STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345187	A. BUILDING: _____ B. WING _____	5/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHABILITATION	**109 FOOTHILLS DRIVE MORGANTON, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 657	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews the facility failed to revise a care plan for 1 of 1 resident (Resident #55) to reflect weight-bearing status of the resident. The findings included: Resident #55 was admitted to the facility on 1/4/2022 with diagnoses of right lower extremity fracture and repeated falls. Review of Resident #55's care plan dated 1/19/2022, and last revised on 3/4/2022, revealed a focus for resident requires assistance with activities of daily living (ADL) related to impaired mobility, non-weight bearing to right leg, and controlled ankle motion walking boot (or CAM boot) for transfers and when out of bed. Resident #55's quarterly Minimum Data Set (MDS) dated 4/13/2022 revealed he required extensive assistance of 2 persons for transfers and toileting. Observation of Resident #55 on 5/22/2022 at 10:38 AM revealed him sitting upright in a manual wheelchair beside his bed. He was wearing soft slippers on both feet. Interview with Resident #55 on 5/22/2022 at 10:38 AM revealed he needed help to transfer and toilet due to his frequent falls. Resident #55 stated he did not use a boot. Interview on 5/24/2022 at 1:02 PM with the Occupational Therapist (OT) currently working with Resident

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 657	Continued From Page 1

#55 revealed the resident required a total mechanical lift for transfers when he started with therapy. As he progressed with therapy, an order for a CAM boot was requested by therapy to prevent Resident #55's ankle from rolling.

Interview with the Director of Therapy on 5/24/2022 at 10:23 AM revealed Resident #55 was currently weight bearing as tolerated. He further indicated the CAM boot had been discontinued on 4/27/2022.

Interview with the MDS Coordinator and Director of Nursing (DON) on 5/25/2022 at 11:16 AM revealed the care plan should have been updated to reflect the resident's current status. The MDS Coordinator could not explain why the care plan had not been updated.

Interview with the facility Administrator on 5/25/2022 at 5:54 PM revealed he expected care plans to be tailored to fit each resident specifically.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHABILITATION	109 FOOTHILLS DRIVE MORGANTON, NC 28655

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 5/22/22 through 5/25/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 9BJV11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted on 5/22/22 through 5/25/22. 3 of 11 allegations were substantiated; NC00176621, NC00179890, NC00183551 and NC00186706. Event ID# 9BJV11.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.	F 636		6/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/18/2022

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(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the

This plan of correction constitutes our

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F 636	Continued From page 2	F 636		

facility failed to complete a comprehensive assessment within the required timeframes for 1 of 1 resident reviewed for resident assessment (Resident #1) and failed to complete the Care Area Assessment (CAA) that addressed the underlying causes and contributing factors for pressure ulcer for 1 of 4 sampled residents (Resident #57).

The findings included:

1. Resident #1 was admitted to the facility on 2/11/21.

A review of Resident #1's electronic medical record revealed the most recent Minimum Data Set (MDS) assessment was coded as a quarterly with an assessment reference date (ARD) of 1/12/22. There were no other MDS assessments that were open or started.

An interview was conducted with the MDS Coordinator on 5/25/22 at 11:16 AM with the Director of Nursing (DON) present. The MDS Coordinator stated an annual MDS assessment should have been completed on 4/14/22 for Resident #1 and she had no idea how she had missed it. The MDS Coordinator stated she utilized a tracker that tracked and scheduled all the MDS assessments that were due. The DON stated they usually opened a new assessment once they closed the last assessment, and a new assessment hadn't been opened for Resident #1.

An interview with the Administrator on 5/25/22 at 5:50 PM revealed MDS had been a weak area at the facility, and it was mostly due to having only one MDS Coordinator to complete all the resident assessments. The Administrator stated he had

written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.

Resident # 1 and #resident # 57 Comprehensive Assessment and Care Area Assessments were modified and completed on 06/07/2022 and 06/6/2022 respectively.
All current residents on census as of 05/30/2022 were reviewed for compliance on timing and completion of Comprehensive Assessment and Care Area Assessments. This audit was completed on 5/30/2022 by the Regional Minimum Data Set Manager. Any errors noted were corrected on 06/15/2022.
Minimum Data Set Coordinator was initially educated by the Regional Minimum Data Set Manager on 5/27/2022. This education includes timing and completion of Comprehensive assessment and Care Area Assessment.
Follow up education with Minimum Data Set coordinator on timing and completion of comprehensive assessments and Care Area Assessment conducted by Director of Clinical Reimbursement on 6/15/2022.
Any new M6DS staff hired will be trained on timing and completion of Comprehensive Assessment and Care Area Assessment at the time of orientation.
The Regional Minimum Data Set Manager

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just hired another MDS Coordinator to help out his full-time MDS Coordinator.

2. Resident #57 was admitted to the facility on 4/14/22 with diagnoses that included cerebral infarction (stroke).

The admission Minimum Data Set (MDS) assessment dated 4/21/22 indicated Resident #57 was at risk of developing pressure ulcers/injuries, had no pressure ulcers on admission and received application of nonsurgical dressings.

A progress note dated 4/23/22 at 3:58 PM in Resident #57's medical record indicated an open area to his sacrum was observed and measured 1.2 cm (centimeters) in length and 2 cm in width. Foam dressing applied to area.

The Care Area Assessment (CAA) for pressure ulcer dated 4/26/22 indicated Resident #57 needed a special mattress or seat cushion to reduce or relieve pressure and had the following intrinsic risk factors: immobility, cognitive loss, incontinence, and poor nutrition. Under the section "Analysis of Findings" was a statement that read: See activities of daily living (ADL) CAA. There was no ADL CAA in the CAA Summary.

An interview was conducted with the MDS Coordinator on 5/25/22 at 11:16 AM with the Director of Nursing (DON) present. The MDS Coordinator stated Resident #57 did not have a CAA for ADL because it was not triggered based on the responses to the questions on his admission MDS. She further stated that she made a mistake and thought she had placed the

or designee will conduct 5 chart audits weekly on completion and timing of Comprehensive Assessments and Care Area Assessment for 4 weeks, then 3 chart audits weekly for 4 weeks then 1 audit for 4 weeks.
The Administrator will bring the audit for completion and timing of comprehensive assessments and Care Area Assessment to the Quality Assurance Committee monthly for 3 months. At that time, the Quality assurance performance improvement committee will evaluate the effectiveness of the training to determine if continued auditing is necessary to maintain compliance. Date of completion 6/15/2022

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F 636	Continued From page 4 analysis of findings for the pressure ulcer under his cognitive CAA. The MDS Coordinator stated the pressure ulcer CAA should have been specific to pressure ulcer and she should have completed an analysis of the causes and Resident #57's risk factors that predisposed him to develop a pressure ulcer. An interview with the Administrator on 5/25/22 at 5:50 PM revealed MDS had been a weak area at the facility, and it was mostly due to having only one MDS Coordinator to complete all the resident assessments. The Administrator stated he had just hired another MDS Coordinator to help out his full-time MDS Coordinator.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the required Significant Change in Status Assessment (SCSA) following admission to hospice care for 2 of 2 residents reviewed for hospice (Resident #23 and Resident	F 637	Resident # 23 and resident # 82 Significant Change assessments were completed on 6/3/2022 and 6/7/2022. All current hospice residents on census as of 05/30/2022 were audited for	6/15/22

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#82).

The findings included:

1. Resident #23 was re-admitted to the facility on 5/2/22 with diagnoses that included encephalopathy, dementia, and adult failure to thrive.

A progress note dated 5/4/22 at 4:01 PM in Resident #23's medical record indicated a new order was received to admit Resident #23 to hospice.

A review of the facility's payer source for Resident #23 indicated hospice Medicaid was active as of 5/5/22.

A review of Resident #23's Minimum Data Set (MDS) assessments indicated the most recent MDS was a quarterly dated 5/9/22 and it was in process. A Significant Change in Status Assessment had not been completed within 14 days of Resident #23's admission to hospice care (5/5/22).

An interview was conducted with the MDS Coordinator on 5/25/22 at 11:16 AM with the Director of Nursing (DON) present. The MDS Coordinator stated when Resident #23 was re-admitted to the facility, she was admitted to hospice care on 5/5/22. The MDS Coordinator stated she should have initiated a Significant Change in Status Assessment within 14 days of Resident #23 being admitted to hospice care. The MDS Coordinator stated she did not know how or why she missed initiating this assessment for Resident #23.

compliance with Significant Change assessment when admitted to Hospice care. This audit was completed on 5/30/2022 by the Regional Minimum Data Set Manager. No other residents were affected by the same deficient practice.
Minimum Data Set Coordinator was educated by the Regional Minimum Data Set Manager on 05/27/2022. This education includes timing and completion of Significant Change within 14 days of Hospice election. Follow up education with Minimum Data Set coordinator on timing and completion of Significant Change assessment within 14 days of hospice election conducted by Director of Clinical Reimbursement on 6/15/2022. This education will be included on any new Minimum Data Set staff hired at the time of orientation.
The Regional minimum data set Manager or designee will conduct 5 chart audits weekly on residents newly admitted to hospice care for 4 weeks, then 3 chart audits weekly for 4 weeks, and then 2 chart audits weekly for 4 weeks.
The Administrator will bring the audit for Significant Change Assessment related to Hospice care to the Quality Assurance Committee monthly for 3 months. At that time, the Quality Assurance Performance Improvement committee will evaluate the effectiveness of the training to determine if continued auditing is necessary to maintain compliance. Date of completion 6/15/2022.

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F 637	Continued From page 6	F 637		

An interview with the Administrator on 5/25/22 at 5:50 PM revealed MDS had been a weak area at the facility, and it was mostly due to having only one MDS Coordinator to complete all the resident assessments. The Administrator stated he had just hired another MDS Coordinator to help out his full-time MDS Coordinator.
2. Resident #82 was admitted to the facility on 6/6/2019.

Review of Resident #82's quarterly MDS dated 2/19/2022 revealed no diagnosis of cancer or hospice treatment.

Electronic medical record review indicated Resident #82 had received a new diagnosis of malignant neoplasm of esophagus on 4/16/2022.

Review of electronic hospice records revealed Resident #82 was admitted to hospice services on 4/29/2022 for diagnosis of malignant neoplasm of the esophagus with poor prognosis.

Review of Resident #82's electronic medical record revealed a Significant Change in Status Minimum Data Set (MDS) Assessment was not completed after the resident was admitted to hospice services.

An interview on 5/25/2022 at 11:16 AM with the MDS Coordinator and Director of Nursing (DON) revealed the MDS Coordinator was aware a significant change MDS should have been completed within 14 days of the resident's admission to hospice. The MDS Coordinator could not explain why the significant change MDS had not been started or completed.

An interview on 5/25/2022 at 5:54 PM with the

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F 637	Continued From page 7 facility Administrator revealed having one MDS Coordinator was not enough for a facility of this size. The Administrator further revealed a recently hired MDS Nurse had been hired, but quit abruptly, leaving the one MDS Coordinator to manage the entire facility. The Administrator stated a replacement had been hired but was not yet on board. The Administrator stated he expected MDS to be completed per regulations.	F 637		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments to reflect the diagnoses for 2 of 2 residents reviewed for dementia care (Resident #67 and Resident #90) and 1 of 5 residents reviewed for unnecessary medications (Resident #85), use of hearing aid for 1 of 7 residents reviewed for activities of daily living (Resident #55) and urinary continence for 2 of 2 residents reviewed for urinary appliance (Resident #61 and Resident #66). Findings included: 1. Resident #67 was admitted to the facility on 04/09/21. Diagnosis included cognitive communication deficit and dementia. Review of Resident #67's annual MDS assessment dated 04/14/22 revealed resident	F 641	Resident #6, resident #90, resident #85, resident #55, resident#61, resident #66, Minimum Data Set were modified on 06/13/2022. All current residents on census as of 05/30/2022 were audited for the following: 1. Residents with active diagnosis of dementia were audited for accuracy on Minimum Data Set coding; 2.Residents with diagnosis of depression were audited for appropriate Minimum Data Set coding; 3.Residents with hearing aid were audited for accurate Minimum Data Set coding: 4. Residents with indwelling foley catheter or urostomy were audited for appropriate coding of continence status and accurate appliance; These audits were completed by the Regional Minimum Data Set Manager 05/30/2022. Any errors noted were corrected by 6/15/2022. Minimum Data Set Coordinator was	6/15/22

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was not coded as having a dementia diagnosis.

Review of Resident #67 revised care plan dated 04/18/22 revealed no care plan specific to dementia.

An interview with the MDS Coordinator and Director of Nursing (DON) on 05/25/22 at 12:04 PM revealed Resident #67 has an active diagnosis for dementia and verified resident is not coded for dementia on the MDS assessment and there is no approach for dementia in resident's care plan. The MDS Coordinator and DON further revealed the MDS assessment should reflect active diagnosis and had no knowledge as to why the resident was not coded as having dementia on the MDS or why there is no approach for dementia in resident's care plan.

An interview with the Administrator on 05/25/22 at 06:37 PM stated the MDS assessment should reflect current diagnosis for resident.

2. Resident #90 was admitted to the facility on 05/02/22. Diagnosis included cognitive communication deficit and dementia.

Review of Resident #90's admission MDS assessment dated 05/09/22 revealed resident was not coded as having a dementia diagnosis.

Review of Resident #90's admission care plan dated 05/12/22 for dementia with interventions that included assess degree of disorientation to time, place and person and provide orientation to resident in conversation and monitor response.

An interview with the MDS Coordinator and

educated by the Regional Minimum Data Set Manager on 05/27/2022. This education includes accurate coding of urinary appliance with correct continence level, hearing aid use, Diagnosis of dementia and depression. Follow up education with Minimum Data Set coordinator on accurate coding of urinary appliance with appropriate continence level, hearing aid use, diagnosis of dementia and depression conducted by Director of Clinical Reimbursement on 6/15/2022. This education will be included on any new Minimum Data Set staff hired at the time of orientation.
The Regional Minimum Data Set Manager or designee will complete 5 Minimum Data Set(MDS) audits weekly for accurate coding for continence status with use of Urostomy and or use of foley catheter and accurate coding for Dementia and Depression for 4 weeks, then 3 MDS audits weekly for 4 weeks, and then 1 MDS audit for 4 weeks.
The Administrator will bring the audit for Minimum Data Set accuracy audit to Quality Assurance Performance Improvement Committee monthly for 3 months. At that time, the Quality Assurance Performance Improvement committee will evaluate the effectiveness of the training to determine if continued auditing is necessary to maintain compliance. Date of completion 6/15/22.

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Director of Nursing (DON) on 05/25/22 at 12:07 PM revealed Resident #90 has an active diagnosis for dementia and verified resident is not coded for dementia in MDS assessment. The MDS Coordinator and DON further stated the MDS assessment should reflect active diagnosis and had no knowledge as to why resident was not coded on the MDS assessment as having dementia.

An interview with the Administrator on 05/25/22 at 06:37 PM stated the MDS assessment should reflect current diagnosis for resident.

3. Resident #85 was admitted to the facility on 10/15/21. Diagnosis included cognitive communication deficit and depression.

Review of Resident #85's quarterly MDS assessment dated 04/24/22 revealed resident was not coded as having a diagnosis of depression.

Review of Resident #85's revised care plan dated 04/29/22 for anti-depressant medication use with interventions that included assess and record effectiveness of drug treatment and monitor and report signs of sedation, hypotension, or anticholinergic symptoms.

An interview with the MDS Coordinator and Director of Nursing (DON) on 05/25/22 at 12:12 PM revealed Resident #85 has an active diagnosis for depression and verified resident is not coded for depression on the MDS assessment. The MDS Coordinator and DON further revealed the MDS assessment should reflect active diagnosis and had no knowledge as

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to why resident was not coded on the MDS assessment as having depression.

An interview with the Administrator on 05/25/22 at 06:37 PM stated the MDS assessment should reflect current diagnosis for resident.

4. Resident #55 was admitted to the facility on 1/4/2022.

His quarterly Minimum Data Set (MDS) dated 4/13/2022 revealed he had moderate difficulty hearing and did not use a hearing aid.

Observation of Resident #55 on 05/22/22 10:38 AM revealed he was wearing a hearing aid in his left ear. Interview with Resident #55 revealed he only wore a left ear hearing aid and kept it in a drawer of his nightstand. Resident #55 stated Nurse Aides (NA) helped him get his hearing aid out of its box every morning.

Interview with NA #11 on 5/25/2022 at 2:57 PM revealed Resident #55 did ask for assistance with his hearing aid in the mornings.

A joint interview with the MDS Coordinator and Director of Nursing (DON) on 05/25/22 at 11:16 AM revealed the MDS Coordinator was not aware Resident #55 wore a hearing aid. The MDS Coordinator and DON both stated the use of the hearing aid should have been included on the MDS.

Interview with the Administrator on 5/25/2022 at 5:54 PM revealed he expected MDS to accurately reflect the current condition of each resident.

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5. Resident #61 was admitted to the facility on 10/11/21 with diagnoses which included neurogenic bladder, and obstructive uropathy among others.

Review of Resident #61's electronic medical record (EMR) revealed during the look back period of 7 days beginning 04/06/22 and ending 04/12/22 the resident had a urinary catheter during the entire time.

Resident #61's annual Minimum Data Set (MDS) assessment dated 04/13/22 revealed he had an indwelling catheter and was occasionally incontinent of urine.

Interview on 05/25/22 at 11:15 AM with the MDS Coordinator and the Director of Nursing (DON) revealed the MDS assessment should have been coded as "not rated" instead of occasionally incontinent of urine. The MDS Coordinator and the DON both stated it was an error and should have been coded as not rated.

Interview on 05/25/22 at 5:54 PM with the Administrator revealed it was his expectation that all MDS assessments accurately reflect the current condition of each resident.

6. Resident #66 was admitted to the facility on 4/26/22 with diagnoses that included neuromuscular dysfunction of bladder.

The admission Minimum Data Set (MDS) assessment dated 5/3/22 indicated Resident #66 was cognitively intact and had an ostomy appliance particularly a urostomy. The MDS further indicated Resident #66 was occasionally incontinent of urine (less than 7 episodes of

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F 641	Continued From page 12 incontinence). An observation and interview with Resident #66 on 5/24/22 at 3:19 PM revealed a urostomy bag on the right lower quadrant of her abdomen. Resident #66 stated she had the urostomy for about a year and all her urine went straight into the bag. An interview was conducted with the MDS Coordinator on 5/25/22 at 11:16 AM with the Director of Nursing (DON) present. The MDS Coordinator stated that she made an error in coding the urinary continence in Resident #66's admission MDS and that she should have coded her as not rated because she had a urostomy. The MDS Coordinator stated it might have been a finger slip and she meant to code Resident #66's urinary continence as not rated. An interview with the Administrator on 5/25/22 at 5:50 PM revealed the MDS assessments should be coded accurately.	F 641		
F 656 SS=E	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	F 656		6/15/22

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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 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 record review, observations and resident and staff interviews, the facility failed to develop a comprehensive person-centered plan of care to address specific needs of the residents in the areas of activities of daily living for 2 of 7 residents reviewed (Resident #57 and Resident #66) and dementia care for 1 of 2 residents reviewed (Resident #67).

Resident #57, resident #66 and resident #67 Care Plans were updated on 06/13/2022
All current residents on census as of 05/30/2022 with urostomy, diagnosis of dementia and resident requiring extensive assistance with transfer with impairment to upper and lower extremities were reviewed for appropriate care plan

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The findings included:

1. Resident #57 was admitted to the facility on 4/14/22 with diagnoses that included cerebral infarction (stroke).

The admission Minimum Data Set (MDS) assessment dated 4/21/22 indicated Resident #57 was severely impaired for cognitive skills for daily decision making and had fluctuating altered level of consciousness. The MDS further indicated Resident #57 required extensive physical assistance with all activities of daily living including transfer and had impairment to both sides of upper and lower extremities. Resident #57 was always incontinent of both urine and bowel.

A review of Resident #57's care plans indicated the following information:
a. Initiated on 4/26/22 - Resident #57 was limited in ability to transfer self. The goal of Resident #57 to safely transfer self independently was listed and the only approach was to follow therapy recommendations.
b. Initiated on 4/26/22 - Resident #57 had actual skin integrity issues related to weakness and incontinence. The goal that Resident #57 would not have any signs and symptoms of infection was listed and the only approach was to keep call light in reach.
c. Initiated on 5/18/22 - Resident #57 required an indwelling urinary catheter.

An observation of incontinence care on Resident #57 on 5/24/22 at 12:59 PM revealed Resident #57 did not have an indwelling urinary catheter.

interventions. This audit was completed on 05/30/2022 by the Regional Minimum Data Set Manager. Any errors noted were corrected by 6/15/2022.
Minimum Data Set Coordinator was educated by the Regional Minimum Data Set Manager on 5/27/2022. This education includes appropriateness of care plan interventions for urostomy, diagnosis of dementia and resident requiring extensive assistance with transfer with impairment to upper and lower extremities. Follow up education with Minimum Data Set coordinator on appropriateness of care plan interventions for urostomy, diagnosis of dementia and resident requiring extensive assistance with transfer with impairment to upper and lower extremities conducted by Director of Clinical Reimbursement on 6/15/2022.
This education will be included on any new Minimum Data Set staff hired at the time of orientation.
The Regional Minimum Data Set Manager or designee will complete 5 care plan audits weekly for appropriate care plan intervention for Activity Daily Living transfer, brace, hearing aid for 4 weeks, then 3 care plan audits weekly for 4 weeks, and then 1 care plan audit weekly for 4 weeks.
The Administrator will bring the audit for comprehensive care plan to the Quality Assurance Committee monthly for 3 months. At that time, the Quality Assurance Performance Improvement committee will evaluate the effectiveness of the training to determine if continued auditing is necessary to maintain

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An interview with Nurse Aide (NA) #1 on 5/24/22 at 1:13 PM revealed she had taken care of Resident #57 ever since he was admitted to the facility, and she did not remember him ever having an indwelling urinary catheter.

An interview with the Rehabilitation Director on 5/24/22 at 10:23 AM revealed Resident #57 received therapy services when he was admitted to the facility, but they were stopped on 4/27/22 when his family member had deferred therapy services.

An interview was conducted with the MDS Coordinator on 5/25/22 at 11:16 AM with the Director of Nursing (DON) present. The MDS Coordinator stated she did not know why Resident #57 had a care plan for both urinary incontinence and indwelling urinary catheter. She couldn't remember if Resident #57 had a urinary catheter when he was first admitted to the facility. The MDS Coordinator further stated Resident #57 being able to transfer self was not reflective of Resident #57's current functional ability.

An interview with the Administrator on 5/25/22 at 5:50 PM revealed care plans should be tailored to reflect the specific resident they were developed for and should not be generic. He stated Resident #57's care plan should indicate his current level of functional status including his continence and should not indicate both urinary incontinence and the presence of a urinary indwelling catheter.

2. Resident #66 was admitted to the facility on 4/26/22 with diagnoses that included neuromuscular dysfunction of bladder.

compliance. Date of completion 6/15/2022.

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The admission Minimum Data Set (MDS) assessment dated 5/3/22 indicated Resident #66 was cognitively intact, required extensive physical assistance with toileting and had an ostomy appliance specifically a urostomy.

A review of Resident #66's care plan initiated on 5/18/22 indicated Resident #66 required a nephrostomy related to neurogenic bladder. The following goal was listed: Resident #66 will have nephrostomy catheter care managed appropriately as evidenced by: not exhibiting obstruction, signs of infection, dislodgment of catheter, bowel perforation or trauma.

An observation and interview with Resident #66 on 5/24/22 at 3:19 PM revealed a urostomy bag on the right lower quadrant of her abdomen. Resident #66 stated she had the urostomy for about a year and all her urine went straight into the bag. Resident #66 stated she did not have a nephrostomy tube.

An interview was conducted with the MDS Coordinator on 5/25/22 at 11:16 AM with the Director of Nursing (DON) present. The MDS Coordinator stated she did not know why Resident #66 had a care plan for nephrostomy instead of urostomy. The DON stated she got confused when staff asked her about Resident #66's urostomy and she noted that Resident #66 had been care planned for nephrostomy instead of urostomy.

An interview with the Administrator on 5/25/22 at 5:50 PM revealed care plans should be tailored to reflect the specific resident they were developed for and should not be generic. He stated Resident #66's care plan was not accurate and

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F 656	Continued From page 17 should have indicated that she had a urostomy instead of a nephrostomy tube. 3. Resident #67 was admitted to the facility on 04/09/21. Diagnosis included cognitive communication deficit and dementia. Review of Resident #67's annual Minimum Data Set (MDS) assessment dated 04/14/22 revealed resident was not coded as having a dementia diagnosis. Review of Resident #67 revised care plan dated 04/18/22 revealed no care plan specific to dementia. An interview with the MDS Coordinator and Director of Nursing (DON) on 05/25/22 at 12:04 PM revealed Resident #67 has an active diagnosis for dementia and verified resident was not coded for dementia in the MDS assessment dated 04/14/22 and there is no approach for dementia addressed in resident's care plan. The MDS Coordinator and DON further revealed resident's care plan should reflect active diagnosis and had no knowledge as to why the resident was not coded as having dementia on the MDS assessment or why there is no approach for dementia in resident care plan. An interview with the Administrator on 05/25/22 at 06:37 PM stated the resident's care plan should reflect current diagnosis for resident.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		6/24/22

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services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on record reviews, family and staff interviews, the facility failed to provide showers or complete bed baths for 1 of 6 dependent residents (Resident #150) reviewed for activities of daily living (ADL).

The findings included:

Resident #150 was admitted to the facility on 10/13/21 and discharged home on 11/18/21. The resident's admitting diagnoses included nondisplaced fracture of the left fibula, unsteadiness on feet, diabetes, and repeated falls.

Review of Resident #150's admission Minimum Data Set (MDS) assessment dated 10/20/21 revealed she was cognitively intact, displayed no behaviors for refusing care and required total assistance of 1 staff with bathing.

Review of Resident #150's care plan dated 10/25/21 revealed a focus area for ADL functional/rehab potential related to resident being limited in ability to transfer self. The approach was to follow physical therapy/occupational therapy recommendations.

Review of the master shower schedule revealed Resident #150 was scheduled for showers on Wednesday and Saturdays on 2nd shift (3:00 PM to 11:00 PM).

Review of Resident #150's electronic medical record and bathing sheets documented the

Resident #150 was discharged from the facility on 11/18/2021, prior to the survey.
A 100% audit for all in house residents was conducted on 5/28/22 by the Assistant Director of Nursing (ADON) to ensure documentation and provision of showers or complete bed baths were completed for the week prior. Any resident that did not have documentation of showers/complete bed baths for the week prior, was provided a shower or complete bed bath and documentation completed by 5/31/22.
Education was initiated on 5/28/22 by the ADON to all licensed nurses, certified nursing assistants, medication aides and facility assistants on the imprtance completion of showers/complete bed baths per the weekly schedule, documenting in resident chart, and notification of nurse upon refusal. No licensed nurses, certified nursing assistants, personal care aides, or medication aides will be allowed to work after 6/24/22 without education being completed. This education will be added to the new hire process.
The Director of Nursing or designee will conduct shower audits to include 10 residents weekly for 4 weeks, then 5 residents weekly for 4 weeks, and then will 1 resident weekly for 4 weeks to include completion of shower/complete bed bath, and appropriate documentation. Any concerns identified will be addressed

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following showers and/or complete bed baths:

- On Wednesday 10/13/21, Sunday 10/17/21 and Saturday 10/30/21 a shower and/or complete bed bath were documented as completed - There was not a shower or completed bed bath documented as completed on Wednesday 10/20/21, Saturday 10/23/21 and Wednesday 10/27/21. During the month of October 2021, there were 12 consecutive days when a shower or complete bed bath were not documented as completed.
- For the month of November 2021, it was documented the resident received her showers or complete bed baths on Wednesday and Saturday.

Phone interview on 05/23/22 with Resident #150's responsible party (RP) revealed she visited the resident at least 2 to 3 times per week while at the facility. The RP stated there was a period during her stay that she had not received a shower or bed bath and had a strong scent of body odor. The RP further stated she did not get her hair combed consistently. According to the RP, when she asked staff (could not remember specific names) about Resident 150's showers she was told she had not gotten them due to admissions and COVID positive residents in the building.

Interview on 05/23/22 at 3:28 PM with the Unit Coordinator for the rehab unit revealed she remembered Resident #150. The Unit Coordinator stated she did not recall her not getting showers as scheduled and said she was one of the residents she made rounds on daily and recalled giving her a washcloth to wash her face and assisting her with brushing her teeth.

immediately.
The Director of Nursing will bring shower audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of training and observations to determine if continued auditing is necessary to maintain compliance. Date of completion 6/24/2022.

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The Unit Coordinator stated she did not recall ever noticing the resident having a body odor when she had assisted her.

Several attempts were made to contact Nurse Aide (NA) #6 who took care of Resident #150 without success.

Interview on 05/25/22 at 5:46 with the Director of Nursing (DON) revealed she was not sure why Resident #150 had not received her showers as scheduled. The DON stated it was her expectation that each resident received their showers as scheduled unless they refused. She further stated if the resident refused, she expected the NAs to try again later in the day to get them to shower.

Interview on 05/25/22 at 7:22 PM with NA #3 who took care of Resident #150 revealed when the NAs documented they did not give the resident their complete bed bath or shower it was because of call outs or just a busy evening. NA #3 further stated when they could not get the shower done on 2nd shift, they would pass it on to the next shift and try to get the shower done the next day if not done that evening.

F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		6/18/22

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered

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care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interviews with resident, staff and the physician, the facility failed to conduct blood glucose monitoring as ordered by the physician for 1 of 2 sampled residents (Resident #252).

The findings included:

Resident #252 was admitted to the facility on 5/12/22 with diagnoses that included diabetes mellitus.

The admission Minimum Data Set (MDS) assessment dated 5/19/22 indicated Resident #252 was cognitively intact.

A review of Resident #252's Physician's Order summary revealed Resident #252 had an active order for blood glucose monitoring before meals and at bedtime at 7:30 AM, 11:30 AM, 4:30 PM and 8:00 PM.

An observation on 5/24/22 at 5:26 PM revealed Nurse #2 was performing Resident #252's blood glucose monitoring. Upon entering Resident #252's room, an empty dinner plate was observed on her bedside table in front of her. Resident #252 stated she had just finished eating her supper. Nurse #2 checked Resident #252's blood sugar by sticking the tip of her right second finger. Nurse #2 told Resident #252 that her blood sugar reading was 194 and that it was high because she had just eaten her supper.

During an interview with Nurse #2 on 5/24/22 at 5:50 PM, she stated she should have checked

The Director of Nursing notified resident #252, the resident representative and the physician of the lateness of performing blood glucose check. Immediate education was provided to the nurse on blood glucose checks prior to meal as ordered.
A 100% audit of all in house residents with orders for blood glucose checks before meals was conducted on 5/29/22 by the Director of Nursing (DON). Any resident who did not have their blood glucose check completed per physician order or before meals, the physician, resident and resident representative was notified on 5/29/22.
Education was initiated on 5/29/22 by the DON for 100% licensed nurses and medication aides on completing blood glucose checks per orders to include prior to meals. This education was completed on 6/18/22, any licensed nurse or medication aide that did not receive this education prior to 6/18/22, will not be allowed to work until education complete. This education will be added to the new hire process for licensed nurses and medication aides.
The Director of Nursing or designee will observe 5 blood sugar test weekly times 4 weeks to ensure proper time, then will drop to 3 blood sugar test weekly times 4 weeks, and then 1 blood sugar test weekly for 4 weeks. Any concerns identified will be corrected immediately.
The Director of Nursing or designee will

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F 684	Continued From page 22 Resident #252's blood sugar before eating but she was late starting her medication pass, so she didn't get to her until after she had already eaten. Nurse #2 further stated Resident #252 did not have a sliding scale insulin related to the blood glucose monitoring order and had a scheduled set dose of regular insulin that should have been given prior to the meal as well. A phone interview with the physician revealed blood glucose monitoring should be done before meals because the result would not be an accurate representation of the blood sugar record for Resident #252. The physician stated eating a meal would cause the blood sugar to be higher than if it was taken before the meal. An interview with the Director of Nursing (DON) on 5/25/22 at 12:14 PM revealed blood glucose monitoring should be done before meals because blood sugar taken after a meal would not be accurate. The DON stated Nurse #2 should have followed the physician's order that indicated to check Resident #252's blood sugar before meals.	F 684	bring blood sugar audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of training and observations to determine if continued auditing is necessary to maintain compliance. Date of completion 6/18/22.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with staff and pharmacists, the facility failed to maintain a medication error rate of less than 5% as evidenced by omission of 1	F 759	Nurse #1 and Nurse #2 were provided education on the 6 rights of medication administration on 5/25/22 by the Director of Nursing. Resident # 26 and resident	6/18/22

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medication and failure to administer 4 medications according to physician's orders. These errors constituted 5 out of 29 opportunities, resulting in a medication error rate of 17.24% for 2 of 7 residents (Residents #26 and Resident #252) observed during medication administration.

The findings included:

1. Resident #26 was admitted to the facility on 10/29/20 with diagnoses that included benign prostatic hyperplasia (enlarged prostate gland) (BPH).

The Physician's Orders in Resident #26's medical record indicated an active order for the following medications:
12/14/21 - Finasteride 5 mg (milligrams) 1 tablet by mouth once a day at 8:00 AM for BPH.
4/25/22 - Tamsulosin 0.4 mg 1 capsule by mouth once day at 6:00 PM for BPH.

An observation was made on 5/24/22 at 7:53 AM of Nurse #1 while she prepared and administered Resident #26's medications. Nurse #1 looked at Resident #26's electronic Medication Administration Record (MAR) and pulled the resident's medications off the medication cart. Nurse #1 did not make a final check to make sure she pulled all of Resident #26's medications that were scheduled to be given at that time. Nurse #1 then proceeded to administer the medications she had pulled to Resident #26 which included one capsule of Tamsulosin 0.4 mg. The medications did not include Resident #26's Finasteride 5 mg tablet.

An interview with Nurse #1 on 5/24/22 at 9:12 AM

#252 medications errors were addressed with the nurses, resident, resident representative, and medical provider on 5/24/22 by the Director of Nursing.
The Regional Clinical Manager pulled the Medication Administration Records for all current in-house residents on 5/25/2022 to assess for correct administration times or omission. Any concerns identified were immediately addressed by notification to the resident and/or resident responsible party and medical provider. Medication pass observation was completed on all current licensed nurses and medication aides by the Director of Nursing on 6/10/22.
Education for 6 rights of Medication Administration was initiated on 5/26/22 by the Assistant Director of Nursing for current licensed nurses and medication aides. No licensed nurse or medication aide is allowed to work after 6/18/22 if this education has not been completed. This education will be included in the new hire licensed nurse and medication aide process.
The Director of Nursing or designee will complete 5 med pass observations weekly for 4 weeks, then 3 med pass observations weekly for 4 weeks then one med pass observation weekly for 4 weeks.
The Director of Nursing will bring the medication pass observation audits to the Quality Assurance Committee monthly for 3 months. At that time, the QAPI committee will evaluate the effectiveness of the training and observations to determine if continued auditing is

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revealed she did not know how she missed giving Resident #26's Finasteride tablet and thought she had included it in the medication cup. Nurse #1 stated she had flipped the screen to show the medications that were due later so she could see any medications that were scheduled for 9:00 AM and include them with the medications that were scheduled for 8:00 AM. Nurse #1 stated she failed to read the full medication order for Tamsulosin and did not see that it was scheduled to be given at 6:00 PM.

A phone interview with Pharmacist #1 on 5/24/22 at 11:42 AM revealed Finasteride and Tamsulosin were different medications which could be used together. Finasteride was often used for BPH and to control urinary urgency while Tamsulosin was often used to treat an overactive bladder. Pharmacist #1 stated both medications could not be interchanged because each medication belonged to a different drug class.

An interview with the Director of Nursing (DON) on 5/25/22 at 12:14 PM revealed Nurse #1 should have looked at the entire order on the MAR and verified the time the medications were supposed to be given.

2. Resident #252 was admitted to the facility on 5/12/22 with diagnoses that included gastroesophageal reflux disease (GERD) and diabetes mellitus (DM).

The Physician's Orders in Resident #252's medical record indicated an active order for the following medications:
5/13/22 - Insulin aspart 100 units/ml (milliliters) 7 units subcutaneous before meals at 7:30 AM,

necessary to maintain compliance.
Completion date 6/18/2022.

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11:30 AM and 4:30 PM. Insulin aspart is a short-acting, manmade version of human insulin used to treat diabetes.
5/17/22 - Esomeprazole magnesium 40 mg (milligrams) 1 capsule by mouth twice a day at 6:00 AM and 4:30 PM, give before meals. Esomeprazole is a medication used to treat GERD.
5/23/22 - Sucralfate 1 gram 1 tablet by mouth twice a day at 6:00 AM and 4:00 PM, give before meals. Sucralfate is a medication used to treat ulcers.

An observation was made of Nurse #2 on 5/24/22 at 5:22 PM while she administered medications to Resident #252. Upon entering Resident #252's room, an empty dinner plate was observed on her bedside table in front of her. Resident #252 stated she had just finished eating her supper. Nurse #2 proceeded to administer Resident #252's pills which included one capsule of Esomeprazole 40 mg and one tablet of Sucralfate 1 gram. Nurse #2 checked Resident #252's blood sugar by sticking the tip of her right second finger. Nurse #2 told Resident #252 that her blood sugar reading was 194 and that it was high because she had just eaten her supper. Nurse #2 left Resident #252's room and obtained 7 units of Insulin aspart from the medication cart. Nurse #2 then administered Insulin aspart 7 units to Resident #252's right upper arm.

An interview with Nurse #2 on 5/24/22 at 5:50 PM revealed she had been late starting her medication pass. Nurse #2 stated she knew she should have checked Resident #252's blood sugar and given her medications before meals but she wasn't familiar with all the residents, and she often got assigned to different halls.

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A phone interview with Pharmacist #2 on 5/25/22 at 10:40 AM revealed all medications should be given the way they were ordered so if the order stated to give before meals, the medications should be given before meals. Pharmacist #2 stated Sucralfate was a medication used to coat the stomach and act as a barrier to prevent discomfort and indigestion. He also stated Esomeprazole was a medication that prevented acid production and was usually prescribed to be given on an empty stomach because food would affect its absorption. He further stated Insulin aspart was a short-acting insulin that should be given before meals to combat the sugar spike in the blood after consumption of a meal.

An interview with the Director of Nursing (DON) on 5/25/22 at 12:14 PM revealed Nurse #2 should have given Resident #252's medications to her before meals.

F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		6/10/22

§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

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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 and staff interviews, the facility failed to secure 1 of 4 medication carts (Laurel medication cart) observed during medication administration.

The findings included:

During an observation of medication administration with Nurse #2 on 5/24/22 from 4:55 PM to 5:08 PM on the Laurel hall, Nurse #2 stepped away from the medication cart to administer medications to Resident #355 in her room. Nurse #2 did not lock the medication cart which was parked outside Resident #355's room and was not within eyesight of Nurse #2 when she went inside Resident #355's room. After administering medications to Resident #355, Nurse #2 pushed the medication cart to the adjacent hall and parked it in front of Resident #68's room. She prepared Resident #68's medication and entered Resident #68's room without locking the medication cart. The medication cart was not within reach or eyesight of Nurse #2 when she was inside Resident #68's room. Other staff members were observed walking in the hallway and Resident #20 in her

Nurse #2 was educated on securing medication cart on 5/26/22 by the Director of Nursing, all carts were observed being locked at this time.
To identify additional areas of concern a 100% observation of medication carts was completed on 5/27/2022 by Assistant Director of Nursing to ensure proper locking of cart was completed when not in use by the nurse or medication aide. Any issues identified were immediately addressed.
Education on locking medication carts was initiated on 5/25/22 by the Director of Nursing to include all licensed nurses and medication aides. Any licensed nurse or medication aide that did not receive the education by 6/10/22, was not allowed to work until completed.
The Director of Nursing or designee will conduct 10 cart observations weekly times 4 weeks, then 5 cart observations weekly times 4 weeks and then 1 cart observation weekly times 4 weeks. Any issues identified will be corrected immediately.

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F 761	Continued From page 28 wheelchair passed by the unlocked medication cart in the hallway. After Nurse #2 administered Resident #68's medication, she exited the room and saw the unlocked medication cart and stated that she forgot to lock the medication cart. An interview with Nurse #2 on 5/24/22 at 5:11 PM revealed that she should have locked the medication cart whenever she stepped away from it. Nurse #2 stated she forgot to do so. An interview with the Director of Nursing (DON) on 5/25/22 at 12:14 PM revealed Nurse #2 should have locked the medication cart whenever she had to step away from it.	F 761	The Director of Nursing will bring Medication storage audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of training and observations to determine if continued auditing is necessary to maintain compliance. Date of completion 6/10/2022	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		6/24/22

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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 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

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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 record reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 when 2 of 2 staff members (Nurse #2) failed to wear an N95 mask prior to entering a room of a COVID-19 positive resident (Resident #252) and (Nurse Aide #1) failed to remove her N95 mask, disinfect her goggles and perform hand hygiene after leaving a room of a COVID-19 positive resident (Resident #251). In addition, 2 of 3 staff members (Nurse #3 and Nurse #1) failed to perform hand hygiene during wound care on 2 of 3 residents (Resident #57 and Resident #61) reviewed. These failures occurred during a COVID-19 pandemic.

The findings included:

The Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," updated on 2/2/22 indicated the following information under "Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection": *HCP (healthcare personnel) caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator).

Nurse #1 was educated on 5/25/22 by the Director of Nursing regarding proper PPE use and proper PPE removal when caring for a COVID -19 positive resident. Nurse #2 & Nurse #3 were educated on 5/25/22 by the Director of Nursing regarding proper hand hygiene practice during wound care. Resident #251 remained on transmission-based precautions. The licensed nurses monitored resident #57 and resident #61 for signs and symptoms of a wound infection and dressing changes continued as ordered.

To identify any other residents that could be affected a 100% observation of staff entering and exiting COVID positive rooms was completed on 5/30/2022 by the Director of Nursing to ensure proper procedure was followed regarding PPE use. Any issues identified were immediately addressed.

A 100% observation of residents with scheduled wound care was completed on 5/30/2022 by the Director of Nursing to ensure proper procedure for hand hygiene was followed. Any issues identified were immediately addressed.

All staff will be re-educated by 6/10/22 by the Director of Nursing on donning and

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The facility's infection control policy entitled, "Personal Protective Equipment," revised on 4/22/22 indicated the following Personal Protective Equipment (PPE) were required in the COVID-19 positive unit: N95 mask at all times, face shield and/or goggles must be worn at all times and must be cleaned upon being visibly soiled and when leaving the unit, gown must be worn in all rooms and with patient contact and gloves must be worn in residents' rooms and must be changed when soiled and between residents.

During the entrance conference with the Director of Nursing (DON) on 5/22/22 at 10:03 AM, the DON stated that the facility had 4 residents who had tested positive for COVID-19 and were on enhanced droplet precautions. 2 of the 4 COVID-19 positive residents were Resident #252 and Resident #251.

1. During a medication pass observation on 5/24/22 at 5:22 PM with Nurse #2, she was observed preparing to give medications to Resident #252. The door to Resident #252's room was closed, and PPE was located on a hanging organizer on the door as well as a plastic drawer cart next to Resident #252's door. Nurse #2 put on a gown and gloves in addition to the goggles and a black KN95 mask that Nurse #2 was wearing. Prior to entering the room to administer Resident #252's medications, Nurse #2 was asked if she needed to change her mask into one of the N95 masks on the hanging organizer. Nurse #2 stated she didn't need to and didn't like the way the N95 mask fit on her face. Nurse #2 went inside Resident #252's room while wearing a KN95 mask, goggles, gown, and gloves and administered Resident #252's

doffing proper PPE for transmission-based precaution. All nurses will be educated 6/10/22 by the Director of Nursing on proper hand hygiene practices related to wound care. Any employee that does not receive the required education by 6/24/22 will not be allowed to work until education is completed.

The Director of Nursing or designee will conduct 5 observations of proper procedure for entering and exiting rooms under transmission-based precautions weekly times 4 weeks, then 3 observations weekly times 4 weeks and then 1 observation weekly times 4 weeks. Any issues identified will be corrected immediately and re-education provided as needed.

The Director of Nursing or designee will conduct 5 observations of proper procedure for hand hygiene with wound care weekly times 4 weeks, then 3 observations weekly times 4 weeks, and then 1 observation weekly times 4 weeks. Any issues identified will be corrected immediately and re-education provided as needed.

Director of Nursing will report audit findings at the monthly Quality Assurance Performance Improvement Committee meeting for review for 3 months to review for any needed changes or further education. Date of completion 6/24/2022.

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medications. While inside, a staff member knocked on the door and handed Nurse #2 an N95 mask. Nurse #2 placed the N95 mask in her pocket. When she was done administering Resident #252's medications, Nurse #2 removed her gown, gloves and KN95 mask and discarded them into the trash can inside Resident #252's room. While exiting the room, she placed the N95 mask that was in her pocket on her face, disinfected her goggles with a disinfecting wipe and used hand sanitizer to both hands.

An interview with Nurse #2 on 5/24/22 at 5:50 PM revealed she did not know that the black mask that she was wearing was a KN95 mask and was different from the N95 masks that were available at Resident #252's room. Nurse #2 stated she was wondering why a staff member handed her an N95 mask when she was inside Resident #252's room and thought it was just a mask she could change into when she exited Resident #252's room.

An interview with the Infection Preventionist (IP) on 5/25/22 at 5:04 PM revealed Nurse #2 had received education regarding PPE use especially for COVID-19 positive residents and she should have looked at the signs on the door. The IP stated he had talked to Nurse #2, and she did not know the difference between the KN95 masks and N95 masks, and Nurse #2 thought they were the same. The IP stated he needed to work on providing more education to staff regarding the COVID-19 unit. He also stated the facility had plenty of PPE supplies including the N95 masks that were required to be used for COVID-19 positive residents.

An interview with the Director of Nursing (DON)

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on 5/25/22 at 12:14 PM revealed Nurse #2 was fairly new to the facility, and she was not sure if Nurse #2 had worked with COVID-19 positive residents before but they needed to provide education to her so she would know what PPE to use when providing care to COVID-19 positive residents.

2. The Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," updated on 2/2/22 indicated the following information under "Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection":
*HCP (healthcare personnel) caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator).

The facility's infection control policy entitled, "Personal Protective Equipment," revised on 4/22/22 indicated the following Personal Protective Equipment (PPE) were required in the COVID-19 positive unit: N95 mask at all times, face shield and/or goggles must be worn at all times and must be cleaned upon being visibly soiled and when leaving the unit, gown must be worn in all rooms and with patient contact and gloves must be worn in residents' rooms and must be changed when soiled and between residents.

During the entrance conference with the Director of Nursing (DON) on 5/22/22 at 10:03 AM, the DON stated that the facility had 4 residents who had tested positive for COVID-19 and were on

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enhanced droplet precautions. 1 of the 4 COVID-19 positive residents were Resident #251.

During an observation of the COVID unit on 05/23/22 at 9:00 AM there were 4 rooms on the left side of the hall that were designated as COVID (+) rooms with signage and personal protective equipment either in caddies on the door or in cabinets outside the door. Nurse Aide (NA) #1 was observed coming out of Resident #251's room with N95 mask on, goggles, gloves and gown and placed the resident's meal tray inside the dining cart. NA #1 then removed her gown and gloves and without sanitizing her goggles, changing her mask or sanitizing her hands she proceeded down the hall to a non-COVID area to another dining cart talking with another staff member.

Interview on 05/23/22 at 9:06 AM with NA #1 revealed she had taken the breakfast tray out of Resident #251's room and stated she forgot to sanitize her goggles and change her mask because she "was busy." NA #1 stated she knew she was supposed to change her mask and clean her goggles but had failed to do so when she came out of the resident's room and before going to the non-COVID area of the building.

Interview on 05/23/22 at 9:20 AM with the Director of Nursing (DON) who was at the nurse's station and heard part of the interview with NA #1 revealed she would provide more education to NA #1 about proper use of personal protective equipment (PPE). The DON stated NA #1 had been educated to change her mask and clean her goggles but said they would provide additional education to her one on one.

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Interview on 05/25/22 at 5:04 PM with the Infection Preventionist revealed NA #1 had received education regarding PPE use specifically for COVID-19 positive residents and she should have looked at the signs on the door. The IP preventionist stated he needed to work on providing more education to staff regarding the COVID-19 unit and PPE use when working on the unit. He also stated the facility had plenty of personal protective equipment (PPE) supplies including the N95 masks that were required to be used for the COVID-19 positive residents.

Follow up interview on 05/25/22 at 12:14 PM with the Director of Nursing (DON) revealed NA #1 had worked with COVID-19 residents before during an outbreak but said they needed to provide education again to her about proper use of PPPE when providing care to COVID-19 positive residents.

3. The facility's infection control policy entitled, "Handwashing/Hand Hygiene," revised in August 2015 indicated the following statements:
7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:
m. After removing gloves
9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

An observation of wound care on Resident #57 was made on 5/24/22 at 12:59 PM by Nurse #3. Nurse #3 was observed using hand sanitizer to

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both hands prior to putting gloves on to start the procedure. Nurse #3 removed an old dressing from Resident #57's left hand which revealed a skin tear. Nurse #3 removed her gloves and put a new one on without sanitizing her hands. She cleaned the skin tear with a normal saline-soaked gauze and applied a foam dressing. Nurse #3 removed her gloves and put on a new one without sanitizing her hands. Nurse #3 proceeded to remove an old dressing from Resident #57's sacrum and wiped Resident #57's bottom with an incontinence wipe. She removed her gloves and put on a new pair without sanitizing her hands. She cleaned Resident #57's sacral wound with a normal saline-soaked gauze and then removed her gloves. She put on new gloves without sanitizing her hands first and then applied the ordered treatment to Resident #57's wound and covered it with a foam dressing. She then repositioned Resident #57 and placed a pillow underneath his legs. Nurse #3 removed her gloves and washed her hands in the sink inside the room.

An interview with Nurse #3 on 5/24/22 at 4:34 PM revealed she had received education on hand hygiene during wound care which consisted of washing hands before starting procedure and making sure to change gloves after removing an old dressing. Nurse #3 stated she had missed the step of doing hand hygiene after removing her gloves and that she realized it as soon as she was done with performing wound care on Resident #57. Nurse #3 stated she was focused on making sure that she changed her gloves that she forgot to do hand hygiene in between. She further stated she should have kept a hand sanitizer handy or washed her hands in the sink prior to putting on clean gloves during the

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procedure.

An interview with the Infection Preventionist (IP) on 5/25/22 at 5:04 PM revealed all staff members had been educated to wash their hands or use a hand sanitizer after removing gloves especially while performing wound care. The IP stated Nurse #3 should have sanitized her hands whenever she removed her gloves when she changed Resident #57's wound dressing.

An interview with the Director of Nursing (DON) on 5/25/22 at 12:14 PM revealed Nurse #3 should have done hand hygiene after removing her gloves. The DON stated the facility used to have hand sanitizer that were small and could be carried around by staff, so they had something convenient to use but they no longer had those available.

4. The facility's infection control policy entitled, "Handwashing/Hand Hygiene," revised in August 2015 indicated the following statements:
7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:
m. After removing gloves
9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

Observation on 05/24/22 at 3:02 PM of wound care on Resident #61 by Nurse #1 was made. Nurse #1 washed her hands and donned clean gloves to start the procedure. Nurse #1 removed

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the old dressing from Resident #61's right leg. Without removing her gloves or sanitizing her hands she moved to the left leg and removed the old dressing from the left leg. Both legs were resting on a clean pad Nurse #1 had placed under the resident's legs before starting the procedure. With the same gloves on and without sanitizing her hands Nurse #1 opened a gauze pack and poured normal saline into the package and with her gloved hand removed the gauze and cleansed the right foot wound. Without removing the gloves or sanitizing her hands she opened a 2nd gauze packet and patted dry the wound she had cleansed and rested the resident's leg on the pad. Without changing her gloves or sanitizing her hands she opened a third packet of gauze and poured saline into the packet and cleansed the wound on the left calf area. Without removing her gloves or sanitizing her hands she opened a 4th packet of gauze and patted the area on the left calf dry. Without removing her gloves or sanitizing her hands she moved back to the resident's right leg and wrapped the leg from the toes to 3 fingers below the knee with kerlix. Without removing her gloves or sanitizing her hands, she then wrapped the leg with Coban (light weight cohesive elastic that adheres to itself for compression or support) over the kerlix. Nurse #1 without removing her gloves or sanitizing her hands moved to the left leg and wrapped the left leg with kerlix and then without removing her gloves or sanitizing her hands she wrapped Coban over the kerlix. After completing the wound care to Resident #61, Nurse #1 tossed the remaining supplies in the trash, and she removed her gloves and washed her hands in the sink inside the room with soap and water.

Interview on 05/24/22 at 3:53 PM with Nurse #1

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F 880	Continued From page 39 revealed she had received education on hand hygiene during wound care which consisted of washing hands before starting procedure and making sure to change gloves after removing an old dressing. Nurse #1 stated she was nervous and forgot to sanitize her hands and change her gloves after removing the old dressings and forgot to sanitize her hands and change gloves when moving from one leg to the other leg. She stated there was no hand sanitizers in the rooms but said she should have gotten some to use in the room during the wound care. Interview on 05/25/22 at 5:04 PM with the Infection Preventionist (IP) revealed all staff members had been educated to wash their hands or use a hand sanitizer after removing gloves especially while performing wound care. The IP stated Nurse #1 should have sanitized her hands and removed her gloves after removing the old dressings and repeated the procedure when moving from the left leg to the right leg during Resident #61's wound care. Interview on 05/25/22 at 12:14 PM with the Director of Nursing (DON) revealed Nurse #1 should have changed her gloves and performed hand hygiene after removing her gloves. The DON stated the facility used to have hand sanitizers that were small and could be carried around by staff, so they had something convenient to use but they no longer had those available.	F 880		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility	F 888		6/18/22

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must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:

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(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical

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exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the

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CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to implement an effective process for tracking COVID-19 vaccination status of 5 of 5 facility staff (Nurse Aide (NA) #3, NA #7, NA #8, NA #9, and NA #10) reviewed for COVID-19 Vaccination Status. The facility was currently in outbreak status and failed to have 100% of staff vaccinated.

The findings included:

The facility's "COVID-19 Vaccine" policy with no reviewed or revised date, read in part: It is the policy that all persons be offered the COVID-19 vaccine. This includes residents and staff. Staff includes all fulltime, part-time and prn employees, contract staff such as therapy, staffing agency, management company and consultants. The COVID-19 vaccine is not considered a condition of employment."

Review of the facility's surveillance line list for residents and staff received on 05/22/22 revealed a COVID outbreak was identified on 05/20/22 and 2 residents tested positive for COVID-19. In addition, 2 other residents were admitted from the hospital with COVID-19 so there was a total of 4 residents at the facility who were positive for COVID-19 and on transmission-based precautions.

The facility COVID-19 staff vaccination spreadsheet provided by the Administrator on 05/22/22 was reviewed and included in-house staff and contract staff. NA #8 was listed on the

The Wellness Coordinator (WC) and Infection Preventionist (IP) were educated on the mandatory vaccine procedure and tracking of staff vaccine status and exemption status on 5/26/22 by the Regional Operations Manager. Nurse Aide(NA) #1 and NA#2, received their second dose of vaccine on 5/25/22. Two of the NA's reported as unvaccinated and no exemption, had not started employment in the facility at the time of survey, and were placed on the list prior to employment. They were not allowed to work until vaccinated or exempt. The last NA had not worked in the facility since 1/16/2022, and was removed from the employee roster and vaccine listing on 5/25/22 by the Wellness Coordinator.
The Wellness Coordinator completed 100% audit of all current staff on 5/26/2022 to ensure that the vaccine status or exemption status was current and listed correctly on vaccine tracker and exemption tracker. Any staff found not to be fully vaccinated or exempt were removed from schedule until vaccination up to date or exemption approved and not allowed to work.
The Regional Operations Manager educated all current Facility Administrative Staff on 5/27/2022 regarding the COVID-19 mandatory vaccine process.
The Infection Preventionist (IP) initiated education on 5/27/2022 for all non-up to date, unvaccinated or exempted staff on

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facility employee line list with no vaccine status indicated by her name. NA #3, NA #7, NA #9, and NA #10 who were all listed as facility staff were listed as partially vaccinated and had only received one dose of a two-dose vaccine.

A review on 05/22/22 of the National Healthcare Safety Network (NHSN) data for the week ending on 05/08/22 revealed the following staff vaccination information:

· Recent Percentage of Staff who are Fully Vaccinated = 78.9%.

An interview on 05/25/22 at 4:00 PM with Nurse Aide (NA) #3 revealed she had been sent during shift on 05/25/22 to get her 2nd dose of her vaccine and was currently working at the facility. She stated it had just slipped her mind to go back and get her 2nd dose of the vaccine.

A phone interview on 05/25/22 at 8:30 PM with NA #7 revealed she had received her 2nd dose of the COVID-19 vaccine on 05/25/22. She stated she had been contacted by the facility to go get her 2nd dose of the vaccine.

Phone interviews were attempted on 05/25/22 at 4:16 PM with NA #8, NA #9, and NA #10 without success.

An interview on 05/25/22 at 5:34 PM with the Infection Preventionist (IP) and the Wellness Coordinator (WC) revealed the WC was responsible for COVID testing, tracking resident and staff vaccinations, weekly NHSN reporting and updating tracking reports weekly. The IP stated the WC did not realize the seriousness of the tracking of the vaccination status of the

the COVID 19 vaccine and benefits and risks of the vaccine. Any staff not educated by 6/18/2022 were not allowed to work until educated. Education added to the new hire packet.
The Infection Preventionist, Administrator or designee will audit the staff vaccine status and exemption listing weekly for 4 weeks times 3 months to ensure all staff follow up on vaccine dates, and all new employee vaccine status must be signed off by Administrator, Director of Nursing or Infection Preventionist before start date.
The Administrator or designee will bring the vaccine status and approved exemption audit to the monthly Quality Assurance Committee meeting for 3 months. The Quality Assurance Committee will evaluate the effectiveness of the training and observations to determine if the continuation of audits or additional education is needed.
Completion date 6/18/2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	C 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHABILITATION	109 FOOTHILLS DRIVE MORGANTON, NC 28655

(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 888	Continued From page 45	F 888		

employees and stated going forward they were putting a process in place so that no one is hired and allowed to work unless they are fully vaccinated or have an exemption. The WC indicated she had reminded staff each week during testing to get their 2nd vaccine but stated she had not reported to anyone the staff that had not received the vaccinations. The WC further indicated all the NAs that were partially vaccinated were past due for their second vaccine and had been reminded to get the vaccine. The WC and IP both said the NAs that were partially vaccinated had not requested exemptions from the vaccine.

An interview on 05/25/22 at 6:02 PM with the Administrator revealed the Wellness Coordinator did not realize the seriousness of tracking the staff vaccination status. He stated going forward they were putting a process improvement plan (PIP) in place so that no employee is hired to work until they are fully vaccinated, and the facility has received proof of their vaccine status.