

Administrator notified Resident #3's family on 4/10/2021 at 2:00 PM regarding Resident #3 exiting the facility, physical assessment following the event, and plan for increased monitoring. No new physician orders were received.

Resident #3 wears a wander guard bracelet on right ankle. Maintenance Director checked the wander guard and exit doors, and both were working properly.

At 4:00 PM Administrator and Director of Nursing (DON) completed an additional head-to-toe assessment finding no signs of injury. When asked why he exited the facility, Resident #3 said he was going to his car to get some money for the vending machine. He exhibited no signs of distress.

Address how corrective action will be

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accomplished for resident(s) having potential to be affected by the same issue needing to be addressed.

On 4/10/2021 Maintenance Director checked all exit doors and wander guards. All were working properly.

On 4/10/2021, Director of Nursing (DON) and Minimum Data Set (MDS) Nurse completed a review of all residents in the entire facility to identify residents that have exit-seeking behaviors, ensure they have an updated wandering risk assessment (Gates Wandering Assessment), and care plan is reflective of interventions. "Wandering Risk" books containing face sheets with photographs of each resident at risk were updated and placed at the nurse's station and front desk.

Address what measures will be put in place and systematic changes made to ensure that the identified issue does not occur in the future.

On 4/10/2021, current staff were educated by the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC) or Minimum Data Set (MDS) Nurse. Education included the facility policy on elopements and wandering residents. It also included recognition of exit seeking behaviors in residents and what intervention strategies could be put into place along with the supervision required. This education was done in person and via phone. Staff were not permitted to work until they were educated. Therefore, 100% of current staff were educated by 4/10/2021.

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Hired a weekend receptionist to monitor the front lobby and enter/exit screening process on 4/10/2021. If the receptionist needs a break the nurse or Certified Nurse Assistant will cover.

Indicate how the facility plan to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness.

Maintenance Director checked the wander guard system and door alarms for proper functionality on 4/10/21 and will continue it on a daily basis. If the wander guard system or door alarms are not working properly, the Maintenance Director will notify the Administrator and correct the problem. This is documented daily on a log and kept by the Administrator.
Director of Nursing (DON) updated the Wandering Assessment in Point Click Care to populate quarterly for the nurses to assess all residents exhibiting new behaviors of wandering or exit-seeking on 4/10/21 and will continue it.

Director of Nursing (DON) placed wander guard checks on the Medication Administration Record for the nurses to check placement and functionality each shift on 4/10/21 and will continue it.

The Director of Nursing (DON) will review residents at risk for wandering or exit-seeking weekly for 12 weeks to ensure interventions remain in place. Residents exhibiting new behaviors of wandering or exit seeking will be reviewed to ensure the wandering assessment is

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accurate and interventions are in place. The Director of Nursing (DON) will report findings monthly to the QAPI Team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book.

The Administrator will review the wander guard system and door alarms daily check log, weekly for 12 weeks to ensure the wander guards and door alarms are functioning properly. The Administrator will report findings monthly to the QAPI Team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book.

The facility alleges compliance as of 4/11/2021.

The corrective action plan was validated on 5/6/2021 and concluded the facility implemented an acceptable correction action plan on 4/11/2021. Record review of wandering residents revealed care plans with interventions were updated and in place along with elopement/wander alarm checks on the medication administration records. Record review revealed a skin assessment was completed for Resident #3 on 4/10/2021. An interview with the maintenance supervisor revealed wander/elopement alarm checks were implemented. An interview was conducted with the weekend front desk receptionist confirming wandering residents were monitored for elopement risks. Interviews were conducted with staff members confirming training was conducted on 4/10/2021 regarding monitoring of wandering residents and elopement procedures. Observations were made of "Wandering Risk" books located at the front desk and the nursing station.

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F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record review and consultant pharmacist, pharmacy and staff interviews the facility failed to accurately account for and maintain record of the disposition (the	F 755	Address how corrective action will be accomplished for resident(s) found to have been affected: The record of the disposition of controlled	5/31/21

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F 755	Continued From page 34 process of returning and/or destroying unused medications) of controlled medications (substances that have an acceptable medical use, medications which fall under the US Drug Enforcement Agency (DEA) schedules II-V, have the potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) destroyed on site by the facility for at least two years. Findings included: A review of the facility policy titled "Disposal of Medications and Medication Related Supplies IE1: Controlled Substance Disposal" dated April 2018 indicated the administrator, nurses and/or pharmacist witnessing the destruction of controlled medications would ensure the date of destruction, resident's name, name and strength of medication, prescription number, amount of medication destroyed and signatures of witnesses were entered on the individual controlled substances accountability record. It further indicated accountability records for controlled substances that were disposed of or destroyed were maintained with the unused supply until it was destroyed and then stored for 5 years or per applicable state law or regulation. On 04/29/2021 at 11:57 AM an interview with the director of nursing (DON) indicated when she began with the facility in March 2021, she discovered the previous DON had been storing controlled medications from discharged residents in a locked file cabinet in the DON office. She stated these medications went back as far as 2019 and some were dispensed by a pharmacy the facility no longer used. The DON went on to say she was not comfortable with this, so she	F 755	medications was of residents who were discharged. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: On 5/6/2021, all medication carts were audited by the Nursing Supervisor to ensure the facility accurately accounted for and maintained record of the disposition of controlled medications according to the facility's policy titled "Disposition of Medications and Medication Related Supplies IE:1 Controlled Substance Disposal." Based on findings of this audit, changes were implemented as indicated. On 5/6/2021, the Staff Development Coordinator (SDC) started re-education to current licensed nurses and medication aides on the facility's policy titled "Disposition of Medications and Medication Related Supplies IE: 1 Controlled Substance Disposal." Education will be completed on 5/20/2021. Address what measures will be put in place and systematic changes made to ensure that the identified issue does not occur in the future: Starting the week of the 5/9/2021, the Nursing Supervisor or designee will complete a weekly audit tool of medication carts to ensure the facility accurately accounts for and maintains record of the disposition of controlled medications according to the facility's policy. Based on findings of this audit,	

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F 755	Continued From page 35 began the process of returning the medications to the facility's current pharmacy. She further indicated the controlled medications were reconciled (refers to a system of record keeping that ensures an accurate inventory of medications by accounting for controlled medications that have been received, dispensed, administered, and/or including the process of disposition) and the facility pharmacy was contacted. The DON stated the controlled medications dispensed by the facility pharmacy were returned to them, but the pharmacy would not accept return of the controlled medication that had not been dispensed by them and instructed the facility to destroy those. The DON indicated she did not participate in the destruction of these controlled medications, two facility nurses destroyed them. On 04/29/2021 at 12:05 PM an observation of the DON office with the DON indicated a metal file cabinet in the back-left corner of the office. The file cabinet was secured with a single lock. No controlled substance medications were observed to be present in the file cabinet at the time of the observation. At the time of the observation the DON indicated the file cabinet was the same file cabinet she discovered contained discharged resident's controlled substance medications when she began with the facility in March 2021. On 04/30/2021 at 1:34 PM an interview with the administrator indicated prior to the DON notifying her of the controlled medication from discharged residents in the file cabinet in the DON office in March 2021, she had no knowledge of the situation. The administrator stated Nurse #8 witnessed the destruction of the controlled medications with Nurse #7. She further indicated the facility had no written record of the destruction	F 755	changes will be implemented as indicated. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness: The Director of Nursing (DON) will review the audit tool weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month, to ensure the facility accurately accounts for and maintains record of the disposition of controlled medications according to the facility's policy and will report audit findings monthly to the QAPI Team for review times 3 months. Documentation of the review will be kept by Administrator in the QAPI Book. Completion Date: 5/31/2021	

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F 755	Continued From page 36	F 755		

which included the date of destruction, resident's name, name and strength of medication, prescription number, amount of medication destroyed and signatures of witnesses.

On 04/30/2020 at 1:36 PM an interview with Nurse #7 indicated she and another nurse destroyed these controlled medications. She stated she did not recall how many resident's medications were destroyed or what the medications were, however, there were multiple blister pack cards of controlled substance medication and liquid morphine (a DEA schedule II narcotic pain medication). She stated the medications were first reconciled, and then destroyed. She went on to say she did not recall who witnessed the destruction with her or whether any written record of the destruction was kept.

On 04/30/2021 at 2:06 PM an interview with Nurse #8 indicated she and Nurse #7 were notified by the DON that controlled medications from approximately 25-30 discharged residents needed to be destroyed. She went on to say she could not remember exactly but this included multiple blister pack cards of controlled substance medication and liquid morphine (a DEA schedule II narcotic pain medication). She stated she and Nurse #7 reconciled the medication with each resident's individual controlled medication utilization record which was attached to the medication. Nurse #8 stated no discrepancies (lack of similarity between the two) were noted. She went on to say she and Nurse #8 removed the pills from the blister pack cards and the liquids from their containers and placed the medications into the destruction solution container. She further indicated the container was

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F 755	Continued From page 37	F 755		

then disposed of in the facility trash. Nurse #8 stated the blister pack cards were shredded. She went on to say she could not recall if she wrote any information on the individual controlled medication utilization records, signed any forms or maintained any written record of the destruction. She stated she did not know what happened to the individual controlled medication utilization records.

On 04/30/2021 at 3:07 PM an interview with the DON indicated the facility had no written record of this controlled medication destruction nor any records which included the date of destruction, resident's name, name and strength of medication, prescription number, amount of medication destroyed and signatures of witnesses.

On 04/30/2021 at 12:42 PM a telephone interview with the facility pharmacy consultant (RPh #1) indicated she had been the facility pharmacy consultant since the facility began using the company in June 2019. She stated normally she visited the facility monthly for medication review but since March 2020 she had been doing these reviews remotely. RPH #1 stated she was not aware the facility was storing controlled medications from discharged residents in the DON office rather than immediately returning them to the pharmacy. RPh #1 indicated the DON called her in March 2021 and was very upset about the controlled medication in her office. She went on to say the DON was instructed to return the controlled medication dispensed by the pharmacy according to the pharmacy return procedure and destroy the controlled medication that was dispensed by the previous pharmacy according to the facility destruction procedure.

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F 755	Continued From page 38 RPh #1 stated in accordance with North Carolina (NC) Board of Pharmacy rules, 2 licensed nurses are sufficient to witness the destruction of the controlled medications, however, written record of the destruction which included the date of destruction, resident's name, name and strength of medication, prescription number, amount of medication destroyed and signatures of witnesses must be documented. She went on to say this written documentation must kept by the facility for a minimum of 2 years. On 04/30/2021 at 09:49 AM a telephone interview with the facility pharmacist in charge (RPh #2) indicated there was a short period of time beginning in March 2020 during the COVID-19 pandemic where the pharmacy was not accepting any returns of medication from facilities. She further indicated all medication returns for all medications dispensed by the pharmacy had been accepted from all facilities since June 2020. RPh #2 went on to say the pharmacy had no record of the controlled medications destroyed by the facility in March 2021. On 05/03/2021 at 10:45 AM a telephone interview with the pharmacist in charge at the facility's previous pharmacy (RPh #3) indicated the pharmacy had no record of any controlled medication destruction that took place at the facility in March 2021. She stated the facility should have kept written records of the destruction which included the date of destruction, resident's name, name and strength of medication, prescription number, amount of medication destroyed and signatures of witnesses for 2 years.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals	F 761		5/31/21

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F 761	Continued From page 39 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and pharmacist interviews the facility failed to maintain the security of unused resident specific controlled substance medications (substances that have an acceptable medical use, medications which fall under the US Drug Enforcement Agency (DEA) schedules II-V, have the potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) under double lock by storing it in a	F 761	Address how corrective action will be accomplished for resident(s) found to have been affected: On 4/30/2021, the Director of Nursing (DON) was educated by the Infection Preventionist and Facility Corporate Consultant on maintaining the security of unused resident specific controlled substance medications under double lock.	

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F 761	Continued From page 40 file cabinet in an unlocked office for one of one medication storage areas reviewed. Findings included: A review of the facility policy titled "Controlled Substance Administration and Accountability" provided by the facility indicated the facility would have safeguards in place in order to prevent loss, diversion (the transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use) or accidental exposure compliant with state and federal regulations. It further indicated patient-specific controlled substances would be stored under double lock. On 04/29/2021 at 11:57 AM an interview with the director of nursing (DON) indicated when she began with the facility in March 2021, she discovered the previous DON had been storing controlled substance medications from discharged residents in a locked file cabinet in the DON office. She stated these controlled substance medications went back as far as June 2019. She further indicated the file cabinet had been locked and she had the only key. The DON stated the DON office door also locked, she and the administrator had the only keys, and she had always maintained both the file cabinet and her office door locked when she was not physically present in her office until she was able to get the controlled substance medications returned to the pharmacy. She went on to say controlled substance medication needed to be secured by double lock and this process met the double lock requirement. The DON further indicated she was not comfortable continuing to keep controlled substance medications in her office, so she	F 761	Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: On 4/30/2021, the Infection Preventionist and Facility Corporate Consultant audited the DON office to ensure there were no longer any controlled substance medications stored in the file cabinet. No controlled substance medications were found. On 4/30/2021, the Staff Development Coordinator (SDC) started re-education to current licensed nurses and medication aides on the facility's policy titled "Controlled Substance Administration and Accountability" and to not store controlled substance medications in the DON office. Address what measures will be put in place and systematic changes made to ensure that the identified issue does not occur in the future: Starting the week of the 5/9/2021, the Nursing Supervisor or designee will complete a weekly audit tool of medication carts to ensure the facility maintains the security of unused resident specific controlled substance medications under double lock according to the facility's policy. Based on findings of this audit, changes will be implemented as indicated. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must	

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F 761	Continued From page 41 began the process of returning the medications to the facility's current pharmacy. She further indicated these controlled substance medications were reconciled (refers to a system of record keeping that ensures an accurate inventory of medications by accounting for controlled medications that have been received, dispensed, administered, and/or including the process of disposition) and the facility pharmacy was contacted. The DON stated these controlled medications dispensed by the facility pharmacy were returned to them on 03/22/2021 and 03/23/2021 and listed on the return pharmacy packing slips with those dates. A review of the return packing slips for the controlled substance medications returned to the facility pharmacy dated 03/22/2021 and 03/23/2021 provided by the DON indicated one hundred and seventy-two separate controlled substance medication prescriptions ranging in DEA schedule from II through V with prescription dispense dates ranging from 06/01/2019 through 03/18/2021. On 04/29/2021 at 12:05 PM an observation of the DON office with the DON indicated a metal file cabinet in the back-left corner of the office. The file cabinet was secured with a single lock. No controlled substance medications were observed to be present in the file cabinet at the time of the observation. At the time of the observation the DON indicated the file cabinet was the same file cabinet she discovered contained discharged resident's controlled substance medications when she began with the facility in March 2021. On 04/29/2021 at 5:58 PM a telephone interview with DON #2 indicated she served as the facility	F 761	be implemented and the corrective action evaluated for its effectiveness: The Infection Preventionist and Facility Corporate Consultant will review the audit tool weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month, to ensure the facility maintains the security of unused resident specific controlled substance medications under double lock according to the facility's policy and will report audit findings monthly to the QAPI Team for review times 3 months. Documentation of the review will be kept by Administrator in the QAPI Book. Completion Date: 5/31/2021	

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DON from August 2020 through January of 2021. She stated there were already controlled substance medications from discharged residents present in the file cabinet in the DON office when she started in August 2020. She stated she did not think this was unusual because she had experienced this as a DON at other facilities. She stated she continued the practice, reconciling the medications as nurses gave them to her and storing them in the locked file cabinet in her office. DON #2 stated she had maintained the only key to the file cabinet. She further indicated she had not bothered to attempt to return any of these medications to the pharmacy because that was not her priority. DON #2 stated she had not always kept the door to her office closed and locked when she was not physically present in her office if she was in the building.

On 04/30/2021 at 10:20 AM an interview with Nurse #1 indicated she had been employed in the facility working three days per week while DON #2 was the facility DON. Nurse #1 stated at least daily during this period when she went to look for DON #2 in her office, she observed DON #2's office door to be open and not locked and DON #2 not present.

On 04/30/2021 at 10:33 AM an interview with the admissions coordinator indicated she had been employed with the facility for two and a half years. She stated she recalled walking past DON #2's office at times and her door would be open and not locked and no one would be in the office. She further indicated she could not really recall how often this occurred.

On 04/30/2021 at 12:42 PM a telephone interview with the facility pharmacist consultant (RPh # 1)

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F 761	Continued From page 43 indicated controlled substance medications needed to be secured by double lock. She stated if DON #2 was not physically present in her office when the office door was unlocked the locked file cabinet alone would not meet this requirement. On 04/30/2021 at 1:34 PM an interview with the administrator indicated prior to the DON notifying her of the controlled medication from discharged residents in the file cabinet in the DON office in March 2021, she had no knowledge of the situation. She stated controlled substance medications needed to be secured by double lock but if the file cabinet and the DON office door were locked, she felt this met the requirement.	F 761		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		5/31/21

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F 883	Continued From page 44 and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, resident representative (RP) and physician interviews the facility failed to: offer a resident the influenza vaccine during the 2020-2021 influenza vaccine season (Resident #8), administer the	F 883	Address how corrective action will be accomplished for resident(s) found to have been affected: The facility is unable to offer or administer Resident #8 and Resident #9 the	

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F 883	Continued From page 45 influenza vaccine to a resident after informed consent was obtained from the resident's RP (Resident #9) and offer a resident the 23 Valent Pneumococcal Polysaccharide vaccine (PPSV 23) (Resident #10) for 3 of 5 residents reviewed for influenza and pneumococcal immunizations. These failures occurred during a COVID-19 pandemic. Findings included: 1. Resident #8 was admitted to the facility on 04/19/2017 with diagnoses including cerebral infarction (damage to brain tissue from loss of oxygen). A review of a quarterly minimum data set assessment (MDS) for Resident #8 dated 04/09/2021 indicated she was independent with daily decision making. It further indicated she had not received an influenza vaccine in this year's influenza vaccine season because none had been offered. A review of the immunization section of Resident #8's medical record did not indicate any information regarding the offer or refusal of the 2020-2021 influenza vaccine. A review of Resident #8's medical record did not reveal any information indicating she was offered or refused the influenza vaccine during the 2020-2021 influenza season. On 04/29/2021 at 8:50 AM an interview with Resident #8 indicated she did not recall being offered the influenza vaccine this past year. She further indicated she would have accepted one if it had been offered to her.	F 883	influenza vaccine due to being outside of the 2020 - 2021 influenza vaccine season. Resident #10 was offered the pneumococcal vaccine on 4/29/2021, which he declined. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: On 4/27/2021, the Infection Preventionist and Facility Corporate Consultant completed a 100% audit of resident's influenza and pneumococcal vaccine status. Based on findings of this audit, the immunization was offered as indicated. Address what measures will be put in place and systematic changes made to ensure that the identified issue does not occur in the future: Starting the week of the 5/9/2021, the Director of Nursing (DON) or designee will complete a daily audit tool for all new admissions for their influenza and pneumococcal status (acceptance/decline or history) during the clinical morning meeting. Based on findings of this audit, changes will be implemented as indicated. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness: The Infection Preventionist and Facility Corporate Consultant and/or designee will	

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F 883	Continued From page 46 On 04/29/2021 at 9:17 AM a telephone interview with Resident #8's RP indicated the facility had not called her regarding the influenza vaccine for her family member this past year. On 04/29/2021 at 4:26 PM an interview with the infection preventionist (IP) indicated she could not find any information in Resident #8's medical record regarding the offer or refusal of the influenza vaccine for this season. She stated there should be documentation in Resident #8's record that she was educated on the risks versus the benefits of this vaccine and either a signed consent form and record of administration or a refusal of the vaccine. On 04/30/2021 at 1:34 PM an interview with the administrator indicated there should be documentation in Resident #8's record that she was educated on the risks versus the benefits of the influenza vaccine and either a signed consent form and record of administration or a refusal of the vaccine. 2. Resident #9 was admitted to the facility on 03/23/2020 with diagnoses including cerebral infarction (damage to brain tissue from loss of oxygen). A review of a quarterly MDS assessment for Resident #9 dated 03/16/2021 indicated he was independent with daily decision making. It further indicated he had not received an influenza vaccine in this year's influenza vaccine season because none had been offered. A review of the immunization section of Resident #9's medical record did not indicate any	F 883	review the audit tool weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month, to ensure that new admissions have in place or are offered the influenza and/or pneumococcal vaccine as the season indicates. Audit findings will be reported monthly to the QAPI Team for review times 3 months. Documentation of the review will be kept by Administrator in the QAPI Book. Completion Date: 5/31/2021	

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F 883	Continued From page 47	F 883		

information related to the 2020-2021 influenza vaccine.

A review of Resident #9's medical record revealed an informed consent form for the influenza vaccine signed by Resident #9's RP on 10/23/2020 indicating Resident #9 desired to receive the influenza vaccine.

A review of Resident #9's medical record indicated no evidence the influenza vaccine was administered to him during the 2020-2021 influenza vaccine season.

On 04/29/2021 at 2:15 PM an interview with Resident #9 indicated he did not recall receiving the influenza vaccine this year.

On 04/29/2021 at 2:23 PM a telephone interview with Resident #9's RP indicated she had given the facility consent for the influenza vaccine to be administered to her family member after speaking with him and she would have expected the facility to administer it.

On 04/29/2021 at 4:26 PM an interview with the infection preventionist (IP) indicated she could not find any information in Resident #9's medical record to indicate he was administered the influenza vaccine this season. She stated Resident #9 had a signed consent form for the vaccine and there should be documentation in Resident #9's record that the vaccine was administered.

On 04/30/2021 at 1:34 PM an interview with the administrator indicated there should be documentation in Resident #9's record that he received the influenza vaccine this season.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	C 05/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL ELIZABETH CITY LLC	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 48	F 883		

3. Resident #10 was admitted to the facility on 10/17/2018 with diagnoses including diabetes mellitus (DM).

A review of the admission clinical assessment for Resident #10 dated 10/17/2018 indicated Resident #10 had no known history of receiving the pneumococcal vaccine.

A review of the facility pneumococcal vaccine policy dated 11/1/2020 indicated each resident would be assessed for pneumococcal vaccine upon admission and the type of pneumococcal vaccine (PCV13, PPSV23/PPSV) offered would depend on the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations.-

A review of the Center for Disease Control and Prevention (CDC) policy titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate last revised November 21, 2019 read in part CDC recommends PPSV23 for anyone with any of the conditions listed below which included diabetes mellitus.

A review of a quarterly MDS for Resident #10 dated 04/12/2021 indicated he was independent for daily decision making. It further indicated his pneumococcal vaccine was not up to date because it had not been offered to him.

A review of the immunization section of Resident #10's medical record indicated no information regarding any education, offer or refusal of the pneumococcal vaccine.

On 04/29/2021 at 8:55 AM Resident #10 refused

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 49 to be interviewed. On 04/29/2021 at 4:26 PM an interview with the IP indicated there was no documentation in Resident #10's medical record regarding the offer or refusal of the pneumococcal vaccine. She stated based on the current vaccine recommendations from the CDC, because Resident #10 had DM he should have been offered this vaccine. She went on to say the facility had initiated the process of education on the risks versus the benefits and obtaining consent or refusal from Resident #10 for the PPSV23 vaccine. On 04/30/2021 at 4:12 PM a telephone interview with MD #1 indicated he was Resident #10's facility physician. He stated if Resident #10 had no data to suggest he previously received the PPSV23 vaccine, due to his DM and the current CDC guidelines the facility should have offered one to him.	F 883		