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E 000	Initial Comments An unannounced recertification survey was conducted onsite 4/3/2023 to 4/6/2023. The facility was found not in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # WU6K11.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness	E 001		5/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/01/2023

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 correction is requisite to continued program participation.

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E 001	Continued From page 1 program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a facility and comprehensive Emergency Preparedness (EP) plan which had been developed, reviewed, and maintained specifically for the facility. The facility failed to maintain, review, and update the EP plan, update for current contacts, collaborate with local stakeholders, develop, update and review EP policies and procedures based on the developed EP plan, development of the communication plan, emergency official contact information, put into place EP training, testing, and establish a program, and perform drills or community-based risk assessments. The findings included: A review of the facility's Emergency Preparedness plan was conducted on 4/6/2023 revealed the following issues: a. The EP plan provided by the facility was a blank template EP plan and did not provide facility specific information, such as information about	E 001	Facility failed to ensure the establishment of the Emergency Plan (EP). All current residents have the potential to be affected. The facility Administrator was in serviced on 4/17/23 by the Director of Operations regarding the requirements for establishing the Emergency Preparedness (EP) plan - which should be developed, reviewed, and maintained specifically for the facility. Components included - maintain, review, and update the EP plan, update for current contacts, collaborate with local stakeholders, develop, update and review EP policies and procedures based on the developed EP plan, development of the communication plan, emergency official contact information, put into place EP training, testing, and establish a program, and perform drills or community-based risk assessments.	

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E 001	Continued From page 2 the facility staff, local surroundings, potential emergency specific situations related to the facility's location, or information regarding local resources such as the fire department, in the event of an emergency. b. The facility EP plan had the signature of the former Administrator that indicated he had reviewed the EP on 4/1/2022. The EP plan policies and procedures, emergency plan for risk assessment, and the communication plan were not reviewed and updated annually by the facility. Current facility staff were not listed in the plan. c. The EP plan did not address the procedures for EP collaboration with local, tribal, regional, state, and federal EP officials. The facility did not identify a method for sharing information and medical documentation to promote continuity of care, did not develop a procedure for sharing information related to occupancy availability or needs, and did not develop a method for communicating with families. d. The EP plan did not address the patient population, including persons at-risk, the types of services the facility could provide in an emergency, or the continuity of operations, including delegations of authority and successions plans. e. The EP plan for communication was not facility specific and was a blank template. f. There were no names nor contact information for facility specific staff, physician, and/or volunteers in the supplied EP plan. There were no policies or procedures related to evacuation, the continued care of evacuees, staff responsibilities,	E 001	The Administrator updated the EP with all of its components and reviewed/educated the interdisciplinary team during the facility Quality Assurance Performance Improvement (QAPI) meeting on 4/28/23. The Administrator will be responsible for monitoring for any new changes needed for EP, either by rule change or facility need as necessary in the facility. The findings will be reviewed in the monthly QAPI meeting by the Interdisciplinary team to ensure continuous compliance. The Director of Operations will monitor annual for sustained compliance.	

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transportation, identification of evacuation locations, or primary/alternative means of communication. There were no methods of primary or alternative communication methods identified.

g. There were no policies or procedures developed related to the use of volunteers during an emergency.

h. The facility failed to develop policies and procedures related to sheltering in place for residents, staff, and volunteers.

i. The facility failed to develop policies and procedures related to a system medical documentation the preserved resident information, protected confidentiality of resident information, and secured the availability of medical records.

j. The facility failed to provide information regarding EP training program which would include training of the facility specific EP policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. There were no drills or table-top exercises documented as completed in 2022.

k. The EP plan failed to identify if the facility was part integrated health system.

An interview with the Administrator, the Maintenance Director, and the Maintenance Assistant was conducted on 4/6/2023 at 10:25 AM. The Administrator stated he was the interim Administrator, and he started his position on 3/9/2023. The Administrator reported he had

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started to review the emergency plan but had not completed the review. The Administrator reported that the former Administrator had collected templates for the emergency plan but had not completed the plan.

The Maintenance Director reported that that the former Administrator did not permit him or the Maintenance Assistant to perform any kind of drills for the facility and had not completed a table-top exercise or a community-based risk assessment or identify an all-hazards approach. The Maintenance Director reported he has started to provide information to the charge nurses, unit managers, and nursing staff related to the evacuation zones in the facility.

The Maintenance Assistant reported he had talked to the former Administrator, and he was told that no drills of any kind were to be performed.

Unit Manager (UM) #2 was interviewed on 4/6/2023 at 11:15 AM. UM #2 reported that she had been working at the facility for approximately 5 months and no fire drills or any other drills had been performed in the facility during that time. The Director of Nursing (DON) was interviewed on 4/6/2023 at 4:31 PM. The DON reported she started her position 2/2/2023 and no drills had been performed in the facility since that time. The DON reported she had not received any training related to the EP for the facility.

F 000 | F 000

INITIAL COMMENTS

A recertification and complaint investigation survey was conducted from 4/3/2023 to 4/6/2023.

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F 000	Continued From page 5 Event ID# WU6K11 Intakes NC00200611, NC00199601, NC00199289, and NC00199652 were investigated and 6 of the 20 complaint allegations resulted in deficiencies.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		5/12/23

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F 584	Continued From page 6 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, the facility failed to maintain a clean safe and homelike environment by the failure to cover fluorescent tube lighting in 1 of 18 rooms (room 102), failed to secure television cable outlet covers and electrical outlet covers in 4 of 33 resident rooms (rooms 107, 320, 326 and 333), failed to maintain window blinds that were in disrepair with missing and bent slats in 2 of 18 rooms (rooms 109 & 116), failed to provide a window blind in 1 of 18 rooms (room 113), failed to maintain intact sheetrock and clean walls for 1 of 18 rooms (room 109) failed to maintain resident cabinetry in 2 of 18 rooms (room 113 bed 2 & room 115 bed 1), failed to maintain the interior bathroom cabinet where residents' belongings were stored which was rusted and peeling in 1 of 18 rooms (room 115), failed to repair a leaky bathroom sink 1 of 30 rooms (room 123), failed to secure a bathroom handrail 1 of 30 rooms, (room 224), failed to maintain clean filters and clean front grills of Packaged Terminal Air Conditioner units (PTAC - a type of heating and air conditioning system used in a single living space) in 8 of 15 resident rooms and a day room on the 300 hall (rooms 319, 324, 325, 326, 328, 329, 330 and 333), failed to replace burned out	F 584	Identified homelike environment concerns to include the Cover of the fluorescent tube lighting in 102 completed on 4/5/23, television cable outlet covers and electrical covers secure in rooms 107, 320, 326, and 333 will be completed by 5/5/23, window blinds replaced/ provided in rooms 109, 116, and 113 completed on 4/6/23, sheetrock and walls cleaned in 109, cabinetry in rooms113 and 115, bathroom cabinet replaced in room 115, leaky bathroom sink in room 123 repaired on 4/4/23, bathroom handrail secured in room 224 repaired on 4/4/23, Terminal Air Conditioner (PTAC) filters and front grills cleaned in day room and rooms 319, 324, 325, 326, 328, 329, 330, and 333 will be completed on 5/5/23 and replacement of the light bulbs in rooms 320, 323, 325, and 330 was corrected on 4/5/23. All identified items will be corrected by 5/11/23 by the maintenance department. All current residents have the potential to be impacted. An audit of all rooms will be completed by Administrator and Maintenance Director by 5/11/23 to	

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light bulbs over the sinks of 5 of 15 resident rooms on the 300 hall (rooms 320, 323, 325, 327 and 330) reviewed for environment.

The findings included:

1. a. An observation on 4/3/23 at 10:37 AM in room 116 revealed a broken window blind with bent and missing slats (the individual pieces of a horizontal blind that cover the window) on the window.

b. An observation on 4/3/23 at 11:06 AM in room 115 revealed the inside of the bathroom wall cabinet had peeling and flaking rust on the bottom shelf. The wooden wall closet on bed 1 had words written in black permanent marker that had been scribbled out making it not home like.

c. An observation on 4/3/23 at 11:10 AM in room 113 bed 2 revealed the window had no blinds and the 4-drawer dresser had one drawer missing.

d. An observation on 4/3/23 at 11:59 AM of room 109 bed 2 revealed a broken blind and the wall behind bed 2 had holes in the drywall as well as brown dots splattered on the wall.

e. An observation on 4/3/23 at 12:03 PM of room 107 bed 3 revealed the outlet which was plugged into the Packaged Terminal Air Conditioner had come loose from the wall and was observed lying on the floor.

f. An observation on 4/3/23 at 12:15 PM of room 102 (a single room) revealed an over the bed light had fluorescent tube lighting exposed with no lens cover.

F 584

include a timeline for the replacement and/or repairs of any identified concerns.

The Maintenance Director and maintenance staff will be educated by the Administrator by 5/11/23 related to ensuring that identified facility maintenance concerns are addressed and corrected timely.

The facility staff will be educated by the Staff Development Coordinator (SDC) by 5/11/23 related to ensuring that identified facility maintenance concerns are placed on the maintenance log on each nursing unit to ensure that facility maintenance concerns are addressed timely.

Facility staff to include agency staff and maintenance staff will not be allowed to work until the education is completed. New hire staff will be required to complete the education.

The Maintenance staff will complete audits starting 5/15/23 of 5 rooms weekly for 12 weeks to ensure that facility rooms continue to maintain a safe, clean, comfortable homelike environment for the residents.

The Administrator will submit the findings to the Quality Assurance Program Interdisciplinary (QAPI) committee meeting monthly for 3 months for review and follow up with recommendations to ensure the facility□s continued compliance.

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A second observation on 4/4/23 from 4:56 PM to 5:08 PM revealed no changes had been made regarding environment for rooms 102, 107, 109, 113, 115, and room 116.

A review of work orders from 12-29-22 to 4-4-23 revealed no work orders had been issued for rooms 102, 107, 109, 113, 115, and room 116 regarding broken or missing window blinds, peeling rust in bathroom cabinet, holes in drywall, loose outlets lying on floor, broken furniture, or missing lens covers on an over the bed light.

A round of the facility in conjunction of an interview was conducted with the Maintenance Director, Maintenance Assistant, and Administrator on 4/5/23 from 9:09 AM to 9:22 AM. The Administrator stated room 102 should have had a lens cover to cover the bulbs. The Maintenance Director stated he was not aware the lens cover was missing. The Maintenance Director stated that in room 107 it appeared that the outlet was hit by the bed and knocked down but had not been made aware this was lying on the floor. The Assistant Maintenance Director stated they have extra blinds and will replace the blinds in room 109 and 116 and install a blind in room 113. The Maintenance Director stated they are on a project now to fix all the drywall in the 300 hall and working through the facility, but all the rooms will be assessed and repaired including room 109. The Maintenance Director stated that they will be ordering new furniture for room 113 and painting furniture that needs painting such as the cabinet with permanent marker scribbled on it in room 115. The Maintenance Director stated that once issues are noticed in the room a work order should be written up and put in the book which is kept at

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each nurse's station. The Maintenance Director stated we check the book 4-5 times a day and that he and his assistant rely heavily on the nursing staff to let us know when things are broken or in disrepair.

An interview was conducted with a Nurse Aide #2 on 4/6/23 at 10:46 AM who stated if they see anything that was broken, we will fill out a slip and put it in the Maintence book.
An interview was completed with Housekeeping Aide #1 on 4/6/23 10:49 AM outside of room 102 who stated that if she would see something broken she would tell her manager first and if her manager was not in the building she would tell someone in the maintenance department. Housekeeping Aide #1 was not familiar with any book to fill out request or where it was located.
An interview was completed with the Maintenance Director on 4/6/23 at 12:09 PM who stated that he had a meeting with the Director of Nursing, The Assistant Director of Nursing and the lead nurses on each unit regarding not stopping the maintenance staff in the hallway to verbally tell them about an issue that needed fixing but to have all staff utilized the maintenance request book located at each nurse's station.

An interview was completed with the Administrator on 4/6/23 at 5:29 PM who stated that he would expect the environment would meet the regulations and would be a safe and clean and homelike environment.
2. a. An observation conducted on 4/3/23 at 1:15 PM revealed visible dust on the removable air filter and front grill slats of the PTAC unit in room 319.

b. An observation conducted on 4/3/23 at 1:15

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PM revealed visible dust on the removable air filter and front grill slats of the PTAC unit in room 324.

c. An observation conducted on 4/3/23 at 1:18 PM revealed visible dust on the removable air filter and front grill slats of the PTAC unit in room 325.

d. An observation conducted on 4/3/23 at 1:18 PM revealed visible dust on the removable air filter and front grill slats of the PTAC unit in room 326.

e. An observation conducted on 4/3/23 at 1:23 PM revealed visible dust on the removable air filter and front grill slats of the PTAC unit in room 328.

f. An observation conducted on 4/4/23 at 9:16 AM revealed visible dust on the removable air filter and front grill slats of the PTAC unit in room 329.

g. An observation conducted on 4/4/23 at 9:21 AM revealed visible dust on the removable air filter and front grill slats of the PTAC unit in room 330.

h. An observation conducted on 4/4/23 at 9:22 AM revealed visible dust on the removable air filter and front grill slats of the PTAC unit in room 333.

i. An observation conducted on the 300 hall on 4/3/23 at 1:14 PM revealed visible dust on the removable air filter and front grill slats of the PTAC unit in the resident's day room.

A round of the facility in conjunction with an

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interview was conducted with the Maintenance Director, Maintenance Assistant, Housekeeping Manager and Administrator on 4/4/23 at 4:03 PM. The round revealed visible dust on the removable air filter and front grill slats of the PTAC units in rooms: 319, 324, 325, 326, 328, 329, 330 and 333 and the 300 hall day room. The Maintenance Director revealed that the maintenance department was responsible for checking and changing the removable air filters and front grill covers of the PTAC units routinely.

On 4/05/23 at 11:24 AM an interview was conducted with the Maintenance Director and Administrator. The Maintenance Director and Administrator explained they were not aware of a monthly audit for maintenance or a cleaning schedule of the PTAC units before their employment at the facility in the past month and a half. The Maintenance Director revealed the PTAC air filters and front grill covers were special order items, and the facility did not maintain a surplus of them. The Administrator revealed the facility had 2 new PTAC units in storage but no other PTAC replacement parts.

On 4/6/23 at 1:48 PM an interview with the Administrator revealed that all PTAC filters and grills needed to be audited and cleaned, repaired, or replaced as needed.

3. a. An observation conducted on 4/3/23 at 1:15 PM revealed the light fixture over the sink in room 320 contained one burned out light bulb.

b. An observation conducted on 4/3/23 at 1:14 PM revealed the light fixture over the sink in room 323 contained one burned out light bulb.

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F 584	Continued From page 12 c. An observation conducted on 4/3/23 at 1:18 PM revealed the light fixture over the sink in room 325 contained one burned out light bulb. d. An observation conducted on 4/3/23 at 1:18 PM revealed the light fixture over the sink in room 327 contained one burned out light bulb. e. An observation conducted on 4/4/23 at 9:21 AM revealed the light fixture over the sink in room 330 contained one burned out light bulb. A round of the facility in conjunction with an interview was conducted with the Maintenance Director, Maintenance Assistant, Housekeeping Manager and Administrator on 4/4/23 at 4:03 PM. The round revealed a burned-out light bulb in the light fixtures over the sinks in rooms: 320, 323,325,327 and 330. The Maintenance Director revealed that the Maintenance Department did not check light bulbs when making maintenance rounds. On 4/5/23 at 4:03PM PM an interview was conducted with the Maintenance Director and Administrator. The Maintenance Director and Administrator explained checking for burned out light bulbs was a regular audit on their daily rounds. . On 4/6/23 at 0 1:48 PM an interview with the Administrator revealed that checking light fixtures for burned out light bulbs or other needed repairs needed to be part of daily or weekly maintenance rounds. The Administrator also revealed that facility staff needed to report any maintenance concerns to that Maintenance department either verbally or complete a form titled Maintenance Repair Requisition located in a	F 584		

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binder at each nurse station and checked daily by the Maintenance Director or Maintenance Director and the repairs need to addressed and repairs made immediately or as soon as possible with no harm to residents.

4. a. On 4/4/23 at 9:13 AM an observation of room 320 revealed a white television (tv) cable screwed into a silver cable connector laid on top of a three-drawer bedside table and draped onto the floor. A rectangle shaped square was located above the floor baseboard to the left of the three-drawer table and the three prongs of an electrical cord protruded through the opening. No electrical outlet cover was observed.

b. On 4/4/23 at 9: 20 AM an observation of room 326 revealed a tv cable cord draped loosely over a three- drawer bedside table and the cable junction at the outlet cover revealed the cover was loose and attached securely to the wall.

c. On 4/4/23 at 9:22 AM an observation of room 333 revealed an outlet cover above the floor base board was hanging by one screw and not secured to the wall.

A round of the facility in conjunction with an interview was conducted with the Maintenance Director, Maintenance Assistant, Housekeeping Manager and Administrator on 4/4/23 at 4:03 PM. The round revealed an unsecured television cable on the three -drawer nightstand in room 320 and a three-pronged electrical cord sticking out of an uncovered rectangular square cut into the sheetrock with no outlet cover in place. In room 326 a cable tv cord lay draped over the 3 -drawer nightstand with the outlet cover loose and not secured to the wall. Room 333 revealed an

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outlet cover not secured by 2 screws to the wall. The Maintenance Director and the Maintenance Assistant revealed they were not aware of the missing or loose outlet covers.

On 4/5/23 at 4:03 PM PM an interview conducted with the Maintenance Director and Administrator. The Maintenance Director revealed that he was not aware of the disrepair or missing outlet covers.

On 4/6/23 at 0 1:48 PM an interview with the Administrator revealed that checking all electrical outlet covers needed to be secured in place and that cables needed to be secured off the floors and secured to the walls in a safe fashion to prevent the cords being pulled and left draped over furniture or on the floor.

5. An observation on 4/3/23 at 10:20 AM in room 123 revealed a towel under leaky bathroom sink.

A second observation on 4/3/23 at 5:28 PM in room 123 revealed the towel remained under the leaky bathroom sink and a soiled towel was in the sink.

A review of work orders from January 2023 through April 3, 2023, indicated no maintenance requests were submitted for the leaking sink in room 123.

During an interview with cognitively intact Resident # 37 (who resided in room #123), on 4/4/23 at 2:25 PM revealed his bathroom sink was leaking for two weeks and he reported it to several nursing staff but could not remember their names. He further revealed staff would place a towel on the floor under the sink to catch the leak.

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He stated that although the towel was placed under the sink, he used the sink less often due to the heavy flow of water that would gush out of the pipe whenever he turned on the faucet. He was unaware if a maintenance request form was completed after staff was made aware.

An interview with the Maintenance Assistant on 4/4/23 at 4:00 PM revealed all staff were responsible for completing maintenance requests if they identify a maintenance issue. The forms should be placed in the maintenance books that were located at each nursing station. He further revealed at times, staff may report a maintenance issue instead of completing the required written maintenance form.

An interview with the Maintenance Director on 4/4/23 at 4:05 PM indicated Nursing staff informed him of the leaking sink two weeks prior (date unknown) and he repaired it although a maintenance form was never completed by staff or himself. He further Indicated he was unaware the sink was still broken until he was informed by the unit manager on 4/3/23. He then stated the leaking sink was successfully repaired on the morning of 4/4/23.

During an interview on 4/4/23 between 2:30 PM and 2:45 PM Unit Manager #3 revealed she was made aware of the leaking sink over the weekend and informed Maintenance. She further revealed she did not complete a maintenance repair form.

During an interview on 4/6/23 at 11:35 AM Nurse Aide #2 indicated Resident #37 told her about his leaking sink on 3/31/23, as she replenished his ice. She further indicated she told his assigned NA about the sink but could not recall her name.

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She also stated she did not submit a maintenance repair request since she informed his assigned NA (unknown name) about the leaking sink.

During an interview on 4/6/23 at 11:44 AM Housekeeping Aide #3 revealed she was assigned to clean room 123 on a regular basis, saw the sink leaking and reported it to maintenance instead of submitting a maintenance repair request form. For several days after she first reported the leaking sink to maintenance, she came into work and the leaky sink was still not fixed.

6. An observation on 4/3/23 at 10:50 AM revealed a broken hand railing hanging out of the bathroom wall of room 224.

A second observation on 4/4/23 at 2:50 PM in room 224 revealed the bathroom hand railing had not been repaired.
A review of work orders from January 2023 through April 3, 2023, indicated no maintenance requests were submitted for the broken hand railing in room 224.

During a simultaneous interview and observation of the broken bathroom handrail in room 224, on 4/4/23 at 3:05 PM, the Maintenance Director and Maintenance Assistant revealed they were unaware of the broken hand railing, and they did not receive a maintenance repair request form from staff. After the interview, the Maintenance Director repaired the broken handrail in the bathroom of room 224.

During an interview on 4/6/23 at 12:00 PM Housekeeping Aide #2 indicated she worked

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F 584	Continued From page 17 part-time and was usually assigned to clean room 224. She further indicated she did not notice the bathroom handrail was broken and was not aware there were maintenance repair request forms. During an interview on 4/6/23 at 5:29 PM the Administrator stated he expected all residents to feel like they resided in a safe, clean and homelike environment. He further stated he expected all staff to follow the process for submitting maintenance repair request forms.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		5/12/23

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F 609	Continued From page 18 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy in the areas of reporting allegations of abuse to the state regulatory agency within the required timeframe for 1 of 5 abuse allegation reports reviewed for reporting alleged violations. (Resident #128, #52). The findings included: Review of the facility policy revised on 10/22/22 titled "Abuse-Neglect and Exploitation," read in part: "Section VII. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Resident # 128 was admitted to the facility on 7/20/22 with a diagnosis of bipolar, aortic valve stenosis, and hemiplegia. A MDS quarterly assessment dated 1/24/23	F 609	The abuse allegation reporting report confirmation for Resident #128 and Resident #52 was reviewed by the Director of Nursing (DON) on 4/6/2023. All current residents who the facility has reported allegations of abuse have the potential to be affected. An audit will be completed by 5/11/23 by the Director of Nursing/designee of the facility abuse allegation reports in the last 60 days to ensure the reports have been submitted to the state in the required timeframe. Director of Nursing (DON) and the Administrator will be educated by the Chief Nursing Officer by 5/11/23 related to ensuring that abuse allegation reports are sent to the state in the required timeframe. New hire DONs and Administrators will not be allowed to work until the education is completed. The Administrator will complete audits starting 5/15/23 weekly for 4 weeks and monthly for 2 months to ensure that allegations of report are being submitted to the state in the required timeframe. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement committee	

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revealed Resident #128 had no cognitive deficits.

Resident #52 was admitted to the facility on 9/23/14 with a diagnosis of dementia and anxiety. A MDS assessment quarterly assessment dated 1/14/23 revealed Resident #52 was severely cognitively impaired.

A review of a Complaint Intake and Health Care Personnel Investigations Initial Allegation Report, allegation report by facility/provider dated 3/3/23 revealed the allegation/incident type was resident abuse. The time the facility became aware of the incident was 3/3/23 at 8:00 PM.

The allegation description indicated that Resident #128 and Resident #52 were intimate in bed. The incident was reported to law enforcement on 3/3/23. The report was signed by the Director of Nursing (DON) on 3/3/23. A review of the fax confirmation report revealed the report was faxed to the state agency on 3/5/23 at 17:15 (5:15 PM) with a result of 'OK' printed on the report.

An interview was completed with the DON on 4/6/23 at 5:00 PM who stated that all incidents or allegations of abuse are to be reported within 2 hours from the time the facility is made aware of the incident. DON stated that she does not keep a main list of reportable incidents, but she would be the one to fax the initial reports regardless of if she was working in the facility. The DON stated that she would complete them on her computer, email, and fax them to the state agency.

The DON presented the fax cover sheet on 4/6/23 at 5:55 PM. The Fax was dated 3/8/23 at 16:17 (4:17 PM) with a fax result of OK. The fax cover sheet read; 'I resent the initial report, I

meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance.

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F 609	Continued From page 20 noticed there was a fax error, hopefully the fax resent it, but if not, I have enclosed it.' The DON stated that she had sent the initial allegation reports the day of the incident for one incident and the other incidents that happened in the evening were faxed that evening (3/3/23). The DON explained she had three incidents on 3/23/23 and stated she saw that there was an error report (the reports had not been successfully faxed) and she re-faxed the reports because she was concerned the reports did not go through. The DON explained that she re-faxed the reports to the state agency on 3/8/23. An interview was completed with the Administrator on 4/6/23 at 5:29 PM who stated that all alleged violations should be reported per the regulation.	F 609		
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655		5/12/23

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F 655	Continued From page 21 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to initiate a baseline care plan on admission for 1 of 1 resident (Resident #30) reviewed for hospice services. Findings included: Resident #30 was admitted to the facility on 2/28/23 with diagnoses of diabetes, peripheral vascular disease, chronic pain, and hospice services.	F 655	Resident #30 care plan for hospice services was initiated by the Unit Manager on 4/4/23. All current residents who receive hospice services have the potential to be affected. An audit will be completed by 5/11/23 by the Director of Nursing/designee to ensure residents that receive hospice services have care plans. The licensed nurses to include agency	

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An admission Minimum Data Set assessment dated 2/28/2023 indicated Resident #30 was cognitively intact, was on hospice services and had occasional pain which required pain medication; and he received an opioid pain medication for 7 days of the 7 day assessment period.

A review of Resident #30's medical record revealed a baseline care plan was not initiated for Resident #30.

The Hospice Nurse was interviewed on 4/5/2023 at 9:55 am and stated Resident #30 had hospice services before he came to the facility and continued on hospice services starting from the time he was admitted to the facility. The Hospice Nurse also stated she visits Resident #30 weekly, and he has a home health hospice aide that visits once a week also.

Nurse #6 was interviewed on 4/5/2023 at 12:24 pm and stated Resident #30 is visited by the hospice nurse once weekly and has a home health hospice aide visit once a week. Nurse #6 stated Resident #30's baseline care plan would be in the electronic record, but she did not know if he had a baseline care plan.

Unit Manager #1 stated Resident #30 should have a baseline care plan on admission in the electronic medical record for pain and hospice services. She stated the baseline care plan should be initiated when the admission assessment is completed by the admitting nurse.

On 4/5/2023 at 4:44 pm the Director of Nursing was interviewed and stated Resident #30 came to the facility on hospice services and hospice

F 655

nurses will be educated by the Staff Development Coordinator (SDC) / designee by 5/11/23 related to ensuring residents that receive hospice services have a hospice care plan. New hire licensed nurses to include new agency licensed nurses will not be allowed to work until the education is completed.

The Director of Nursing/Designee will complete audits weekly for 4 weeks and monthly for 2 months to ensure that residents who receive hospice services have a care plan. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance.

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F 655	Continued From page 23 services and potential for pain should have been included on the baseline care plan.	F 655		
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 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to provide nail care for one of 26 residents (Resident # 69) who was dependent on staff for nail care. The findings included: Resident #69 was admitted to the facility on 3/25/19 with a diagnosis of chronic obstructive pulmonary disease, and major depressive disorder. A review of the quarterly Minimum Data Set (MDS) dated 3/18/23 coded Resident #69 as being cognitively intact, had no rejections of care and required extensive assistance of one staff member to complete personal hygiene. A review of Resident #69's care plan revised on 3/23/23, included a focused area for self-care needs. The intervention included checking nail length, trim and clean nails on bath day as necessary and report any changes to the nurse. The care plan did not include any refusals for resident care. An observation was completed on 4/3/23 at 11:03	F 677	Resident #69 nails were cleaned and trimmed by the certified nursing assistant on 4/4/23. A referral appointment for dermatology related to the resident□s nails has been made by the scheduler on 4/28/23. All current residents have the potential to be affected. An audit will completed by 5/11/23 by the Unit Managers to ensure residents receive nail care as required. The nursing staff to include agency nursing staff will be educated by the Staff Development Coordinator (SDC) / designee by 5/11/23 related to ensuring residents nail care as required. New hire nursing staff to include new agency nursing staff will not be allowed to work until the education is completed. The Director of Nursing/Designee will complete audits starting 5/15/23 of 10 residents weekly for 4 weeks and monthly for 2 months to ensure that residents continue to be provided nail care as required. The Director of Nursing will	5/12/23

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(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 677	Continued From page 24 AM of Resident #69 who was lying in bed with a jacket on and covered with sheets, his hands were on top of the sheets. Resident #69 reached to drink some coffee and was observed to have long thick yellow fingernails approximately a ½ inch long which had dark brown debris on the underside of his nails. Both hands were observed to have long nails except the right middle finger. Resident #69 was asked about his nails, and he responded that he was going home this week with his cousin and would cut his nails. An observation and interview were completed on 4/4/23 at 4:31 PM with Resident #69 who was asked about his long nails and was asked if he would prefer to have shorter nails and he stated that he would like to have his nails cut. Resident #69 stated he had a lot of calcium in his neck and did not know if he could cut his own nails. While in Resident #69's room the Team Lead Nurse Aide (LNA) walked into the room. The LNA was asked about Resident #69's nails and she stated that she had thought they had put him (Resident #69) on the book (a book for communication at the nurse's station) to have his nails looked at and his nails had been reported to the Charge Nurse (Nurse #3). The LNA explained that Resident #69's nails would need to be done with heavier clippers and usually nail care is done on shower days. An interview on 4/4/23 at 4:37 PM with Medical Records Coordinator who coordinates nail appointments was asked about Resident #69's nails and she stated that Resident #69 had been scheduled for nail care for his toes with a podiatrist, but she did not have anything to do with fingernail care.	F 677	submit the findings to the Quality Assurance Performance Improvement committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance	

F 677 Continued From page 25 F 677

An interview was conducted with the Nurse #3 on 4/4/23 at 4:40 PM. Nurse #3 stated that nail care residents' names are put on a list and given to medical records who would coordinate nail care. Nurse #3 stated that Resident #69's nails were bad and had been like that for a long time and that he was not on any list for nail care that she could recall. Nurse #3 explained that usually the Nurse Aides (NA) could cut nails within reason but due to the condition of Resident #69's nails they could not. Nurse #3 stated that he had once been on a list for his nails to be cut but "that was several Director of Nursing (DON) ago and It would take more than a regular clipper to cut them." Nurse #3 stated he used to get fungal cream to his nails quite some time ago if she remembered correctly but could not recall the dates.

At 4:51 PM on 4/4/23 Nurse #3 stated that she had just contacted Resident #69's Nurse Practitioner (#2) and told the NP #2 about Resident #69's long nails and reported that NP #2 stated that she did not think that any cream would do any good but would look at them on 4/5/23 and would attempt to cut them. The Charge Nurse was asked how have Resident #69's gone so long without any care and she stated, "that I cannot answer".

An interview was completed on 4/5/23 at 9:30 AM with Medication Aide #1 (MA) who stated that she did remember that at one time Resident #69 did have fungal cream for his nails and that a former DON had been trying to get his nails cut down. The MA stated that as far as she knew Resident #69's nails have always been thick and long.

An interview was completed with Nurse #4 who

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stated that a previous DON had trimmed them with a special clipper but could not recall when this occurred and stated Resident #69's nails have always been thick.

An interview was completed with Nurse Aide #2 (NA) on 4/5/23 at 12:35 PM who stated that sometimes she would try and clean Resident #69's nails but would ask a nurse to clip them. NA #2 stated that Resident #69's nails had not been clipped in a long time.

On 4/5/23 at 12:51 PM The Medical Director stated that he had seen resident #69 today. The Medical Director was asked if he was aware of his long fingernails and stated that normally regarding fingernails he would not become aware of them unless they were infected or complaining of pain, and stated he would be happy to take a look at Resident #69's nails and cut them. The Medical Director returned and stated the NP had already trimmed Resident #69's nails.

A telephone interview was completed with NP #2 on 4/6/23 at 2:41 PM who stated that until this week no one had asked her to look at Resident #69's nails. NP stated that she had noticed them and stated that she had asked Resident #69, and he had not told her (NP) it was a concern. NP #2 stated that she did start prescribe fungal cream to see if it would be beneficial and would be checking on his nails but it could take several weeks for a change to be noticed. NP #2 stated that she just did not know what treatment is warranted for the nails and thought of soaking them but decided to try the fungal cream first.

An interview was completed with the DON on

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F 677	Continued From page 27 4/6/23 at 5:04 PM who stated that all we (facility staff) could do with Resident #69 was to use the Emory board on his nails and clean them. DON stated his care plan was updated yesterday 4/5/23 because she (DON) was concerned about the nails and wanted to document he refused for staff to use the little clippers. The DON clarified that Resident #69 "does not refuse, he just does not want us (facility staff) to hurt him". The DON stated that she would inquire about someone coming into the facility regarding what device could be used for Resident #69's nails and was aware his nails had been long for a while. An interview was completed with the Administrator on 4/6/23 at 5:29 PM who stated that nail care and Activities of daily living care would be attended to, per the residents wishes.	F 677		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff, resident and Nurse Practitioner interviews the facility failed to manage a resident's pain for 1 of 2 residents (Resident #74) reviewed for pain. Findings included: Resident #74 was admitted to the facility on 2/20/2023 with diagnosis of arthritis.	F 697	Resident #74 Pain Management Program was reviewed by the Director of Nursing on 4/11/23 to ensure that resident #74 is maintaining acceptable levels of comfort. All current residents have the potential to be affected. An audit will be completed by 5/11/23 by the Unit Managers to ensure that the residents' Pain Management	5/12/23

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Resident #74's Physician's Orders indicated he had an order for Oxycodone HCl 10 milligrams 1 tablet by mouth every 12 hours as needed for severe pain dated 2/21/2023 for 14 days. Resident #74's physician's orders did not include any other medications for pain.

The admission Minimum Data Set assessment dated 2/26/2023 indicated Resident #74 was cognitively intact. The assessment further indicated Resident #74 rated his pain at 5 on a scale of 1 to 10, and stated his pain was occasional.

A Care Plan dated 3/6/2023 stated Resident #74 would maintain acceptable level of comfort, but the interventions did not include pharmacological or nonpharmacological interventions for pain.

A Physician's Order written 3/9/2023 indicated Resident #74 was ordered Oxycodone HCl 10 milligrams 1 tablet by mouth every 12 hours for moderate to severe pain for 21 days (end date on 3/29/23).

A review of Resident #74's Medication Administration Record (MAR) for March 2023 indicated he did not receive Oxycodone HCl 10 milligrams 1 tablet by mouth every 12 hours as needed for severe pain. Resident #74's March 2023 MAR indicated Resident #74 did not receive any other medications for pain.

Further review of Resident #74's medical record revealed there was no documentation of complaints of pain, assessment of pain or having received pain medication from 03/29/23 through 04/03/23.

F 697

Program is in place and the residents are maintaining acceptable levels of comfort.

The licensed nurses to include agency licensed nurses will be educated by the Staff Development Coordinator (SDC) / designee by 5/11/23 related to ensuring residents have a Pain Management Program and the residents are maintaining acceptable levels of comfort. New hire licensed nurses to include new agency licensed nurses will not be allowed to work until the education is completed.

The Director of Nursing/Designee will complete audits of 10 residents weekly for 4 weeks and monthly for 2 months to ensure that residents continue to have a Pain Management Program in place and that the residents are maintaining acceptable levels of comfort. The Director of Nursing will submit the findings to the Quality Improvement Performance committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance.

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During an observation and interview with Resident #74 on 4/3/2023 at 2:45 pm he stated he has been in pain for the past 4 days and he has not been able to sleep due to the pain in his joints, especially the pain in his hands. Resident #74 rubbed his knuckles and grimaced while he spoke. Resident #74 stated Nurse #2 told him either 4/1/2023 or 4/2/2023 his prescription had not been renewed and it could not be renewed until the Nurse Practitioner visited again. He stated Nurse #2 did not tell him when the Nurse Practitioner would visit again.

A Physician Order written 4/3/2023 indicated Resident #74 was ordered Oxycodone HCI 10 milligrams 1 tablet by mouth every 12 hours as needed for severe pain.

On 4/6/2023 at 3:22 pm the Nurse Practitioner (NP) was interviewed and stated she saw Resident #74 recently but was not able to state the date of her visit with him. The NP stated Resident #74 stated he wanted to continue his pain medication because of arthritis pain. The NP stated she had not completed the note for the visit but she had renewed Resident #74's pain medication.

Resident #74 was observed and interviewed on 4/4/2023 at 2:03 pm and he stated he continued to be in pain and rated his pain at an 8 on a scale of 1 to 10. Resident #74 stated he had not asked for pain medication.

On 4/5/2023 at 9:27 am Resident #74 stated he got pain medication yesterday (04/04/23) and was feeling better.

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On 4/6/2023 at 2:20 pm Nurse #2, an agency nurse, was interviewed and stated Resident #74 did not have a prescription for pain medication because his as needed order had expired. Nurse #2 stated she could not recall if this was reported to Nurse #1 who worked the evening shift on 4/1/2023 or 4/2/2023. Nurse #2 stated she did not call the Physician or Nurse Practitioner to obtain an order to renew Resident #74's pain medication and Resident #74 did not report he was having pain to her.

During an interview with Nurse #1 on 4/6/2023 at 11:34 am he stated he worked on the evening shift on 4/2/2023 and was told by the day shift nurse, Nurse #2, during report Resident #74's pain medication was not available because the prescription was out of date and the Nurse Practitioner or Physician needed to sign the prescription. Nurse #1 stated Resident #74 did not tell him he was in pain during his shift.

An interview was conducted with Unit Manager #1 on 4/6/2023 at 2:41 pm and she stated the nurses did not report to her Resident #74's as needed pain medication prescription had expired. Unit Manager #1 stated if Nurse #1 or Nurse #2 had reported Resident #74's prescription expired she would have notified the Nurse Practitioner and asked her to fax a copy of the prescription to the pharmacy. Unit Manager #1 stated she would have also used the facility's standing orders to give Resident #74 acetaminophen (an over-the-counter analgesic) or obtained his pain medication from the automated medication dispensing system.

The Director of Nursing (DON) was interviewed on 4/6/2023 at 4:48 pm and stated if Resident

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F 697	Continued From page 31 #74 had complained of pain to Nurse #2; Nurse #2 should have assessed the Resident's pain and notified the NP if the resident was in severe pain to request a new pain medication prescription. On 4/6/2023 at 5:33 pm the Administrator was interviewed and stated Resident #74 should have his pain medication ordered by the physician and offered when needed.	F 697		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews, the facility failed to provide palatable food for 2 of 4 residents (Resident #51 and Resident #107). Resident #51 was upset because he received gravy without sausage, and his oatmeal was served on his meal plate without a bowl and without sugar or butter. Resident #107 received gravy without sausage and could not eat her oatmeal because it was served on her meal plate without a bowl and without sugar or butter. Findings included: 1. A. Resident #51 was admitted to the facility on 7/22/2022 with diagnoses of Parkinson's	F 804	Resident #51 and #107 concerns related to the gravy without sausage and the oatmeal not in a bowl were reported to the dietary manager on 4/5/2023. The current residents have the potential to be affected. A dietary audit of the current residents will be completed by 5/11/23 by the dietary manager/designee to ensure food is being served in a method that conserve nutritive value, flavor, and appearance to include gravy with adequate amounts of sausage, foods served in a bowl if required and condiments on the tray. Completed audits reveal no new concerns.	5/12/23

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disease and dementia.

An annual Minimum Data Set assessment dated 2/8/2023 indicated Resident #51 was moderately cognitively impaired and was able to feed himself with set up of his meals. The assessment further indicated Resident #51 had no significant weight loss.

The facility's menu for Wednesday, 4/5/2023, indicated the residents would be served sausage and gravy, oatmeal, and fruit.

On 4/5/2023 at 8:46 am an observation and interview was conducted with Resident #51. Resident #51 was up in his wheelchair eating breakfast and there were no condiments (sugar, butter, salt, or pepper) on Resident #51's breakfast meal tray. He stated he does not eat oatmeal without sugar, butter, and milk. Resident #51 stated he would also like to have his oatmeal in a bowl so he could add milk to it without it running into his gravy biscuit. Resident #51 stated his gravy does not have any sausage in it. Resident #51's gravy is thin with no meat observed.

Nurse Aide # 1 stated on 4/5/2023 at 8:54 am she passed the breakfast meal trays on the 200-hall but had not paid attention to whether the trays had condiments on them because she was concentrating on getting the trays out to the residents. Nurse Aide # 1 stated she was not sure if she or someone else gave Resident #51 his breakfast meal tray.

During an interview with the Dietary Manager on 4/5/2023 at 8:57 am he stated there was supposed to be sausage in the gravy on Resident

F 804

The dietary manager purchased additional bowls for the kitchen.
The Dietary Manager was educated on 4/28/23 by the Administrator to ensure food is being served in a method that conserve nutritive value, flavor, and appearance to include gravy having adequate amounts of sausage, foods served in a bowls if needed and condiments on the tray.
The dietary staff will be educated by 5/11/23 by the dietary manager related to ensuring food is being served in a method that conserve nutritive value, flavor, and appearance.

The dietary staff to include agency dietary staff will not be allowed to work until the education is completed. New hires also will be required to complete the education.

The Administrator/ Dietary Manager will review 10 resident meals weekly for 4 weeks and monthly for 2 months to ensure resident meals continue to be served in a method that conserve nutritive value, flavor, and appearance.

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#51's breakfast meal tray and sausage was included on the menu for the breakfast meal. The Dietary Manager stated the oatmeal was served on the plate because the facility did not have enough bowls to serve the oatmeal in a bowls to the residents.

During an interview with Cook #1 on 4/5/2023 at 8:58 pm she stated she did put sausage in the sausage gravy and the sausage is ground in a food processor. Cook #1 also stated they served Resident #51's oatmeal on the plate because they did not have enough bowls.

B. Resident #107 was admitted to the facility on 8/9/2021 with diagnoses of hemiplegia and epilepsy.
A quarterly Minimum Data Set assessment dated 2/16/2023 indicated Resident #107 had modified independence for cognitive skills for daily decision making; she could feed herself with set up of her meal tray, and she had no significant weight loss.

Resident #107 was observed and interviewed on 4/5/2023 at 9:14 am with her meal tray set up in front of her. She stated her gravy did not have sausage in it, but she ate it, and she did not eat her oatmeal because it was not in a bowl and she did not receive any sugar or butter to put on it, and she could not eat it like that. The Scheduler entered the room to pick up Resident #107 breakfast meal tray and heard what Resident #107 said and asked her if she would eat her oatmeal if she brought her a bowl, sugar and milk and Resident #107 stated she would.

The Scheduler was interviewed on 4/5/2023 at 9:18 am and she stated sometimes the

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condiments were sent out on the tray, but they did not send them out on the trays this morning and Resident #107's Nurse Aide should have brought her sugar and a bowl for her oatmeal. The Scheduler stated she did not know why the kitchen sent Resident #107's oatmeal on a plate and it should be in a bowl.

During an interview with the Dietary Manager on 4/5/2023 at 8:57 am he stated there was supposed to be sausage in the gravy on Resident #107's breakfast meal tray and sausage was included on the menu for the breakfast meal. The Dietary Manager stated the oatmeal was served on the plate because the facility did not have enough bowls to serve the oatmeal in a bowls to the residents.

During an interview with Cook #1 on 4/5/2023 at 8:58 pm she stated she did put sausage in the gravy when she made it this morning and she did not know why Resident #107 did not have any sausage in her gravy. Cook #1 also stated they served Resident #107's oatmeal on the plate because they did not have enough bowls.

On 4/5/2023 at 9:14 am the Dietary Manager made gravy with the facility's dry packets and added sausage that had been ground in the food processor to the gravy. The Dietary Manager compared the gravy served at breakfast with the gravy the he made, and the gravy served on the breakfast meal tray for breakfast was much thinner with no chucks of sausage in the gravy. The Dietary Manager agreed there was a noticeable difference in the consistency and there did not appear to be sausage in the gravy from the breakfast meal trays.

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F 804	Continued From page 35 The Administrator was interviewed on 4/6/2023 at 5:04 pm and stated resident's meal trays should be served with food that is appetizing with necessary condiments, the menu should be followed, and resident's nutritional needs should be met.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure dietary staff contained facial hair for staff members with beards serving residents food for the preparation of resident's lunch meal trays. The result of the failure to contain facial hair during meal tray preparation and serving had the potential to affect all residents in the facility who would receive a lunch	F 812	The identified dietary manager and dietary aide #1 placed mask to cover their beard and mustache on 4/3/2023. All current residents have the potential to be affected. The Dietary Manager was educated by	5/12/23

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F 812	Continued From page 36	F 812		

meal tray, and 138 of 139 residents received meal trays.

Findings included:

On 4/3/2023at 11:35 am an observation of the dietary staff preparing and serving the lunch meal trays for residents revealed the dietary staff failed to contain facial hair for staff with beards, during the observation:

The Dietary Manager was preparing trays for plates and handling the plates after the cook served food onto the plates with his facial hair not contained. The Dietary Manager had a full beard and mustache that was approximately 2-inches long.

Dietary Aide #1 did not have his facial hair contained throughout the observations. Dietary Aide #1 was handling uncovered lunch meal plates and placing condiments on the resident's trays. Dietary Aide #1's beard and mustache were approximately 1-inch long.

The Dietary Manager was interviewed on 4/3/2023 at 12:42 pm and stated he does not make the staff who have beards contain their facial hair if they have masks on. He stated he knew the masks, when worn correctly, did not cover the beard completely. The Dietary Manager stated he did have hair nets that contain facial hair available but did not ensure dietary staff with beards wore them during food preparation and serving.

During an interview with the Administrator on 4/6/2023 at 5:33 pm he stated the dietary staff with beards should contain their beards when

Provider's Plan of Correction (F 812):

the Administrator on 4/6/2023 related to ensuring safe food handling practices to include wearing mask to cover beards and mustache is maintained.

The Dietary staff to include agency dietary staff will be educated by the Dietary Manager by 5/11/23 on the proper sanitary practices during food service, including covering beards and mustaches in accordance with professional standards for food service safety.
Dietary staff will not be allowed to work until the education is completed.

The Administrator will monitor the proper sanitary practices in the kitchen, including beard covering 3 times a week, for the next 12 weeks covering different meal services to ensure compliance.

The Administrator will review the findings in the monthly Quality Assurance Performance Improvement meeting monthly for 3 months and follow up as needed.

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F 812	Continued From page 37 preparing and serving resident's food.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to	F 867		5/12/23

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adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse

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F 867	Continued From page 39 resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assurance and	F 867	Quality Assessment and Assurance (QAA) Committee was held on 4/28/2023	

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F 867 Continued From page 40

Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor these interventions the committee put into place in following the complaint investigation of 11/9/2021, the recertification survey of 05/06/22, the complaint investigation of 11/17/2022, and the complaint investigation of 3/2/2023. This was for 4 re-cited deficiencies, E0001, F655, F696, and F812, which were originally cited on 5/6/2022, 1 re-cited deficiency F584 originally cited on 11/9/2021 and 11/17/2022, and 1 re-cited deficiency F677 originally cited on 3/2/2023. The continued failure of the facility during the 4 federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program.

The findings included:

This tag is cross referred to:

1. E0001: Based on record review and staff interview, the facility failed to provide a facility and comprehensive Emergency Preparedness (EP) plan which had been developed, reviewed, and maintained specifically for the facility. The facility failed to maintain, review, and update the EP plan, update for current contacts, collaborate with local stakeholders, develop, update and review EP policies and procedures based on the developed EP plan, development of the communication plan, emergency official contact information, put into place EP training, testing, and establish a program, and perform drills or community-based risk assessments.

During the recertification and complaint investigation survey of 5/6/2022, the facility failed

F 867 (Plan of correction)

by the Administrator related to ensuring the facility has effective systems to obtain information and/or feedback from facility staff, residents and residents representatives to identify problems and opportunities for improvement. The recited deficiencies E0001, F655, F696, F812, F584 and F677 were also reviewed.

The current residents are at risk related to this deficient practice.

The interdisciplinary team to include the Director of Nursing, Staff Development Coordinator, Social Service, maintenance Director, Unit Managers, Treatment nurse, activities, Dietary Manager and Housekeeping Manager was educated on 4/28/2023 by the Chief Nursing Officer related to ensuring the QAA Committee maintain and implement processes to obtain information and/or feedback from facility staff, residents and residents representatives to identify problems and opportunities for improvement. New hire interdisciplinary team members will also be required to complete the education.

The Administrator will be responsible for monitoring the Quality Assurance Performance Improvement Plan process monthly for 3 months to ensure that the facility remains in compliance for identified deficiencies.

The Administrator will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 6 months for

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F 867	Continued From page 41 to provide a facility and comprehensive Emergency Preparedness (EP) plan which had been developed, reviewed, and maintained specifically for the facility. The facility failed to maintain, review, and update the EP plan, update for current contacts, collaborate with local stakeholders, develop, update and review EP policies and procedures based on the developed EP plan, address subsistence needs for residents and staff, development of the communication plan, emergency official contact information, put into place EP training, testing, and establish a program, and document information in the EP regarding the emergency generator. 2. F655: Based on record review and staff interviews the facility failed to initiate a baseline care plan on admission for 1 of 1 resident (Resident #30) reviewed for hospice services. During the recertification and complaint investigation of 5/6/2022, the facility failed to provide 1 of 4 residents with a Baseline Care Plan which addressed behaviors such as attempting to touch staff members inappropriately and making sexually inappropriate comments. 3. F584 Based on observations, record review, staff interviews, the facility failed to maintain a clean safe and homelike environment by the failure to cover fluorescent tube lighting in 1 of 18 rooms (room 102), failed to secure television cable outlet covers and electrical outlet covers in 4 of 33 resident rooms (rooms 107, 320,326 and 333), failed to maintain window blinds that were in disrepair with missing and bent slats in 2 of 18 rooms (rooms 109 & 116), failed to provide a window blind in 1 of 18 rooms (room 113), failed to maintain intact sheetrock and clean walls for 1	F 867	review to ensure compliance.	

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F 867	Continued From page 42 of 18 rooms (room 109) failed to maintain resident cabinetry in 2 of 18 rooms (room 113 bed 2 & room 115 bed 1), failed to maintain the interior bathroom cabinet where residents' belongings were stored which was rusted and peeling in 1 of 18 rooms (room 115), failed to repair a leaky bathroom sink 1 of 30 rooms (room 123), failed to secure a bathroom handrail 1 of 30 rooms, (room 224), failed to maintain clean filters and clean front grills of Packaged Terminal Air Conditioner units (PTAC - a type of heating and air conditioning system used in a single living space) in 8 of 15 resident rooms and a day room on the 300 hall (rooms 319,324, 325,326, 328,329,330 and 333), failed to replace burned out light bulbs over the sinks of 5 of 15 resident rooms on the 300 hall (rooms 320, 323,325,327 and 330) reviewed for environment. During the Focused Infection Control, complaint investigation and follow-up survey of 11/9/2021, the facility failed to provide clean floors in 2 of 5 resident's rooms (Room #327 and Room 129); and failed to provide clean walls in 1 of 5 resident bathrooms (Room #224). And during the complaint investigation dated 11/17/2022, the facility failed to provide bed linens in good condition for 1 of 5 residents. 4. F677 Based on observations, record review, resident, and staff interview the facility failed to provide nail care for one of 26 residents (Resident # 69) who was dependent on staff for nail care. During the complaint investigation of 3/2/2023 the facility failed to provide nail care for 2 of 4 residents who were dependent on staff for	F 867		

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F 867	Continued From page 43 personal care. 5. F697: Based on record review, observations, and staff, resident and Nurse Practitioner interviews the facility failed to manage a resident's pain for 1 of 2 residents (Resident #74) reviewed for pain. During the recertification and complaint investigation of 5/6/2022, the facility failed to assess the burning, stabbing, and numbness pain for a diabetic resident during auto-amputation (to fall off when the tissue was dead) of toes for 1 of 2 residents reviewed for pain. 6. F812: Based on observations and staff interviews the facility failed to ensure dietary staff contained facial hair for staff members with beards serving residents food for the preparation of resident's lunch meal trays. The result of the failure to contain facial hair during meal tray preparation and serving had the potential to affect all residents in the facility who would receive a lunch meal tray, and 138 of 139 residents received meal trays. During the recertification and complaint investigation of 5/6/2022, the facility failed to use hand soap and hot water for hand hygiene, sanitize dishes in a high temperature dish machine using water that reached a minimum temperature of 180 degrees Fahrenheit (F) for the final rinse cycle, and maintain the kitchen floor, clean, and in good repair. This failure had the potential to affect 104 of 106 residents. The Administrator was interviewed on 4/6/2023 at 5:58 PM and he reported he was the interim Administrator, and he started his position on	F 867		

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F 867	Continued From page 44 3/8/2023. The Administrator reviewed the QAPI minutes from the past 3 meetings dated 12/6/2022, 1/13/2023, and 2/27/2023 and reported that the emergency plan, baseline care plans, nail care, environment, pain, nor the kitchen were discussed during any of those meetings. The Administrator reported that he was not certain why the corrective actions for those citations were not sustained.	F 867		
F 883 SS=B	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		5/12/23

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F 883	Continued From page 45 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the Influenza and Pneumococcal Immunizations for 3 of 5 residents reviewed for infection control (Resident #138, #53, and #47). The findings included: 1.a. Resident #138 was admitted to the facility on	F 883	Resident #138, #53, and #47 immunizations records were reviewed on 4/27/23 for documentation regarding the benefits and potential side effects of the Influenza and Pneumococcal Immunizations by the Assistant Director of Nursing (ADON). All current residents have the potential to be affected. An audit was completed on 4/28/23 by the ADON to ensure residents' immunization records have been reviewed	

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F 883 Continued From page 46
1/2/23.
The admission Minimum Data Set assessment (MDS) dated 1/9/23 indicated Resident #138 had moderate cognitive impairment, and the influenza as well as the pneumococcal immunizations were checked as not up to date or offered (section O300).
A review of the immunization section of the medical record profile for Resident #138, revealed no documentation related to influenza or pneumococcal immunization status.

b. Resident #53 was admitted to the facility on 1/4/23.
The quarterly MDS assessment dated 1/24/23 indicated Resident #53 was cognitively intact, and the influenza as well as the pneumococcal immunizations were checked as not up to date or offered (section O300).
A review of the immunization section of the medical record profile for Resident #138, revealed no documentation related to influenza or pneumococcal immunization status.

c. Resident #47 was admitted to the facility on 12/15/22.
The admission MDS dated 12/22/22 revealed Resident #47 had moderate cognitive impairment and the influenza as well as the pneumococcal immunizations were checked as not up to date or offered (section O300).
A review of the immunization section of the medical record profile for Resident #138, revealed no documentation related to influenza and pneumococcal immunization status.

The Assistant Director of Nursing was interviewed via telephone on 4/10/23 at 1:32 PM and indicated she was the acting Infection

F 883
to ensure immunizations to include Influenza and Pneumococcal vaccine have been offered or declined and documentation regarding the benefits and potential side effects are in the medical record.
The licensed nurses to include agency licensed nurses will be educated by the Staff Development coordinator by 5/11/23 related to ensuring residents' immunization records have been reviewed to ensure immunizations to include Influenza and Pneumococcal vaccine have been offered or declined and documentation regarding the benefits and potential side effects are in the medical record.
New hire licensed nurse will not be allowed to work until the education is completed.
The Director of Nursing/ Designee will complete audits of 10 residents weekly for 4 weeks and monthly for 2 months to ensure that residents immunization records continue to be reviewed to ensure immunizations to include Influenza and Pneumococcal vaccine have been offered or declined and documentation regarding the benefits and potential side effects are in the medical record.
The Director of Nursing will review the findings of the audits in the monthly Quality Assurance Performance Improvement meeting monthly for 3 months and follow up as need to maintain ongoing compliance.

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F 883	Continued From page 47 Preventionist and was unable to locate any documentation related to Influenza and pneumococcal immunizations for Resident #138, #53, and #47). She further indicated she began employment at the facility in February 2023 and planned to locate consent forms, add documentation to the medical records and identify residents without immunizations. During an interview on 4/6/23 at 5:47 PM the Administrator revealed his expectation was for the status of all resident immunization record to be documented in the medical record, as being given, or declined.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is	F 887		5/12/23

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F 887	Continued From page 48 provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide documentation in the medical record regarding vaccination status, education on the benefits and potential side	F 887	Resident #47 immunizations records were reviewed on 4/27/23 to ensure the resident immunization records have been reviewed to ensure immunizations to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING ______ B. WING ______	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 887	Continued From page 49 effects before being offered the COVID vaccination or refusal for 1 of 5 residents (#47) reviewed for infection control. The findings included: Resident #47 was admitted to the facility on 12/15/22. A Minimum Data Set assessment dated 1/17/23 indicated Resident #47 had moderate cognitive impairment. A review of the immunizations section of Resident #47's electronic medical record, indicated no documentation related to COVID-19 vaccinations. During a telephone interview on 4/10/23 at 1:32 PM the Assistant Director of Nursing (ADON)/ Infection Preventionist indicated she started working at the facility in February 2023 and the previous Infection Preventionist records were incomplete, whereas some staff entered documentation into the immunizations tab of the medical record and some staff did not. She further indicated she was unable to locate any documentation related to COVID-19 vaccinations for Resident #47. She further indicated she attempted to review facility records, hospital records and contact the previous nursing facility Resident #47 resided but was unable to confirm he received any COVID-19 vaccinations. During an interview on 4/6/23 at 5:47 PM the Administrator revealed his expectation was for the status of all resident immunization records to be documented in the medical record, as being given, or declined.	F 887	include Covid vaccine have been offered or declined and documentation regarding the benefits and potential side effects are in the medical record. All current residents have the potential to be affected. An audit was completed on 4/28/23 by the Unit Managers to ensure residents' immunization records have been reviewed to ensure immunizations to include Covid vaccine have been offered or declined and documentation regarding the benefits and potential side effects are in the medical record. The licensed nurses to include agency licensed nurses will be educated by the Staff Development coordinator by 5/11/23 related to ensuring residents' immunization records have been reviewed to ensure immunizations to include Covid vaccine have been offered or declined and documentation regarding the benefits and potential side effects are in the medical record. New hire licensed nurses will not be able to work until the education is completed. The Director of Nursing/ Designee will complete audits of 10 residents weekly for 4 weeks and monthly for 2 months to ensure that residents immunization records continue to be reviewed to ensure immunizations to include Covid vaccine have been offered or declined and documentation regarding the benefits and potential side effects are in the medical record. The Director of Nursing will submit the findings in the monthly Quality Assurance Performance Improvement meeting for 3 months and follow up as needed to	

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F 887	Continued From page 50	F 887	maintain facility ongoing compliance.	