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	345411	A. BUILDING _____ B. WING _____	C 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD NURSING AND REHABILITATION CENTER	516 WALL STREET WAYNESVILLE, NC 28786

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E 000	Initial Comments An unnanounced Recertification survey was conducted on 12/13/2021 through 12/16/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #4SY011	E 000		
F 000	INITIAL COMMENTS An unnanounced recertification survey and complaint investigation was conducted from 12/13/2021 through 12/16/2021. Event ID # 4SY011. 4 of the 4 complaint allegations were not substantiated.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		1/28/22

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

Electronically Signed | 01/14/2022

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F 655	Continued From page 1 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan in all areas within 48 hours of admission for 1 of 1 resident (Resident #59) reviewed for closed record. The findings included: Resident #59 was admitted to the facility on 09/30/21. Her diagnoses included congestive heart failure, chronic respiratory failure, and kidney disease. Resident #59's admission evaluation dated 09/30/21 revealed Resident #59 was dependent with activities of daily living and mobility.	F 655	Resident #59 was admitted to the center on 9-30-21 and discharged 10-5-21. No baseline care plan was initiated within 48 hours. The resident was discharged before the baseline care plan was initiated. All residents have the potential to be affected. All residents were audited on 12/17/21 for baseline care plans. No additional residents were identified. All nurses will be re-educated on the center□s Baseline Care Plan policy, by the Director of nursing or designee. This education will be completed by 1-28-2022. No nurses will be scheduled to work after	

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F 655	Continued From page 2 An interview with the Director of Nursing (DON) on 12/15/21 at 2:50 PM revealed no baseline care plan was developed for Resident #59. An interview with the Unit Manager on 12/15/21 at 4:00 PM about the baseline care plan for Resident #59 revealed the admission evaluation triggered the baseline care plan and nurses and unit managers were responsible for developing the baseline care plan within three days of admission. She had no knowledge of why a baseline care plan was not developed for Resident #59 or why the admission evaluation did not trigger a baseline care plan. The MDS Coordinator was interviewed on 12/15/21 at 3:34 PM about the baseline care plan for Resident #59. She revealed no baseline care plan was developed for Resident #59. She stated the admission evaluation triggered the baseline care plan and nursing was responsible for completing the baseline care plan. The DON was interviewed on 12/16/21 at 11:54 AM about the process for baseline care plans. She revealed the admission evaluation triggered a baseline care plan for nursing to complete within 48 hours. She was not sure why a baseline care plan would not be completed for a resident or Resident #59. The Administrator was interviewed on 12/16/21 at 11:33 AM about the process for baseline care plans. He knew each resident was supposed to have a baseline care plan within 72 hours and had no knowledge of why a resident would not have a baseline care plan.	F 655	1/28/22 until the above education has been completed. Education on the Baseline Care Plan Policy will be added to New Employee Orientation for all nurses effective 1-21-22. The Director of Nursing or designee will audit all new admissions for a Baseline Care Plans to be implemented within 48 hours of admission during the Morning Clinical Meeting M-F on-going. The results of the Baseline Care Plan Audit will be reported to the QAPI Committee monthly x 3. Completion Date: 01/28/2022	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices	F 689		1/28/22

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F 689	Continued From page 3 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 medical record review, resident and staff interviews, the facility failed to provide 2 staff members when using a sit-to-stand mechanical lift for 1 of 2 residents (Resident #21) as per the care plan which resulted in a fall with fractures of the distal tibia (shin bone) and fibula (calf bone) with displacement. The findings included: Resident #21 was admitted to the facility on 12/15/20 with diagnoses that included muscle weakness, charcot's joint of the right ankle and foot (a complication which affects the bones, joints, and soft tissues of the foot and ankle causing the bones to become weak and break, or the joints to dislocate), type 2 diabetes, and lumbago with sciatica (pain that radiates along the sciatic nerve which runs down one or both legs from the lower back). Review of the quarterly Minimum Data Set dated 3/4/21 for Resident #21 revealed he was cognitively intact and required extensive assist of 1 person for transfers. Resident #21 had a care plan dated 12/16/20 in place for falls and activities of daily living where it stated he required	F 689	Nurse Aide #1 is no longer working at the facility. All residents who use a mechanical lift are at risk for the same deficient practice. On 12/17/21 an audit of all residents requiring mechanical lifts was completed. No additional residents were identified with injuries caused by improper use of the mechanical lift. All nursing staff will be re-educated on the center□s Lift and Transfer policy by 1/28/2022 by the Director of nursing, the Staff developer, or a designee, to ensure that incident will not be repeated. Education was provided to ensure that all staff were knowledgeable to look up ADL information on the kardex. No nursing staff will be scheduled to work after 1/28/2022 until above education has been completed. All new hired nursing staff will complete lift and transfer training during new hire orientation. The Director of Nursing or designee will complete and do three random audits on	

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F 689	Continued From page 4 a mechanical lift assist with 2 staff members for transfers. Interview on 12/13/21 at 10:14 AM with Resident #21 revealed he had a fall in March 2021 from a nurse aide not using the stand-up lift with 2 people. Resident #21 stated a few days later he thought his sciatica was acting up, he went to the hospital, and found out his left leg was broken. Review of the incident report dated 3/12/21 for Resident #21 revealed the nurse stated she was called into the shower room by the nurse aide and saw Resident #21 had slid down from the sit-to-stand lift. The nurse reported Resident #21 stated he slid down in the sit-to-stand lift during a transfer with his left foot and leg under him. Review of the nurse note dated 3/12/21 for Resident #21 revealed he had experienced leg weakness and slid down in the sit-to-stand lift. Resident #21 was assessed by the nurse, had no apparent injury, and did not complain of any pain or discomfort. Review of the nurse note dated 3/16/21 for Resident #21 revealed the nurse was called to therapy to look at Resident #21's left ankle. Resident #21 told the nurse he had rolled his ankle in the shower a few days prior on Friday when transferring to the wheelchair, but he had no pain, discomfort, or swelling with the ankle over the weekend. Resident #21 told the nurse he had rolled his left ankle again in therapy and the ankle was now painful, bruised, and swollen. Review of the physician orders dated 3/16/21 for Resident #21 revealed and order for x-ray to left ankle/foot due to swelling, bruising, and pain, and	F 689	transfers to ensure that all 2-person lifts are completed safely with 2 people, weekly x 4 weeks, monthly x 2 months to ensure that no accidents occurred as a result of improper use of the mechanical lift. The DON or designee will provide on the spot reeducation if necessary. The results of the Incident/Accident Audits will be reported to the QAPI Committee monthly x 3. Completion Date: 01/28/2022	

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F 689	Continued From page 5	F 689		

an order to transfer to the emergency room for evaluation and treatment of left tibia/fibula fractures.

Review of the radiology results report dated 3/16/21 for Resident #21 revealed acute fractures of the distal tibia and fibula with displacement.

The hospital discharge summary dated 3/20/21 revealed Resident #21 presented to the emergency department on 3/16/21 after experiencing a fall, resulting in the fracture of his left ankle. In addition, the x-rays noted a displaced left distal tibial fracture with a comminuted (breakage of bone into more than two fragments) distal fibula fracture. Resident #21 had an intramedullary nail fixation (permanent nail/rod is placed in the center of the bone) on 3/18/21 and due to the amount of bruising and swelling the fibula could not be repaired at that time. It was noted this would be addressed at the outpatient follow-up in approximately two weeks.

Review of a progress note dated 3/22/21 revealed Resident #21 was seen by the physician assistant to review overall status upon readmission following surgical fixation of the left distal tibia/fibula fracture. It was documented Resident #21 complained of ankle pain in the facility last week after a fall in the shower room.

Interview on 12/15/21 at 5:53 PM with Nurse Aide #1 revealed she had assisted Resident #21 out of the shower and back into his wheelchair on 03/12/21. Nurse Aide #1 stated she had Resident #21 in the sit-to-stand mechanical lift and his right knee gave out on him and she lowered him to the floor. Nurse Aide #1 revealed she asked Resident

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F 689	Continued From page 6 #21 if he was hurting anywhere and he said no. Nurse Aide #1 stated she went and got the nurse who also asked Resident #21 if he was hurting which he again denied any pain, so they assisted Resident #21 up to his wheelchair. Nurse Aide #1 revealed she was not aware she was to use 2 staff with the sit-to-stand mechanical lift. Interview on 12/15/21 at 4:35 PM with Nurse #4 revealed the nurse aide had came and told me Resident #21 had slid down from the sit-to-stand lift. Nurse #4 stated Resident #21 had said his left leg hurt a little bit but there was no swelling or discoloration. Nurse #4 revealed Resident #21 was his usual self, laughing with her and the nurse aide and they had assisted Resident #21 back to the wheelchair. Nurse #4 stated Resident #21 did not complain of any pain to her after that. Nurse #4 also stated she did not think there was another nursing staff member assisting the nurse aide with the sit-to-stand lift with Resident #21. Interview on 12/16/21 at 1:21 PM with the Director of Nursing (DON) revealed staff should follow the facility's mechanical lift policy and she expected staff would use a 2 person assist with a mechanical lift. Interview on 12/16/21 at 1:45 PM with the Administrator revealed staff should follow the policy for mechanical lift usage and he expected staff would use 2 people with the mechanical lift at all times.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with	F 726		1/28/22

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F 726	Continued From page 7 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to train 1 of 1 nurse aides on the sit to stand mechanical lift (Nurse Aide #1). The findings included: Interview on 12/15/21 at 5:52 PM with Nurse Aide #1 revealed she knew staff were to use 2 people when using the Hoyer mechanical lift but was not	F 726	Nurse Aide #1 no longer works at the facility. All residents who use a mechanical lift are at risk for the same deficient practice. On 12/22/21 an audit of all nursing staff was completed for skills competency validation for use of the mechanical lifts was completed. Multiple staff were identified	

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F 726	Continued From page 8 aware staff were to use 2 people when using the Sit-To-Stand mechanical lift. Review of the policy for Lift, Transfer, and Repositioning dated 2010 revealed the facility required 2 staff members to assist when lifting with mechanical lifting devices. Interview on 12/16/21 at 11:27 AM with the District Director of Clinical Services revealed all new employees including agency personal received training on resident safety and lift training upon hire and then quarterly through the year. The District Director of Clinical Services stated she was unable to locate Nurse Aide #1's orientation competency paperwork. Review of the materials covered in the Orientation Competency nurse aide packet revealed there was a competency required for mechanical lift use as well as an acknowledgement stating staff must watch a 2-part video and complete a return demonstration for each mechanical lift of the Hoyer mechanical lift and the Sit-To-Stand mechanical lift. The Orientation Competency paperwork also stated a mechanical lift always required 2 nursing staff members. Interview on 12/16/21 at 1:21 PM with the Director of Nursing (DON) revealed staff should follow the facility's policy for mechanical lift usage. The DON stated she expected staff would use 2 people to assist with any mechanical lift. The DON revealed all nursing staff should possess the competencies and skill sets necessary to provide care to meet the residents' needs. The DON also revealed she was responsible for assuring these competencies	F 726	as being deficient in completed Skills Competency for Use of the Mechanical Lifts. All nursing staff will have a Skills Competency validation for the Use of Mechanical Lifts by 1-28-22 by DON and designee. No staff will be scheduled to work after 1/28/2022 until the above education has been completed. The Director of Nursing or designee will maintain a binder with a copy of all skills validation or Skills Competency: Use of Mechanical Lifts for all nursing staff. This will also be added to new employee orientation for all nursing staff The Director of Nursing or designee will audit all nursing staff personnel files for Skills Competency: Use of Mechanical Lift weekly on an on-going basis, comparing the current employee roster with the Skills Competency. The results of the Skills Competency Audit for Mechanical Lifts will be reported to the QAPI Committee on a monthly x3 Completion Date: 01/28/2022	

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F 726	Continued From page 9 were completed for nursing staff. Interview on 12/16/21 at 1:45 PM with the Administrator revealed staff should follow the facility's policy for mechanical lift usage and 2 staff should use the mechanical lift at all times. The Administrator stated he expected all staff to possess the competencies and skill sets necessary to provide care to meet the residents' needs.	F 726		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		1/28/22

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F 761	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to remove expired medication from 3 of 4 medication carts (South medication cart, South Blue medication cart, South Green medication cart) and 1 of 2 medication storage rooms (North medication storage room). Findings included: 1. a. Observation on 12/15/21 at 10:30 AM with Nurse #2 of the North medication storage room revealed the following expired medications unopened and available for use: - Silvasorb Gel 1.5 fluid ounces (oz) expired 10/2021 - Skin Integrity Hydrogel 4 oz expired 2/2021 Interview on 12/15/21 at 10:56 AM with the Unit Manager revealed the nurses were all responsible for making sure wound care supplies were not expired. b. Observation on 12/15/21 at 11:46 AM with Nurse #3 of the South medication cart revealed the following expired medications labeled for a resident and available for administration: - Loperamide hydrochloride (HCL) 2 milligram (mg) capsule medication card expired 10/31/2021 - Divalproex 250 mg tablet medication card expired 11/30/2021 - Divalproex 250 mg tablet medication card expired 11/30/2021	F 761	Nurse # 2 was re-educated on center□s Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy on 12/17/21. Nurse #3 was re-educated on center□s Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy on 12/17/21. Medication Aide #1 was re-educated on center□s Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy on 12/17/21. All residents have the potential to be affected. An audit was completed of all medication carts, treatment carts and medication storage rooms on 12/17/21. No additional expired or improperly labeled medications were identified. All Licensed Nurses and Certified Medication Aides will be re-educated on the center□s Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy by 1-28-22, by the DON and /or designee. No nurses or CMA□s will be scheduled to work until the above education has been performed. Education will be provided to all nurses and Certified medication Aides in orientation. Director of Nursing/designee will complete a Medication Storage, labeling, and expiration Audit weekly x 4 weeks,	

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F 761	Continued From page 11 - Liquid Pain Relief Acetaminophen 160 mg/ 5 milliliter (ml) 16 fluid oz, stock medication ¾ full, expired 8/2021 Interview on 12/15/21 at 11:46 AM with Nurse #3 revealed the night nurses should be going through the medication cart to remove expired medications monthly. c. Observation on 12/15/21 at 12:46 PM with Medication Aide #1 of the South Blue medication cart revealed the following expired medications were available for administration: - Donepezil HCL 10 mg tablet medication card, labeled for a resident, expired 10/31/2021 - 3 fuchsia-colored tablets in a medication cup with the word cranberry handwritten on the cup, no expiration date present Interview with Medication Aide #1 revealed the fuchsia-colored tablets in the medication cup with the word cranberry handwritten on the cup were the only cranberry tablets she knew of in the facility. Medication Aide #1 stated she did not know who should be checking for expiration dates on medications. d. Observation on 12/15/21 at 12:46 PM with Medication Aide #1 of the South Green medication cart revealed the following expired medications labeled for a resident and available for administration: - Allopurinol 100 mg tablet medication card expired 11/30/21	F 761	monthly x 4 months. The results of the Medication Storage, labeling, and expiration audit will be reported to the QAPI Committee monthly x 3. Completion Date: 01/28/2022	

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	345411	A. BUILDING _____ B. WING _____	C 12/16/2021

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F 761	Continued From page 12 - Bupropion HCL Slow Release 150 mg tablet medication card expired 11/30/21 Interview on 12/15/21 at 3:19 PM with the Unit Manager revealed the nurses should be doing quarterly medication expiration cart audits. The Unit Manager stated the Unit Managers should go through the carts every week or 2 to ensure all expired medications were removed, all narcotics were current, and all medications were ordered. The Unit Manger revealed every nurse on every shift should be looking at the medication cart for expired medications. Interview on 12/16/21 at 1:21 PM with the Director of Nursing (DON) revealed the night shift nurses should check for expired medications every night when they completed their medication cart checks and cleaned the medication carts. The DON stated all nurses were responsible for checking expiration dates of medications. The DON also stated the 3 fuchsia-colored tablets in a medication cup with the word cranberry handwritten on the cup should have not been in the medication cart. The DON revealed she expected the night nurses would check the medication carts for expired medications nightly.	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		1/28/22

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F 880	Continued From page 13 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 14 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to implement a Legionella prevention program that could have affected 55 of 55 residents. The facility also failed to have hand sanitizer or a functioning hand washing station available in 1 of 2 laundry rooms that could have affected 43 of 55 residents reviewed for infection control. 1. Review of the Emergency Preparedness workbook with the Administrator on 12/16/21 at 11:27 AM revealed no information on water safety management for Legionella. He explained he would speak with the Director of Maintenance to acquire about the information. The water safety plan workbook for Legionella dated 09/23/2018 was reviewed. There were no updated facility risk assessments or monitoring logs since 2018.	F 880	All residents have the potential to be affected by the deficient practice. Maintenance manager was reeducated on the requirements of the water safety plan on 1/7/2022 by the director of facility engineering. Hand sanitizer was installed in the south laundry room on 12/14/21. Hand washing sink was repaired on 1/12/22. All residents have the potential to be affected by the deficient practice. Water safety plan will be reviewed and appropriate changes will be made to ensure compliance by 1/12/22. Education was performed by the Director of Facility Engineering to the Maintenance manager.	

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F 880	Continued From page 15 An interview with the Director of Maintenance on 12/16/21 at 12:55 PM revealed he was not aware that he was supposed to complete a yearly facility risk assessment or log his checks and procedures for his water safety plan. An interview with the Administrator on 12/16/21 at 1:57 PM revealed his expectation was for the facility to be in compliance with the Legionella policy. 2. An observation of the South hall laundry room on 12/14/21 at 9:10 AM revealed there was no hand sanitizer available. LA #1 was interviewed at the time of the observation and indicated there was no hand sanitizer in the laundry room. He stated he went outside the laundry room door and sanitized his hands in the resident hallway every time he changed gloves. On 12/14/21 at 9:25 AM, LA #1 stated the sink with the hand soap above it did not work and water could not flow through the pipes. He further stated he was hired a year ago never washed his hands in that sink. An interview with the Environmental Services Manager (ESM) on 12/14/21 at 9:21 AM revealed LA #1 usually cleaned his hands at the sink in the laundry room. On 12/14/21 at 10:42 AM, it was observed that no water flowed out of the sink faucet in the South hall laundry room when the sink handles were used. On 12/14/21 at 10:50 AM, the ESM further stated he was unsure how long the sink had been	F 880	All staff will be educated on legionella, submitting work order, and proper use of hand sanitizer by 1/28/2022 by the DON, staff developer, and or designee. No staff will be scheduled to work after 1/28/2022 until the above education was completed. This education will also be provided at orientation. Water Safety Plan was updated and will be reviewed quarterly to ensure compliance. An audit of the water safety plan will be completed monthly at QAPI meeting x3 months to ensure compliance. Water safety logs are performed in TELS, and will be reviewed in the monthly QAPI meeting. An audit of proper use of hand sanitizer will be completed with 5 staff members per week for 4 weeks and then monthly for 3x months. Results of hand sanitizer use audit will be reported to QAPI committee monthly x3. Completion Date: 01/28/2022	

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F 880	Continued From page 16 inoperable. The ESM was not aware until it was brought to his attention on 12/14/21. An interview with the Director of Nursing (DON) on 12/15/21 at 7:47 AM revealed the sink with the hand soap should have been working and hand sanitizer should have been available in the laundry rooms.	F 880		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;	F 887		1/28/22

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F 887	Continued From page 17 (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, and resident representative (RP) interviews the facility failed to offer 3 of 5 residents (Residents #1, #14, and #41) the COVID-19 vaccine. These failures occurred during a COVID-19 pandemic.	F 887	Resident identified as #1 received Moderna Covid-19 Vaccination at Publix Pharmacy in Waynesville, NC on 12/14/21. Resident #14 received Jannsen COVID-19 Vaccination on 12-14-21 at	

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F 887	Continued From page 18 Findings included: Review of the facility COVID-19 vaccination policy for residents updated October 2021 indicated all residents of the center should be offered the COVID-19 vaccine unless there was a documented medical contraindication, or the resident had already been fully vaccinated. The center would educate residents or RPs, if applicable, regarding the benefits and potential side effects associated with receiving the COVID-10 vaccine and offer the COVID-19 vaccine, unless it is medically contraindicated, or the resident has already been immunized. The center will maintain proper documentation in the resident's MR to reflect the resident was provided the required COVID-19 vaccine education, and whether the resident received the vaccine. The center will track which residents received the vaccine, as well as those who refused or did not get vaccinated. 1. Resident #1 was admitted to the facility on 3/4/21 with diagnoses including stroke and hypertension. A review of a quarterly minimum data set assessment (MDS) for Resident #1 dated 9/8/21 indicated he was cognitively intact. A review of the immunization section of Resident #1's medical record did not indicate any information regarding the offer or refusal of the COVID-19 vaccine since his admission. A review of Resident #1's medical record did not reveal any information indicating he was offered or refused the COVID-19 vaccine since his	F 887	Publix Pharmacy in Waynesville, NC. Resident #41 received Moderna COVID-19 Vaccination on 12-14-21 at Publix Pharmacy in Waynesville, NC. All residents are at risk for the same deficient practice. On 12/17/2021, the Director of Nursing completed an audit of all current resident□s COVID vaccination status. 1 additional resident was identified that needed COVID vaccination, and received Moderna Covid-19 vaccination on 1/11/2022. All licensed nurses will be re-educated by 1-28-22 by the DON, staff developer, and/or designee regarding vaccination documentation, or prior COVID infections. No nursing staff will be scheduled to work until above education is performed. The Admission Coordinator will be responsible for education, determining resident□s vaccination status on admission, and recording in the chart. Admissions coordinator will also obtain consent for COVID-19 Vaccination on all new admissions effective 12/17/21. The Director of Nursing/Designee will audit all new admissions for COVID-19 Immunizations during Morning Clinical Meeting M-F on an on-going basis. The results of the COVID 19 Immunizations Audit will be reported to the QAPI Committee monthly x 3. Completion date: 1/28/2022	

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F 887	Continued From page 19	F 887		

admission.

On 12/13/21 at 12:26 PM an interview with Resident #1 stated he was not offered the COVID-19 vaccine since he was admitted. He further indicated he would have accepted one if it had been offered to him.

On 12/15/21 at 7:52 AM an interview with the Infection Preventionist (IP) indicated she could not find any information in Resident #1's medical record regarding the offer or refusal of the COVID-19 vaccine. She stated there should have been documentation in Resident #1's record that he 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. The IP stated Resident #1 received the first dose of the Moderna COVID-19 vaccine on 12/14/21, which was after surveyor intervention.

On 12/15/21 at 3:01 PM an interview with the Administrator indicated there should have been documentation in Resident #1's record that he was educated on the risks versus the benefits of the COVID-19 vaccine and either a signed consent form and record of administration or a refusal of the vaccine.

2. Resident #14 was admitted to the facility on 2/17/21 with diagnoses including dementia.

A review of a quarterly MDS assessment for Resident #14 dated 10/11/21 indicated she was moderately cognitively impaired.

A review of the immunization section of Resident #14's medical record did not indicate any information related to the COVID-19 vaccine.

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A review of Resident #14's medical record did not reveal any information indicating she was offered or refused the COVID-19 vaccine since her admission.

On 12/16/21 at 11:51 AM an interview with Resident #14 stated she was not offered the COVID-19 vaccine since she was admitted. She further indicated she would have accepted one if it had been offered to her. She stated she was unsure why she didn't get it prior to a few days ago.

Multiple attempts for a telephone interview with Resident #14's Responsible Party (RP) were made, but he was not able to be reached.

On 12/15/21 at 7:52 AM an interview with the Infection Preventionist (IP) indicated she could not find any information in Resident #14's medical record regarding the offer or refusal of the COVID-19 vaccine. She stated there should have been documentation in Resident #14's record that she and her RP were 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. The IP stated Resident #14 received the one-dose Johnson and Johnson COVID-19 vaccine on 12/14/21, which was after surveyor intervention.

On 12/15/21 at 3:01 PM an interview with the Administrator indicated there should have been documentation in Resident #14's record that she and her RP were educated on the risks versus the benefits of the COVID-19 vaccine and either a signed consent form and record of administration or a refusal of the vaccine.

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3. Resident #41 was admitted to the facility on 4/7/21 with diagnoses including dementia and diabetes mellitus (DM).

A review of the significant change MDS assessment for Resident #41 dated 11/17/21 indicated Resident #41 was severely cognitively impaired.

A review of the immunization section of Resident #41's medical record indicated no information regarding any education, offer or refusal of the COVID-19 vaccine.

On 12/16/21 at 11:26 AM a telephone interview with Resident #41's RP indicated she and Resident #41 requested the COVID-19 vaccine from various nurses (names unknown). She stated she could not recall if the vaccine was discussed during the admission process. Resident #41's RP inquired with a nurse (name unknown) about the vaccine one month ago, they said they would look into it, and no one got back to her.

On 12/15/21 at 7:52 AM an interview with the Infection Preventionist (IP) indicated she could not find any information in Resident #41's medical record regarding the offer or refusal of the COVID-19 vaccine. She stated there should have been documentation in Resident #41's record that she and his RP were 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. The IP stated Resident #41 received the first dose of the Moderna COVID-19 vaccine on 12/14/21, which was after surveyor intervention.

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F 887	Continued From page 22 On 12/15/21 at 3:01 PM an interview with the Administrator indicated there should have been documentation in Resident #41's record that he and his RP were educated on the risks versus the benefits of the COVID-19 vaccine and either a signed consent form and record of administration or a refusal of the vaccine.	F 887		