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SIGNATURE HEALTHCARE OF CHAPEL HILL	1602 E FRANKLIN STREET CHAPEL HILL, NC 27514

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E 000	Initial Comments An unannounced Recertification survey was conducted on 3/20/23 through 3/23/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # LZ6G11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted on 3/20/23 through 3/23/23. Event ID # LZ6G11. The following intakes were investigated NC00196300 and NC00194502. 1 of the 4 complaint allegations resulted in a deficiency.	F 000		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and home healthcare agencies interview the facility failed to follow through with the referrals to the home healthcare agency as ordered by the physician, failed to verify their services when discharged from the facility. This was for 2 of 3 sampled residents (Resident #133 and Resident #79) reviewed for discharge.	F 624	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	4/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 04/13/2023

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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F 624	Continued From page 1 The findings included: A review of the medical record revealed Resident #133 was admitted to the facility 11/22/22 with type 1 diabetes mellitus, hyperlipidemia, and hypertension. Resident #133's Admission Minimum Data Set dated 11/22/22 revealed Resident was cognitively intact Resident #133 received therapy during her stay at the facility. Resident #133's care plan indicated that Resident #133 needed a range from supervision with set up help to extensive assistance one-person physical assist with activities of daily living. A physician's order for Resident #133 dated 12/09/22 indicated an order for a referral for home healthcare and physical therapy. Review of the discharge summary dated 12/11/22 indicated that Resident #133 discharged from the facility on 12/11/22. An interview was conducted with the home health agency staff on 03/21/23 at 10:00 am and they indicated a referral was received from the facility on 12/09/22. The home health staff indicated they responded to the facility on 12/14/22 and informed them due staff shortages at the agency they would not be able to go out to see Resident #133 until around 12/21/22. During an interview on 03/23/23 at 11:00 am, Resident #133's family member confirmed Resident #133 was discharged to home on 12/11/22. The family member indicated she was very upset with the discharge because the paper	F 624	F. 624 D Corrective action the resident found to have been affected by the deficient practice: Residents #79 and #133 no longer reside in the facility. All discharges from 3/23/2023 were reviewed by the Director of Social Services to ensure the referrals to home health agencies are honored as ordered by the physician and no other residents were found to be affected by the deficient practice. Corrective action for other residents having the potential to be affected by the same deficient practice: On 3/23/2023, the Director of Social Services (DSS) initiated review off all residents discharged from the facility as of 3/22/2023 had home health services as ordered by the physician. The review was completed on 3/31/2023 and established that all discharged residents had referrals for home health services and a confirmation received from the agency that the referral was accepted. The confirmation is received through email and/or a verbally by phone and documented. The Director of Social Services was educated by the Administrator on the discharge process for all discharges with home health services as ordered by the physician. Systemic changes made to ensure that the deficient practice will not recur: On 3/24/2023, the Administrator initiated and completed education for the Director of Social Services on the discharge process to ensure that home health	

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F 624

Continued From page 2

worked received from the facility had misinformation on it. The family member stated Resident #133 did not receive any home health services until 12/21/22. The family member indicated that during discharge they were informed that they would receive services within 48 hours of the discharge. The family member also indicated that they had reached out to the facility on 12/14/22 because they had not heard from the home health agency. Resident #133's family member stated she was able to get some help from family and friends and was thankful for that. Family member was glad once the home health agency was involved.

An interview with the Social Worker (SW) was conducted on 03/23/23 at 8:00 am, she indicated she had sent an email to the home health agency on 12/9/23 at 10:57 am regarding the referral for Resident #133. She stated she received an email response on 12/14/22 at 11:42 am that the home health agency would be processing the referral. The SW stated she was unable to find an email confirmation which indicated the Resident #133 was accepted by home health services prior to her discharge. The SW was unable to confirm home health service had accepting the resident prior to her discharge.

An interview with Nurse#11 was made on 03/23/23 at 11:15am. Nurse #11 stated Resident #133 was discharged home on 12/11/22. The discharge process was completed with the Resident #133 and her family member. Nurse #11 indicated that family member was not pleased with the discharged information.

On 03/23/23 at 11:30 am an interview was conducted with Physician Assistant (PA). PA

F 624

services as ordered by the physician are followed through and confirmed by the home health agency. The DON and ADON were also educated by the Administrator on the same discharge process as back up in the absence of the Director of Social Services. Any new hires in the Social Services department, a new DON and/or a new ADON, will be educated as indicated above by the Administrator and/or DON during orientation before they are allowed to assume their duties as indicated in their respective job descriptions.

Plans to monitor its performance to make sure that solutions are sustained:

The Administrator and the DON introduced an observation tool on 3/27/2023 to be utilized by the Director of Social Services to track discharges with home health services as ordered by the physician are being honored. The observation tool will be used for all residents discharged from the facility as of 3/23/2023 and onwards. The tool will be reviewed by the Administrator and/or the DON 2 times weekly, then weekly for a month and, then monthly for 3 months until compliance is maintained. Any areas of non-compliance will be reported by the Administrator and/or DON to the QAA Committee monthly or quarterly as needed for further recommendations to ensure compliance.

Date of Compliance: 4/14/2023

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indicated Resident #133 was to be discharged home on 12/11/22 with home health and physical therapy service. The order for home health and physical therapy services for Resident #133 was handled by the SW.

A second Interview was conducted with SW, on 03/23/23 at 2:25 pm and she indicated she had not received any information from the home health agency on the day of discharge for Resident #133. SW confirmed that the referral for home health services had been sent on 12/09/22. The home health agency had not confirmed the date of services before Resident #133 was discharged on 12/11/23. SW indicated she reached out to Resident #133 on 12/14/22 at 11:42am for the purpose of scheduling the initial home visit and the family refused the home health services at that time and stated they was going to get another home health agency.

During an interview with the Director of Nursing (DON) and the Administrator on 03/23/23 at 2:45 pm, the DON stated the discharge process was for the SW to contact the home health agency and to complete the referral process. The home health services should have been in place before Resident #133 was discharged home. The Administrator stated his expectation was the home health services should have been in place before Resident #133 was discharged to home.

2. A review of the medical record revealed Resident #79 was admitted to the facility on -01/25/23 with chronic respiratory failure, asthma, chronic diastolic congestive heart failure, anemia, hypertension, and diabetes.

Resident #79's Admission Minimum Data Set

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F 624	Continued From page 4	F 624		

dated 02/01/23 revealed Resident #79 was cognitively intact. Resident needed limited assistance with bed mobility, transfers, eating, toilet use, dressing, personal hygiene, and bathing. She utilized a rollator and had no impairment with range of motion. Resident #79 was receiving occupational therapy (OT) and physical therapy (PT).

Resident #79's care plan dated 02/03/23 included the focus area of her desire to be discharged home upon completion of rehabilitation and skilled nursing services, and would need assistance with bed mobility, transfer, walking from place to place, with dressing, eating with toileting and personal hygiene.

A review of a physician's order for Resident #79 dated 02/03/23 read in part an order to discharge home with home health, physical therapy (PT), occupational therapy (OT), 3 in 1 bed side commode and shower chair.

Review of the discharge summary dated 02/03/23 revealed Resident #79 was discharged from the facility on 02/03/23.

A review of a social service progress note dated 02/03/23 completed by the SW read in part, "Writer approached by Resident #79 stating that she wants to discharge home today. Writer advised about the discharge protocol, and she states she is aware, but states therapy told her that they are discharging her from therapy and there is no reason for her to stay here. Writer provided supportive listening and discussed the possibility of a discharge plan meeting, and she states her mom was on her way to pick her up but her vehicle which has a trailer hooked up to it is

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F 624	Continued From page 5	F 624		

stuck and as soon as it is repaired, she will be here to pick her up. Writer talked with therapy and PT states that she has been discharged from PT because she has reached her maximum potential, but that OT continues to work with her. Resident states that she wants to go home. OT recommends 3-N-1 Bedside commode and shower chair and PT states they do not recommend any durable medical equipment (DME) as she has weight bearing precautions and has a battery powered wheelchair. She states she has no preference for home health services. Referral sent to home health agency for home health. Writer unable to schedule follow-up appointment with her primary care physician (PCP) as the office is closed. Resident is made aware and states she will schedule an appointment on Monday morning."

A review of a note from the Nurse Practitioner (NP) and it was indicated on 02/03/23 Resident #79 was seen and the following read in part for Resident #79. "Resident is seen today in close follow up to her pulmonology clinic visit. records were reviewed but not written. Asked to acutely discharge this patient ASAP at her request. In discovery and discussion about plan and medications the patient insists that she does not require any medications at discharge. She states she has all the meds she is getting in this skilled nursing facility plus more than she gets here and reiterates she will not require scripts and will leave the facility as soon as her mother arrives. Unsure if ortho had discontinued Lovenox injections or not. I note this on discharge packet and inform SW as well. She was informed this is very irregular, but she is adamant."

A phone interview was conducted with the home

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F 624	Continued From page 6 healthcare agency's staff on 03/22/23 at 8:35 am and she revealed they received Resident #79's home healthcare referral from the facility's SW on 02/06/23. The home healthcare staff said as soon as the agency received resident's referral on 02/06/23 they immediately sent out a nurse to visit Resident #79 on 02/08/23. Interview was conducted with Social Worker (SW) on 03/22/23 at 8:20am she indicated that Resident #79 approached her about going home. SW stated she told Resident #79 that it would be better if the resident stayed at the facility and discharged later. SW indicated that Resident #79 wanted to go home and was discharged on 02/03/23. SW stated she was unable to reach out to home health agency prior to the resident's discharge. Second interview with the SW was conducted on 03/23/23 at 2:30pm, who indicated that she did not get a response from the home health agency until 02/06/23 Resident #79 had been discharged home on 02/03/23. During an interview with the Director of Nursing (DON) and the Administrator on 03/23/23 at 2:45, the discharged documents were reviewed by both the DON and the Administrator. Both agreed that the SW should have contacted the home health agency and ensured the home health agency was in place before the resident was discharged home.	F 624		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		4/14/23

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F 656	Continued From page 7 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 8 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a person-centered care plan with measurable goals and objectives for one of three residents reviewed for activities. (Resident #9) The findings included: Resident #9 was admitted on 7/21/22, with diagnosis that included transient cerebral ischemic attack, hemiplegia affecting the right side, and depressive disorder. Review of Resident #9's admission Minimum Data Set (MDS) assessment dated 8/11/22 revealed, the resident's preference for customary routine and activities were indicated as family involvement in care discussions, listening to music, being around animals, keeping up with news and going outside to get fresh air. Review of the quarterly activity assessment dated 2/11/23 revealed the resident participated in in-room activities, and typically chooses to spend his free time in his room. This assessment was completed by the Activities Director. Resident #9's quarterly MDS assessment dated 2/22/23, revealed the resident was readmitted on 8/4/22. Resident #9 was assessed as having moderate hearing difficulty and impaired vision. The resident was assessed as severely	F 656	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F. 656 D Corrective action the resident found to have been affected by the deficient practice: Resident #9 still resides in the facility. On 3/24/2023, a person-centered (comprehensive) care plan with measurable goals and objectives for activities was developed for resident #9. The care plan was developed by the Activities Director. One-on-one activities for the resident were started on 3/24/23. Corrective action for other residents having the potential to be affected by the same deficient practice: On 3/23/2023, the Activities Director initiated a review of all residents in the facility using the census to determine that every resident has a person-centered care plan with measurable goals and objectives for activities. The review was completed on 4/3/2023 and all residents had a care plan for activities in place. For the residents whose care plan needed to	

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cognitively impaired and needed extensive to total dependence with 1-2 people assistance for activities of daily living (ADL).

Resident #9's care plan dated 3/21/23 indicated the resident was at risk for social isolation related to depression, impaired vision, and cognitive loss. The goal included the resident would attend activity groups of interest three times weekly or as desired. Interventions included life enrichment would continue to provide monthly calendar of activities and reminders of activities as needed. Life enrichment would continue to invite to daily programs and provide independent materials upon request such as large print activities and cognitive activities such as puzzles and memory games.

During an interview on 3/21/23 at 4:58 PM, the Activity Director stated per activity assessment dated 2/11/23 Resident #9 was self-initiating and not currently at risk for social isolation. The Activity Director further stated Resident #9 activity preferences were to do independent in room activities, holidays, parties and socials, animals, and meditation. She added when any resident was assessed as independent or self-initiating, the resident would initiate or could choose the type of activity they liked or wanted to do. Resident #9 could ask for the activity of his choice from the activity cart.

On 3/23/23 at 12:37 PM, the Activity Director stated she was responsible for developing resident's activity care plans. She indicated she developed the care plan based on the resident's activity assessment. The Activity Director confirmed Resident #9 did not have an activity

F 656

be updated, it was updated by the Activities Director during the review period. The Activities Director was educated by the Administrator on care planning every resident for activities to enhance their quality of life.
Systemic changes made to ensure that the deficient practice will not recur:

On 3/24/2023, the Administrator initiated and completed education for the Activities Director, MDS nurses, the DON and ADON on ensuring that every resident has a comprehensive/person centered care plan with measurable goals and objectives for activities. The Activities Director is responsible for activities care plans with the help of MDS nurses. The DON and ADON are to review new admissions and re-admissions to ensure they have a care plan for activities. Any new hires in the activities department, MDS, a new DON and/or a new ADON, will be educated as indicated above by the Administrator and/or DON during orientation before they are allowed to assume their duties as indicated in their respective job descriptions.

Plans to monitor its performance to make sure that solutions are sustained:

The Administrator introduced an observation tool on 3/27/2023 to be utilized by the Activities Director to track and ensure all newly admitted residents have a person-centered care plan with measurable goals and objectives. The observation tool will be reviewed by the

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F 656	Continued From page 10 care plan and, she felt an activity care plan should be developed. On 3/23/23 at 1:11 PM, the Director of Nursing (DON) indicated the Activity Director was responsible for developing the activity care plan for the residents based on the activity assessment. During an interview on 3/23/23 at 1:11 PM, the Administrator indicated the care plan should be person-centered and should reflect the same. The Administrator stated the resident was a good candidate for one-on-one activities and the care plan should be a reflection of the residents needs and preferences.	F 656	Administrator and/or DON twice weekly for 4 weeks, then weekly for a month and then monthly for 3 months until compliance is maintained. Any areas of non-compliance will be reported by the Administrator and/or DON to the QAA Committee monthly or quarterly as needed for further recommendations to ensure compliance. Date of Compliance: 4/14/2023	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide an ongoing activity program that met the individual interests and needs to enhance the quality of life for 1 of 2 sampled cognitively impaired residents	F 679	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the	4/14/23

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F 679	Continued From page 11 reviewed for activities. (Resident #9). The findings included: Resident #9 was admitted on 7/21/22, with diagnosis that included transient cerebral ischemic attack, hemiplegia affecting the right side, depressive disorder, protein-calorie malnutrition, and dysphagia. Review of Resident #9's admission Minimum Data Set (MDS) assessment dated 8/11/22 revealed, the resident's preference for customary routine and activities were indicated as family involvement in care discussions, listening to music, being around with animals, keeping up with news and going outside to get fresh air. Resident #9's most recent quarterly MDS assessment dated 2/22/23, revealed the resident was readmitted on 8/4/22. Resident #9 was assessed as having moderate difficulty in hearing, could make self-understood and had impaired vision. The resident was assessed as cognitively impaired and needed extensive to total dependence with 1-2 people assistance for activities of daily living (ADL). Resident was always incontinent of bowel and bladder. Resident #9's revised care plan redated 3/21/23 indicated the resident was care planned for activities due to risk for social isolation due to depression, impaired vision, and cognitive loss. Resident continues to participate in independent activity. The goal included the resident would attend activity groups of interest three times weekly or as desired. Interventions included life enrichment would continue to provide monthly calendar of activities and reminders of activities as needed. Life enrichment would continue to	F 679	statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F. 679 D Corrective action the resident found to have been affected by the deficient practice: Resident #9 still resides in the facility. On 3/24/2023, the facility started providing an ongoing activity program that meets the resident's interests to enhance his quality of life. The activities are provided by the activities assistant and the Activities Director. The resident is care planned for one-on-one activities. Corrective action for other residents having the potential to be affected by the same deficient practice: On 3/23/2023, the Activities Director initiated a review of all residents in the facility using the census to determine that every resident has an ongoing activity program that meets their interests and needs. The review was completed on 4/3/2023 and established that all residents had an ongoing program for activities that meet their individual interests and needs to enhance their quality of life. For the residents whose care plan for activities needed to be updated, it was updated by the Activities Director during the review period. The Activities Director was educated by the Administrator on ensuring that every resident has an ongoing activities program to meet their interests and needs to enhance their quality of life. Systemic changes made to ensure that the deficient practice will not recur:	

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F 679

Continued From page 12

invite to daily programs and provide independent materials upon request such as large print activities and cognitive activities such as puzzles and memory games.

During an observation 3/20/23 11:09 AM, Resident #9 was observed lying in bed. The resident did not have a radio or music player in his room.

During an observation on 3/20/23 at 3:39 AM, Resident #9 was observed lying in bed with his eyes opened. There was no music playing in his room. There was a television playing in his room and wasn't in his line of view. The TV was shared between the resident and his roommate.

During an observations on 3/22/23 at 1:18 PM, Resident #9 was observed lying in bed. There was no music playing in his room. There was a television playing in his room that was not clearly visible to him. The TV was shared between the resident and his roommate.

Observation on 3/23/23 at 10:44 AM revealed Resident #9 was observed lying in his bed. . No music was playing from the music player. Resident's roommate TV was playing; however, the resident could not watch it as the roommate's privacy curtain was drawn between the resident and his roommate. When the surveyor asked the resident if he liked music, the resident stated " Ya, I like that", when asked if he liked books, he stared at the surveyor and did not respond.

During an interview on 3/21/23 at 2:47 PM, Nurse aide (NA) #1 stated the resident does not like to get out of bed and does not go to group activities. NA #1indicated she had not observed activity staff

F 679

On 3/24/2023, the Administrator initiated and completed education for the Activities Director, on ensuring that every resident has an ongoing activities program that meets their interests and needs to enhance their quality of life. The Activities Director is responsible for ensuring that every resident has an ongoing program for activities. Any new hires in the activities department, will be educated as indicated above by the Administrator, DON and/or SDC during orientation before they assume their duties as indicated in their job descriptions. Residents will be reviewed quarterly or as needed by the interdisciplinary team (IDT) to ensure they have an ongoing activities program to enhance their quality of life.

Plans to monitor its performance to make sure that solutions are sustained:

The Administrator introduced an observation tool on 3/27/2023 to be utilized by the Activities Director to ensure residents have an ongoing activities program that meets their interests and needs. Ten residents will be randomly selected by the Administrator and/or DON and will be reviewed by the IDT team weekly for 4 weeks and then monthly for 3 months until compliance is maintained. The observation tool will be reviewed by the Administrator and/or DON and any areas of non-compliance will be reported by the Administrator and/or DON to the QAA Committee monthly or quarterly as needed for further recommendations to

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F 679	Continued From page 13 conducting any one-on-one activities for the resident. NA #1 stated Resident #9 was totally dependent on staff for ADL care. NA stated they only bring activities from the activity room if the resident request anything. The resident has not requested any activities. During an interview on 3/21/23 at 3:45 PM, Nurse #1 stated she was not sure if Resident # 9 was provided any activities by the staff. Nurse #1 stated Resident #9 could communicate and respond to simple questions. The resident was totally dependent on staff for ADL's. Nurse indicated she had not seen the resident go out for any group activities. The resident was usually by himself in his room. During an interview on 3/22/23 at 11:00 AM, Unit Manager for the hallway, stated the resident does not go to group activities. Unit Manager further stated Resident #9 was quiet and likes to be by himself. Unit Manager indicated the resident could answer simple questions and was totally dependent on staff for ADL care. Resident's needs were anticipated by staff and frequently checked for care. Unit Manager stated the nurses and NA did not provide any 1:1 activities for the residents however they would bring puzzles, books etc. from activity room only if any resident requested them. She added the nursing staff did not take the activity cart around to resident's rooms. During an interview on 3/22/23 at 4:30 PM, NA #2 stated the resident did not like to get out of bed and was not taken to group activities. She indicated Resident #9 preferred to stay in his room. She stated she had not seen anyone conduct any 1:1 activities with the resident. She	F 679	ensure compliance. Date of Compliance: 4/14/2023	

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indicated she did not offer any activities and she does not take the activity cart around. She stated the resident was usually in his room.

During an interview on 3/21/23 at 4:58 PM the Activity Director stated per activity assessment Resident #9 was self-initiating and not currently at risk for social isolation. The Activity Director further stated Resident #9 activity preferences were to do independent in room activities, holidays, parties and socials, animals, and meditation. She added when any resident was assessed as independent or self-initiating, the resident would initiate or could choose the type of activity they liked or want to do. The resident could ask for the activity of his choice from the activity cart. The Activity Director stated if the resident did not ask for any activities or did not attend group activities that was resident right to refuse activities. She indicated a monthly activity calendar was placed in resident's rooms each month. The Activity Director stated she was recently hired in December 2022 and did not have an assistant till last month (February 2023). She indicated that for the past 2 months the nurses and nurse aides would take activities to residents, and she was unsure who has been getting activities from the activity cart. The Activity Director stated she had no activity participation records for residents and was in the process of making participating records to identify residents not coming out of their rooms and not participating in group activities.

During an interview on 3/23/23 at 10:02 AM the Activity assistant indicated she was hired in February 2023. She further indicated Resident #9 did not participate in group activity and she had not conducted any 1:1 activity with the resident.

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F 679	Continued From page 15 The Activity assistant indicated the nursing staff would take the activity cart to resident's rooms during the week and on Sunday she does take the cart around. She indicated she does not recollect resident requesting any activities. During an interview on 3/23/23 at 8:55 AM the Director of Nursing (DON) stated the resident was very quiet, and required total to extensive assistance from staff with ADL's. The DON stated Resident #9 does not like to get out of bed and occasionally had family visits. The DON indicated the activity staff was hired in December 2022 and an activity assistance was hired in February 2023. The activity director took resident's activity preferences, and the activity staff took the activity cart to resident's rooms. The DON stated Nursing or NA staff did not do activities with the resident. However, nursing staff may just bring activity material (crafts, books etc.) from activity room if any resident requested them. During an interview on 3/23/23 at 1:11 PM, the Administrator indicated that the activities should be tailored to individual needs. Th activity staff include resident's preferences in the activity assessment. The Administrator stated the activity participation records should be utilized to accurately reflect the resident participation and activity needs. The resident would be good for 1:1 activity. The Administrator stated the facility hired a new Activity Director in December 2022 and the activity assistance was hired last month. He added the activity staff would be receiving training from the regional director from quality of life next week to improve activity services provided to the residents.	F 679		
F 883 SS=D	Influenza and Pneumococcal Immunizations	F 883		4/14/23

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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.

§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

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F 883	Continued From page 17 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 interview, the facility failed to administer a pneumococcal (pneumonia) vaccine as consented for 2 of 5 residents (Resident #12 and Resident #59) and failed to obtain a consent for 1 of 5 residents (Resident #11) reviewed for immunizations. Findings included: Review of the policy titled Pneumococcal Vaccine, which had a revision date of March 2022, read in part; all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. a. Resident #12 admitted to the facility on	F 883	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F. 883 D Corrective action the resident found to have been affected by the deficient practice: Residents #11, #12 and #59 still reside in the facility. Pneumococcal vaccine consents for residents #12 and #59 were obtained on 3/17/2023 while the consent for resident #11 was obtained on 3/26/2023. On 4/4/2023, all 3 residents received their pneumococcal vaccine. Corrective action for other residents	

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F 883

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06/25/20.

Review of the Quarterly Minimum Data Set (MDS) dated 01/27/23 revealed Resident #12 had cognitive impairment. Further review revealed the MDS coded the pneumonia vaccine as not up to date and the pneumonia vaccine was not offered.

A review of Resident #12's medical record revealed there was no documentation to indicate whether the resident received the pneumococcal vaccine in the community or while in the facility. Consent signed by family on 03/17/23 was noted in Resident #12's electronic medical record. No refusal form or nursing note revealing refusal was on file.

b. Resident #59 admitted to the facility on 10/08/21.

Review of the Quarterly Minimum Data Set (MDS) dated 01/06/23 revealed Resident #59 was cognitively intact. Further review revealed the MDS coded the pneumonia vaccine as not up to date and the pneumonia vaccine was not offered.

A review of Resident #59's medical record revealed there was no documentation to indicate whether the resident received the pneumococcal vaccine in the community or while in the facility. Consent signed by family on 03/23/23 was noted in Resident #59's electronic medical record. No refusal form or nursing note revealing refusal was on file.

c. Resident #11 admitted to the facility on 05/14/22.

Review of the Quarterly Minimum Data Set

F 883

having the potential to be affected by the same deficient practice:
On 3/17/2023, the DON and the SDC initiated a review off all residents for pneumococcal immunizations and started obtaining consents for residents that were not up to date with their immunizations. The review was completed on 4/4/2023. For the residents that gave consent, the vaccine was administered by 4/11/2023. For those that did not consent, the refusal was documented by the Nursing Administration Team. For new admissions, the DON, ADON, and the Unit Managers will follow up to ensure consent and/or refusal was obtained at admission. The Admissions Coordinator or designee will ask residents upon admission of the resident would like to have pneumonia vaccine and notify the nursing admin team. Education on the facility pneumococcal vaccine policy was conduct by the Administrator on 3/27/2023 for the Admissions Coordinator and the Facility Liaison, and the nursing administration team.
Systemic changes made to ensure that the deficient practice will not recur:

Education on the facility pneumococcal vaccine policy was conduct by the Administrator and the DON on 3/27/2023 for the Admissions Coordinator and the Facility Liaison, and the nursing administration team including the DON, ADON, and the Unit Manager. Education was completed on the same day. Any newly hired DON, ADON, Unit Managers, Admissions Coordinator, Facility Liaison

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(MDS) dated 01/25/23 revealed Resident #11 was cognitively intact. Further review revealed the MDS coded the pneumonia vaccine as not up to date and the pneumonia vaccine was not offered.

A review of Resident #11's medical record revealed there was no documentation to indicate whether the resident received the pneumococcal vaccine in the community or while in the facility. There was no consent signed by the resident's representative noted in Resident #11's electronic medical record. No refusal form or nursing note revealing refusal was on file.

An interview was conducted on 03/23/23 at 1:00 pm with the Director of Nursing (DON) and she indicated she was responsible for the vaccination process in the facility. She indicated around the second week of March 2023, they were reviewing the resident's vaccines and noticed that the pneumococcal vaccination rate was low, and they started looking into to getting consents from residents and their resident representatives so that they could offer the vaccines. The DON indicated they had already called half of the families as of last week. She indicated due to a loss of the staff development coordinator; it threw them off course as she was designated to complete the task. She indicated they were in the process of starting the vaccination process on 03/27/23 for all those that have consented. The DON indicated her expectation was for the pneumococcal vaccinations to be offered on admission and given as consented.

F 883

and, SDC will be educated on the pneumococcal vaccine policy by the Administrator and/or DON during new hire orientation before they assume their roles as per their job descriptions.
Plans to monitor its performance to make sure that solutions are sustained:

The Administrator and the DON introduced a pneumococcal vaccine observation tool on 3/23/2023 to be utilized by the DON, ADON, Unit Manager, and SDC for all our new admissions, re-admissions and, any update pneumonia immunizations. Any activity for pneumococcal vaccines will documented on this tool for ease of monitoring. The observation tool will be reviewed 2 times weekly for 4 weeks and then weekly for 3 months until compliance is maintained. The Administrator and the DON will review the observation tool weekly for 4 weeks and then monthly until compliance is maintained. Any areas of non-compliance will be reported by the Administrator and/or DON to the QAA Committee quarterly or as needed for further action to ensure compliance.

Date of Compliance: 4/14/2023