STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR REHABILITATION AND HEALTHCARE CENTER	1306 SOUTH KING STREET WINDSOR, NC 27983

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/07/23 through 08/10/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5JZT11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/07/23 through 08/10/23. Event ID# 5JZT11. The following intakes were investigated: NC00201697, NC00203479, NC00203701, NC00204941, NC00205003, NC00205004, and NC00205380. 11 of the 23 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		8/30/23

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

Electronically Signed | 08/25/2023

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 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to avoid the use of the term 'feeder' to refer to a resident who needed assistance with meals for 1 of 1 dining observation (Resident #22). The reasonable person concept was applied as individuals have the expectation of being treated with dignity and would not want to be labeled 'feeders'. Findings included: Resident #22 was admitted to the facility on 8/24/20. Review of Resident #22's minimum data set assessment dated 7/13/23 revealed he was	F 550	1. Nurse aide #2 and #4 were educated on 8/10/2023 to not use the term “feeder” related to the residents right to dignity. 2. All residents have a right to a dignified existence. No other resident was affected by the deficient practice. 3. All nursing staff will be educated by the DON or designee to ensuring residents are treated with dignity including not using the term feeder when resident requires assistance with being fed completed by 8/29/23. All new hires will be educated regarding dignity during the orientation process. 4. The Director of Nursing (DON) or designee will observe resident care during	

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F 550	Continued From page 2 assessed as severely cognitively impaired and required extensive assistance with eating. Review of Resident #22's care plan dated 6/19/23 revealed he was care planned for and activities of daily living self-care performance and mobility deficit related to dementia with behaviors. The interventions included for staff to provide assistance with meals. During observation on 8/7/23 at 12:32 PM Nurse Aide #4 saw Nurse Aide #2 enter Resident #22's room with his lunch tray. Nurse Aide #4 went to the entrance of Resident #22's room and told Nurse Aide #2 to bring the tray back and put it on the cart because Resident #22 was a 'feeder'. Resident #22 and Resident #22's roommate were within an audible distance of both nurse aides when Nurse Aide #4 stated this. During an interview on 8/7/23 at 12:32 PM Nurse Aide #4 stated she misspoke and should not have used the term 'feeder' as it could be a dignity concern. During an interview on 8/7/23 at 1:54 PM the Director of Nursing stated NA should not use the term feeder due to dignity concerns.	F 550	mealtimes for 15 residents to ensure residents are treated with respect weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the DON to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		8/30/23

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F 561	Continued From page 3 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to allow residents who were assessed to be safe smokers the ability to smoke independently per their individual preference for 2 of 8 residents (Resident # 38, and #41) reviewed for preferences. The findings included: 1. Resident #38 was admitted to the facility on 10/7/2022. A review of Resident #38's Smoking Agreement dated 2/24/2023 revealed he could smoke independently.	F 561	1. The smoking contract was revised on 8/21/23 by the corporate team to reflect all residents identified as smokers will be supervised while smoking. New smoking assessments and contracts were completed for all residents that currently smoke on 8/24/23 to reflect facility policy of supervised smoking for all residents regardless of smoking assessments. Any resident admitted prior to 8/21/23 who were assessed as independent smokers will be grandfathered in and allowed to choose to smoke independently. All new admits, after 8/21/23 that sign the new policy will adhere to supervised smoking. 2. Residents that smoke were affected	

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F 561	Continued From page 4 A review of Resident #38's Annual Care Plan dated 3/30/2023 revealed Resident #38 could smoke unsupervised. A review of the smoking assessments for Resident #38 dated 10/7/2022, 1/22/2023, and 6/8/2023 revealed he was a safe smoker and did not require supervision. The Quarterly Minimum Data Set (MDS) dated 6/8/2023 revealed Resident #38 to be cognitively intact. An interview with Resident #38 on 8/7/2023 at 10:39 a.m. revealed he was required to be supervised at smoke times since June 2023. Resident #38 revealed he had been assessed multiple times by the facility to be a safe smoker, and the facility administration did not explain to him why he must be supervised. Resident #38 stated he did not like the new policy. In an observation on 8/8/2023 at 1:48 p.m. Resident #38 was observed smoking while being supervised by the facility staff. An interview with the Administrative Assistant on 8/8/2023 at 1:45 p.m. revealed she was assigned to supervise residents when they go out to smoke since June 2023. She revealed it was a new facility policy. An interview with the Director of Nursing (DON) on 8/8/2023 at 8:45 a.m. revealed she was aware of a facility protocol requiring all residents who smoke to be supervised despite being assessed to be independent, and not requiring supervision while smoking.	F 561	by this practice. 3. Administrator was educated by the VPO on 8/21/23 regarding the new policy of supervised smoking for increased safety on, and smokers were educated on 8/24/23 by the Administrator. 4. The DON or Designee will audit 100% of smoking assessments for four weeks, then monthly x 2 months to ensure the assessment matches the smoking contract. Results will be presented by the DON to the Quality Assurance and Performance Improvement Committee monthly x 3 months for review and, if warranted, further action	

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F 561	Continued From page 5	F 561		

During an interview with the Administrator on 8/8/2023 at 2:39 p.m. she revealed a new facility policy from the corporate office since June 2023 required all residents who smoke to be supervised during smoking times. She revealed she received the instructions from the corporate office and had to implement the new policy though some residents were not happy with the new change.

2. Resident #41 was admitted to the facility on 4/13/2023.

A review of Resident #41's Annual Care Plan dated 5/1/2023 revealed she did not require supervision while smoking.

A review of the smoking assessment for Resident #41 dated 6/7/2023 revealed she was a safe smoker.

A review of Resident #41's Smoking Agreement dated 6/12/2023 revealed she could smoke independently.

Resident #41's Quarterly Minimum Data Set (MDS) dated 6/29/2023 revealed Resident #41 to be cognitively intact.

An interview with Resident #41 on 8/7/2023 at 10:00 a.m. revealed she signed a smoking agreement as a safe smoker on 6/12/2023. She revealed she was told she must be supervised while smoking. She revealed she was not happy with the new rule but had no choice. Resident #41 stated she felt the administration of the facility was unfair to her.

Resident #41 was observed on 8/7/2023,

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F 561	Continued From page 6 8/8/2023, and 8/9/2023 smoking under supervision of the facility staff. An interview with the Administrative Assistant on 8/8/2023 at 1:45 p.m. revealed she was assigned to supervise residents when they go out to smoke since Jube 2023. She revealed it was a new facility policy. An interview with the Director of Nursing (DON) on 8/8/2023 at 8:45 a.m. revealed she was aware of a facility protocol requiring all residents who smoke to be supervised despite being assessed to be independent, and not requiring supervision while smoking. During an interview with the Administrator on 8/8/2023 at 2:39 p.m. she revealed a new facility policy from the corporate office since June 2023, requiried all residents who smoke to be supervised during smoking times. She revealed she received the instructions from the corporate office and had to implement the new policy though some residents were not happy with the new change.	F 561		
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 interviews, the facility failed to provide showers, bed baths, or nail care for 2 of 5 dependent residents reviewed for activities of	F 677	1. Resident # 33 was offered a shower on 8/11/23. Resident # 16 received nail care on 8/10 /23.	8/30/23

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F 677	Continued From page 7 daily living (Resident #33 & Resident #16). Findings included: 1. Resident #33 was admitted to the facility on 3/15/23 with diagnoses which included Alzheimer's dementia. The quarterly Minimum Data Set dated 6/20/23 revealed that Resident #33 had severe cognitive impairment. He was also coded as total dependence for bathing. He was coded for no rejection of care. Resident #33's care plan last revised on 6/14/23 revealed interventions which included to anticipate and meet needs, use a soft toothbrush, use electric razor, and ensure the resident has an unobstructed path to the bathroom. Review of the facility shower book revealed Resident #33 was scheduled for showers on Tuesday and Friday on the 7:00 AM - 3:00 PM shift. An interview on 8/08/23 at 1:25 PM with NA #2 revealed she provided Resident #33's ADL care often as she was regularly assigned to that hall on the day shift. She stated she had never offered him a shower or bed bath. She also stated that she had never notified the nurse or Director of Nursing that she had not given him a shower or bed bath. NA #2 stated that Resident #33 had never refused care when she was assigned to him. She stated there was a shower book but she had not looked at it to see when Resident #33's showers were scheduled. She had no explanation why she had not provided him with a shower or bed bath.	F 677	2. All residents have the ability to be affected by the deficiency. An audit was completed to ensure all residents received a bed bath/ shower and nail care completed 8/25/23. The audit identified resident preferences for showers and or bed baths, all nail care was completed per resident preference 3. Nurses, Nurse aides, and medication aides will be educated by DON or Designee on ensuring residents receive bed bath/ showers and nail care per preference completed by 8/29/23. New hires will be educated during the orientation process. 4. The Director of Nursing (DON) or designee will observe resident care to ensure showers/bed baths and nail care are completed per resident preference for 15 residents weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the Unit Manager to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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F 677	Continued From page 8	F 677		

An interview on 8/09/23 at 12:59 PM with Nursing Assistant (NA) #4 revealed she was assigned to provide care for Resident #33 at times on the day shift (7:00 AM - 3:00 PM). She stated she had never given him a shower and he had never refused care when she was assigned to him. NA #4 stated she did not know what his shower schedule was, but she had given him bed baths when she was assigned to him. She stated she had not looked at the shower book this shift and was unaware that one of his scheduled shower days was today on her shift.

An interview on 8/09/23 at 1:15 PM with Resident #33 revealed he did not remember if he had a shower or bed bath recently. During this interview, the resident had a very strong body odor, his hair was neat, and his nails were trimmed.

An interview on 8/08/23 at 2:40 PM with the Director of Nursing (DON) revealed that the facility had a shower book with the days of the week each resident should receive a shower. She also revealed that the NAs were supposed to fill out a shower sheet for each resident when they are given a shower. This shower sheet should be given to the hall nurse. She stated that Resident #33 should have received a shower twice a week. The DON stated that Resident #33 lack of showering and other ADL care was due to lack of education and monitoring.

An interview on 8/09/23 at 1:32 PM with Nurse #3 revealed she was regularly assigned to the hall where Resident #33 resided. She stated that she had never observed Resident #33 go to the shower and had never received a shower sheet

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F 677	Continued From page 9	F 677		

from the NA for him. She also stated that the NAs had never told her he refused a shower or bed bath.

An interview on 8/09/23 at 10:13 AM with the Administrator revealed that there were no shower sheets for Resident #33 for the past 60 days. She stated that there was insufficient monitoring in place to ensure residents received complete ADL care.

2. Resident #16 was admitted to the facility on 5/29/13. His active diagnoses included hemiplegia following cerebral infarction affecting his left non-dominant side.

Review of Resident #16's minimum data set assessment dated 6/16/23 revealed he was assessed as cognitively intact. He had no behaviors and required extensive assistance with personal hygiene. He had functional limitation in range of motion on one side for both upper and lower extremities.

Review of Resident #16's care plan dated 6/23/23 revealed he was care planned for an activities of daily living self-care performance and mobility deficit related to a cerebral vascular accident with left hemiplegia and contractures of left arm and left knee. The interventions included to provide assistance with personal hygiene.

During observation on 8/7/23 at 11:38 AM Resident #16 was observed to have long fingernails on both hands.

During an interview on 8/7/23 at 11:42 AM Resident #16 stated his fingernails were long and he had asked for them to be trimmed but they

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F 677	Continued From page 10 had not been trimmed. He did not remember who he asked, and he stated he did not ask that morning during his morning bath. During observation on 8/8/23 at 11:21 AM Resident #16 was observed to have long fingernails on both hands. During an interview on 8/8/23 at 11:22 AM Resident #16 stated he forgot to ask that morning for his nails to be trimmed. During an interview on 8/8/23 at 1:47 PM Nurse Aide #2 stated she had not been trained to clip resident nails and did not know where the clippers were. She stated during morning care she noted his nails were long but did not trim them for this reason. She concluded she had not told anyone. During an interview on 8/8/23 at 3:02 PM the Director of Nursing stated residents should have their nails reviewed and trimmed by staff during morning care or least offered to have them clipped by staff.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		8/30/23

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F 684	Continued From page 11 by: Based on record review, resident, staff, and Physician interviews, the facility failed to provide a resident (Resident #58) medications after returning from the hospital. This occurred for 1 of 1 resident reviewed. Findings included: Resident #58 was admitted to the facility on 7-11-23 with multiple diagnosis that included diabetes. The 5-day Minimum Data Set (MDS) dated 7-16-23 revealed Resident #58 was cognitively intact. Resident #58's July 2023 Medication Administration Record (MAR) was reviewed. The following medications that were to be given between 8:00pm and 9:00pm on 7-26-23 were documented as not provided due to Resident #58 being hospitalized. " Crestor (cholesterol medication) 20 (milligrams) mg at bedtime. " Gabapentin (pain medication) 100mg 2 capsules at bedtime. " Mirapex (treats muscle spasms) 0.25mg 2 tablets at bedtime. " Vitamin E 400 units at bedtime. Review of the emergency room documentation for Resident #58 revealed the resident arrived in the emergency room at 2:07pm and was discharged at 5:57pm. Resident #58's medical record was reviewed. There was no documentation of Resident #58's return to the facility.	F 684	1. Resident # 58 no longer resides at the facility. 2. All residents who return to the facility from LOA have the ability to be affected by the deficient practice. An audit was completed on 8/21/23 to ensure medications have been given as ordered by the physician. The facility did not have any residents to return from LOA during the time of the audit. 3. Charge nurses, to include the Unit Manager and Assistant Director of Nursing will be educated by the DON or Designee on ensuring residents receive medications as ordered by the physician completed by 8/29/23. All new hires will be educated during the orientation process. 4. The Director of Nursing (DON) or designee will audit all residents who return from LOA or ED visit to ensure medications are administered as ordered by the physician weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the DON to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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Resident #58 was interviewed on 8-7-23 at 10:21am. The resident discussed not receiving his evening medications on 7-26-23. He stated he asked the nurse around 10:30pm why he had not received his medications and he said the nurse had told him she was unaware he had returned from the emergency room. Resident #58 stated he did not believe he had any ill effects from not receiving his medications.

During an interview with Nurse #1 on 8-8-23 at 4:12pm, Nurse #1 confirmed she had been assigned to Resident #58 on 7-26-23 and had worked 7:00am to 7:00pm. The nurse explained when a resident returned from the hospital, the hospital would call with a report and the transportation person would provide the receiving nurse with a packet of the paperwork from the hospital. Nurse #1 also confirmed she would have been on shift when Resident #58 returned from the hospital but stated she had not received a call from the hospital saying the resident was returning nor had she received any paperwork from transport. She stated she had walked down Resident #58's hall prior to leaving at 7:00pm but had not seen the resident in his room and said no other staff had informed her the resident had returned. The nurse explained when the 7:00pm nurse (Nurse #4) had come on shift, she reported to Nurse #4 that Resident #58 was still in the hospital.

A telephone interview occurred with Nurse #2 on 8-9-23 at 10:27am. Nurse #2 confirmed she had been working on 7-26-23 on the 7:00pm to 7:00am shift. The nurse explained she did not know the facility's process in receiving a resident who was returning from the hospital but stated

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the resident would have a packet with them containing the paperwork from their hospitalization. She stated she had not received report from Nurse #1 on 7-26-23 but said she had seen in the computer system the resident was sent to the emergency room earlier that day (7-26-23). Nurse #2 explained she did not know he had returned to the facility.

Nurse #3 was interviewed on 8-9-23 at 10:52am. The nurse confirmed she had worked from 7:00am to 7:00pm on 7-26-23. She explained the process for receiving a resident returning from the hospital. She stated the hospital would call with a report and the transportation driver would provide the paperwork to the receiving nurse. Nurse #3 stated she was not assigned to Resident #58 on 7-26-23 and she had not answered any calls from the hospital or received any paperwork from the transportation driver.

During a telephone interview with Nurse #4 on 8-9-23 at 3:34pm, Nurse #4 confirmed she had been assigned to Resident #58 on 7-26-23 during the 7:00pm to 7:00am shift. She stated when she arrived to work on 7-26-23 at 7:00pm, she was informed by Nurse #1 that Resident #58 was still in the hospital. Nurse #4 discussed not providing Resident #58 with any of his medications at bedtime because she believed the resident was still hospitalized. She confirmed she had walked down Resident #58's hall several times, but stated she never looked in his room. She also stated the resident never spoke with her during her shift.

A Nursing Assistant (NA) #1 was interviewed on 8-9-23 at 3:44pm. The NA stated she was aware Resident #58 had returned from the hospital

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because he had put his call light on a "few" times. She said she had provided him with care but had not told the nurses he had returned because she thought they were aware.

The Corporate Medical Director was interviewed by telephone on 8-10-23 at 8:36am. The Corporate medical Director discussed Resident #58 missing one dose of his evening medication would not have caused any harm but stated staff should provide medication as ordered.

During an interview with the Director of Nursing (DON) on 8-10-23 at 8:58am, the DON discussed when a resident was returning from the hospital, the hospital would call with a report and inform the facility the resident was on their way back. She said when the resident entered the facility, the transportation person would provide the hospital paperwork to the receiving nurse. The DON said on 7-26-23, she had received an email from the facility's hospital liaison informing her the hospital had been trying to call report on Resident #58 but had not been able to get through. She stated she informed Nurse #1 of the attempts from the hospital to call report on Resident #58. The DON also stated when she went to the nursing station, she saw the paperwork from the hospital sitting on the top of the rail at the nursing station, so she stated she placed the paperwork on the desk where Nurse #1 had been sitting. She explained when she learned of what had happened, she spoke with Nurse #1 who had told her she had been at lunch and was unaware the resident had returned. The DON also stated she spoke with Nurse #4 who told her she had been informed at the start of her shift that Resident #58 was still in the hospital, and she had not checked Resident #58's room all shift. The DON

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F 684	Continued From page 15 discussed expecting staff to call the emergency room prior to changing shifts to find out the status of the resident, perform room rounds with the on-coming staff, read the hospital paperwork and the midnight census report. The Administrator was interviewed on 8-10-23 at 9:11am. The Administrator stated she had not been aware of Resident #58 missing his medications or that staff were unaware of the resident's presence in the facility. She stated she expected the nurses to receive the paperwork from the hospital and would have expected Resident #58 be provided his medications.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and Physician interviews, the facility failed to follow a physician order for a pressure ulcer dressing change for 1 of 2 residents reviewed for pressure ulcers (Resident #39).	F 686	1. Resident #39 received treatments as ordered by the physician on 8/11/23. 2. All residents with treatments have the ability to be affected by the deficiency. An audit was completed on 8/25/23 by the	8/30/23

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F 686	Continued From page 16 Findings included: Resident #39 was admitted to the facility on 1-4-21 with multiple diagnoses that included stage 4 pressure ulcer to the sacrum, hemiplegia, and diabetes. The annual Minimum Data Set (MDS) dated 5-2-23 revealed Resident #39 was moderately cognitively impaired and was documented as having one stage 4 pressure ulcer. Resident #39's care plan dated 6-23-23 revealed Resident #39 had a potential and actual pressure ulcer related to hemiplegia and diabetes. The goal for Resident #39 was that her pressure ulcer will show signs of healing and remain free from infection. The interventions associated with the goal were administer treatments as ordered, assist with reposition and/or turn frequently, and observe skin integrity. A Physician order dated 6-28-23 revealed to cleanse the stage 4 sacral wound with normal saline or wound cleanser. Skin prep around the wound. Apply collagen powder and calcium alginate to wound bed. Cover with super absorbent silicone dressing daily and as needed. Review of Resident #39's Treatment Administration Record (TAR) for July 2023 revealed no documentation of wound care being performed on the following days. 7-12-23 7-14-23 7-15-23 7-19-23	F 686	DON to ensure all treatments were completed as ordered by the physician, with no negative findings all treatments were given as ordered. 3. Nurses will be educated by the DON or designee to ensure treatments are completed as ordered by the physician by 8/29/23. All new hires will be educated during the orientation process. 4. The Director of Nursing (DON) or designee will audit all residents with pressure ulcers to ensure treatments are administered as ordered by the physician weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the DON to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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Documentation of Resident #39's wound care on 7-5-23 revealed her stage 4 sacral wound measured 2.0 centimeters (CM) long by 0.8cm wide by 0.7cm deep with moderate drainage.

Documentation of Resident #39's wound care on 7-19-23 revealed her stage 4 sacral wound measured 3.0cm long by 1.5cm wide by 0.9cm deep with moderate drainage.

A Physician order dated 7-19-23 revealed to cleanse the stage 4 sacral wound with normal saline or wound cleanser. Skin prep around the wound. Apply iodosorb calcium alginate to wound bed and cover with a gauze island border dressing daily and as needed.

Review of Resident #39's TAR from 8-1-23 through 8-6-23 revealed no documentation of wound care being performed on 8-5-23.

On 8-7-23 at 11:10am Resident #39 was interviewed. The resident discussed having a pressure ulcer on her bottom and voiced concern the pressure ulcer was getting worse. Resident #39 also stated she was not receiving her wound care every day as ordered.

Observation of Resident #39's wound care occurred on 8-8-23 at 11:24am with Nurse #1. The old dressing was observed to be dated 8-7-23. The edges of the wound were within normal limits, there were no signs of maceration. Resident #39's wound bed was observed to be beefy red with minimal drainage and no odor.

Nurse #1 was interviewed on 8-8-23 at 11:55am. The nurse explained she was aware of when wound care needed to be completed when the

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order was highlighted in the computer system. Nurse #1 confirmed she worked on 7-19-23 and was assigned to perform wound care but stated she could not remember if she had completed the wound care for Resident #39. She stated if she had completed the wound care, she would have documented the completion of the resident's TAR. Nurse #1 discussed the facility having a wound care nurse but stated if the wound care nurse was not present then one or two of the nurses working the halls would be assigned to perform wound care.

An interview with Nurse #5 occurred on 8-8-23 at 3:27pm. Nurse #5 confirmed she worked on 7-14-23 and was assigned to do wound care. The nurse stated she could not remember if she had completed wound care on Resident #39 on 7-14-23 but said if she had completed the wound care, she would have documented the completion in Resident #39's TAR.

During a telephone interview with Nurse #6 on 8-8-23 at 3:37pm, Nurse #6 confirmed she was the wound care nurse on 8-5-23 and responsible for performing wound care on all the residents requiring wound care. The nurse explained she had not worked in the facility before and did not have access to the computer until the end of her shift. Nurse #6 stated she had not performed wound care on Resident #39 because she was unaware the resident required wound care.

Nurse #8 was interviewed on 8-9-23 at 10:58am. The nurse stated she was responsible for completing wound care treatments on the residents requiring wound care but said she could not remember if she had completed wound care for Resident #39 on 7-14-23. She explained she

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would have documented on Resident #39's TAR if she had completed the wound care.

The wound care Physician was interviewed by telephone on 8-9-23 at 9:42am. The wound care Physician stated he could not comment if Resident #39's wound could have been prevented. He explained the resident preferred to lay on her back which may have caused the wound. The Physician stated the missed treatments could have caused the deterioration of Resident #39's wound and that he expected staff to complete wound care as ordered.

The Director of Nursing (DON) was interviewed on 8-9-23 at 2:27pm. The DON explained the nurse would have to go to the resident's TAR to view what wound care treatments needed to be completed. She stated if the wound care was not completed, the treatment scheduled would turn red in the computer system indicating to the nurse the care had not been done. The DON discussed in the facility's morning clinical meeting, she would review her dashboard to monitor documentation and see what treatments had not been completed. She stated she was aware Resident #39 had missed wound care on the dates stated but said she had not been able to follow up with the nurses related to why the wound care had not been completed due to the lack of management staff. The DON stated she expected staff to complete wound care as ordered.

During an interview with the Administrator on 8-10-23 at 9:26am, the Administrator stated she was not aware Resident #39 had missed wound care treatments but expected treatment orders to be followed.

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F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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 observations, record review and staff and physician interviews, the facility failed to obtain post dialysis vital signs as ordered by the physician for 1 of 1 resident reviewed for dialysis (Resident #33). Findings included: Resident #33 was admitted to the facility on 3/15/23 with diagnoses which included end stage renal disease. Review of Resident #33's Physician's orders revealed an order dated 3/28/23 for vital signs post dialysis in the afternoon every Monday, Wednesday, and Friday. The quarterly Minimum Data Set dated 6/20/23 revealed that Resident #33 had severe cognitive impairment. He was also coded for dialysis. Review of Resident #33's care plan last revised on 5/05/23 included a focus for renal insufficiency with an intervention to monitor for signs and symptoms of hypovolemia or hypervolemia (fluid imbalances) which included increased pulse, increased respirations, and increased blood pressure.	F 698	1. Resident # 33 vital signs were completed on 8/10/23. 2. Residents that receive dialysis services have the ability to be affected by the deficient practice. All residents receiving dialysis had post dialysis vital signs completed on 8/25/23. 3. Nurses will be educated by the DON or designee to ensure Dialysis residents receive post dialysis vital signs completed on 8/29/23. All new nurse hires will be educated during the orientation process. 4. The Director of Nursing (DON) or designee will audit all residents receiving dialysis to ensure post dialysis vital signs are completed weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the Unit Manager to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	8/30/23

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Review of Resident #33's July 2023 Medication Administration Record (MAR) revealed that he was supposed to have post dialysis vital signs at 5:00 PM. Of the 13 days when he went to dialysis, he had 5 days of vital signs documented. There were no documented vital signs on July 3, 5, 10, 14, 17, 21, 24, and 31. Resident #33's vital signs were documented on July 7, 12, 19, 26, and 28.

Review of Resident #33's August 2023 MAR revealed that he had no vital signs documented on scheduled dialysis days August 2, 4, and 7, 2023.

An interview on 8/09/23 at 1:10 PM with Nurse #3 revealed that she was aware Resident #33 was to have vitals signs post dialysis. She stated Resident #33 was not in the facility at the time for his post dialysis vital signs on the July and August MAR on 7/31/23 and 8/02/23. She stated she documented that the resident was not in the facility at 5:00 PM on the MAR on 7/31/23 and 8/02/23 and the resident had returned after she got off work.

An interview was attempted on 8/10/23 at 9:40 AM for Nurse #8. Nurse #8 documented that Resident #33 was not in the facility on the July and August MAR on 7/03/23, 7/05/23, 7/10/23, 7/14/23, 7/17/23, 7/21/23, 7/24/23, and 8/07/23.

An interview on 8/09/23 at 3:01 PM with the Director of Nursing (DON) revealed that she was unaware that Resident #33's post dialysis vital signs were not being completed or documented. She stated that she did not know why these were not being completed.

An interview on 8/09/23 at 10:13 AM with the

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F 698	Continued From page 22 Administrator revealed that she was unaware of the post dialysis vital signs not being completed and did not know why this was not being done. The Medical Director was not available for interview. An interview on 8/10/23 at 8:47 AM with the Corporate Medical Director revealed that he felt the facility should follow physician's orders and obtain post dialysis vital signs for Resident #33 to monitor for hypotension.	F 698		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 2 days of 19 days (6-11-23 and 7-8-23) reviewed for staffing. Findings included:	F 727	1. All residents had the potential to be affected by the deficient practice. 2. Facility will ensure a Registered Nurse is scheduled at least 8 consecutive hours a day. 3. The Administrator educated the staff scheduler regarding a Registered Nurse	8/30/23

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F 727	Continued From page 23 Review of the facility's daily posting from 5-4-23 through 7-30-23 revealed there was no RN coverage for 6-11-23 and 7-8-23. During an interview with the facility's scheduler on 8-8-23 at 1:03pm, the scheduler stated if there was not a RN scheduled, she would reach out to in-house staff first and then contact the agency to try and find coverage. She said she was aware there was supposed to be a RN in the facility at least eight hours a day. The scheduler explained "somedays there just isn't any RNs to cover." The scheduler confirmed through timesheets 6-11-23 and 7-8-23 did not have RN coverage. The Director of Nursing (DON) was interviewed on 8-8-23 at 2:13pm. The DON discussed meeting with the scheduler two to three times a week to review the schedule. She stated she was aware there needed to be a RN in the facility at least eight hours a day and said the scheduler had informed her that the weekends often did not have RN coverage. The DON discussed she or the Assistant Director of Nursing often would cover the days when there was not RN coverage. She explained she was unaware there were days when there was not RN coverage and that she expected that there would be RN coverage at least eight hours a day. The Administrator was interviewed on 8-10-23 at 9:35am. The Administrator discussed not being aware there was not RN coverage on 6-11-23 and 7-8-23. She stated the facility had not been checking to make sure there was RN coverage but expected the Administration Team members to be checking to ensure there was RN coverage	F 727	being scheduled at least 8 consecutive hours a day completed on 8/10/23. All nurse management will be educated during the orientation process. 4. The Administrator or designee will audit a Registered Nurse is scheduled at least 8 consecutive hours a day weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the Administrator to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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F 727	Continued From page 24 at least eight hours a day.	F 727		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		8/30/23

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F 732	Continued From page 25 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to post accurate nurse staffing information for 19 of 92 days reviewed for daily posted staffing. Findings included: Review of the daily posted staffing from May 2023 through July 2023 revealed the daily posted staffing sheets were missing the daily Registered Nurse (RN) information for the following days: " May 2023: 5-4-23 and 5-14-23. " June 2023: 6-1-23, 6-11-23, 6-16-23, 6-19-23, 6-22-23, 6-24-23, 6-25-23, 6-26-23, and 6-29-23. " July 2023: 7-8-23, 7-9-23, 7-19-23, 7-22-23, 7-23-23, 7-28-23, 7-29-23, and 7-30-23. The facility's scheduler was interviewed on 8-8-23 at 1:03pm. The scheduler explained she was responsible for the daily posted staffing. She also explained when she was not present, the hall nurses were to change the daily posted staffing to reflect the correct working schedule. After reviewing the daily posted staffing from May 2023 through July 2023, the scheduler stated she did not know why there was not a RN documented on some of the daily posted staffing. She discussed being new to the position and stated she had not received training on how to complete the daily posted staffing. During an interview with the Director of Nursing (DON)on 8-8-23 at 2:13pm, the DON discussed the scheduler being responsible for the accuracy	F 732	1. No residents were affected by the deficiency. 2. The facility will ensure that posted nursing staffing is accurate. 3. The administrator completed an education on 8/10/23 with the scheduler to ensure an accurate daily nursing staffing is posted to be completed by 8/10/23. All nurses will be educated during the orientation process. 4. The Administrator will audit 5 postings to ensure an accurate daily nurse staff posting weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the Administrator to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action	

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F 732	Continued From page 26 of the daily posted staffing. The DON also explained she did not know if the daily posted staffing was reviewed by management. After reviewing the daily posted staffing from May 2023 through July 2023, the DON stated she was unaware there was not a RN documented. She stated she expected the daily posted staffing to be accurate. The Administrator was interviewed on 8-10-23 at 9:35am. The Administrator explained the scheduler was responsible for the daily posted staffing. She also explained the facility had not been checking the daily posted staffing for accuracy but expected the nursing administrative team members to be checking the daily posted staffing for accuracy.	F 732		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to schedule an appointment for a mammogram as ordered by the physician for 1 of 1 resident (Resident #19) reviewed for medically related social services. Findings included: Resident #19 was admitted to the facility on 9/02/22. The quarterly Minimum Data Set dated 5/05/23	F 745	1. Resident # 19 had a mammogram completed on 8/15/23. 2. Residents with physician ordered appointments may be affected by this citation. An audit was completed on 8/25/23 to ensure residents with physician ordered appointments are scheduled to be completed. There were no negative findings. 3. Nurses and medical records were educated by the DON or designee on 8/25/23 to ensure physician ordered	8/30/23

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F 745	Continued From page 27 revealed Resident #19 was a 66 year old female who had severe cognitive impairment. Review of Resident #19's physician's orders revealed an order dated 5/09/23 which read to obtain a mammogram to bilateral breasts. Review of the physician's progress note dated 5/09/23 revealed the mammogram was ordered at the resident's request. Review of Resident #19's electronic medical record revealed no evidence of a mammogram appointment. An interview on 8/08/23 at 3:02 PM with the Social Worker (SW) revealed she was responsible for scheduling appointments in May 2023. She stated she sent the request to the hospital to get an appointment scheduled in the radiology department as was the normal process. The SW stated she had not heard anything about the appointment, had not followed up to ensure an appointment was scheduled and the resident had not gotten a mammogram. An interview on 8/09/23 at 2:47 PM with the Director of Nursing (DON) revealed she was not employed at the facility in May 2023 and was unaware there was an order for a mammogram for Resident #19. She stated the changes in staffing had caused the appointment to be missed. An interview on 8/09/23 at 3:14 PM with the Administrator revealed that she was unaware of the physician's order for Resident #19 for a mammogram and did not know what happened or why the resident had not gotten the mammogram	F 745	appointments are scheduled for completion on 8/29/23. All new hires will be educated during the orientation process. 4. The Director of Nursing or Designee will audit 15 residents to ensure physician ordered appointments are scheduled and completed weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the Medical Records Clerk to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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F 745	Continued From page 28 as ordered. An interview on 8/10/23 at 8:47 AM with the Corporate Medical Director revealed he expected the facility to follow the physician's orders.	F 745		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and Physician interview the facility failed to prevent a significant medication error by failing to administer a prescribed antibiotic for 2 of 2 residents (Resident #39 and Resident #58) reviewed for medication errors. Findings included: 1. Resident #39 was admitted to the facility on 1-4-21 with multiple diagnoses that included diabetes, stage 4 sacral pressure ulcer, and hemiplegia and hemiparesis. The annual Minimum Data Set (MDS) dated 5-2-23 revealed Resident #39 was moderately cognitively impaired. A wound care note dated 8-2-23 by the wound care Physician revealed documentation that Resident #39's sacral wound had deteriorated and the Physician "suspected" a wound infection. Documentation also revealed the Physician wanted a wound culture to be completed and Bactrim DS (antibiotic) twice a day for 14 days	F 760	1. Resident #58 no longer resides at the facility. Resident #39 received medications as ordered by the physician. All residents have the potential to be affected by the deficiency. 2. All residents that receive antibiotics medications were audited to ensure that medications have been given as ordered by the physician on 8/29/23. 3. Nurses and Medication Aides were educated by the DON or designee to ensure medications are given as ordered by the physician on 8/24/23, with education to be completed by 8/29/23. All new nurses and medication aides with be educated during the orientation process. 4. The Director of Nursing or Designee will audit all residents with physician orders for antibiotics weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the ADON to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	8/30/23

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started while the results of the culture were pending.

Review of Resident #39's Physician orders from 8-2-23 through 8-6-23 revealed no order for Bactrim DS.

Review of Resident #39's Medication Administration Record (MAR) from 8-2-23 through 8-6-23 had no documentation of the resident receiving Bactrim DS.

Resident #39's wound culture report dated 8-5-23 revealed Resident #39 had a "heavy growth" of gram-positive cocci (indicative of an infection).

The physician's order dated 8-6-23 revealed an order for Linezolid (antibiotic) 600 milligrams (mg) every 12 hours for 10 days for wound infection.

A telephone interview occurred with the wound care Physician on 8-9-23 at 9:42am. The wound care Physician confirmed he had seen Resident #39 on 8-2-23. He described the resident's wound as having increased drainage, an odor, and an "obvious" infection. The wound care Physician stated he had told the nurse (Nurse #9) he wanted a culture performed and Bactrim DS started, and that the antibiotic could be changed depending on what the culture revealed. He stated he was unaware the Bactrim had not been ordered and explained delaying antibiotic therapy could have adversely affected the wound and Resident #39's overall health.

During a telephone interview with Nurse #9 on 8-9-23 at 1:21pm, Nurse #9 confirmed she was the facility's wound care nurse and that she had accompanied the wound care Physician on

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rounds on 8-2-23. She stated she remembered the Physician telling her he wanted Bactrim DS twice a day for 14 days started and a wound culture to be completed on Resident #39 for a possible wound infection but explained she was not told during her training that she was responsible for placing the wound care Physician orders into the computer system. Nurse #9 said she believed the Physician put his own orders into the computer system. The nurse confirmed she never entered the Bactrim order into the system for Resident #39 to receive.

An interview with the Director of Nursing (DON) occurred on 8-9-23 at 2:21pm. The DON discussed it was the responsibility of the wound care nurse to enter any orders from the wound care Physician into the computer system. She also stated the wound care nurse had been trained on the proper procedure for entering the wound care Physician's orders into the computer. The DON explained she had not been aware the Bactrim had not been ordered and Resident #39 had missed seven doses of the antibiotic. She stated she expected the wound care nurse to place orders in the computer system and carry out the Physician's orders.

The Administrator was interviewed on 8-10-23 at 9:21am. The Administrator stated she was unaware that the order for Resident #39's Bactrim had not been placed into the computer system causing the resident to miss seven doses of her antibiotic. The Administrator stated she expected residents to receive medications that had been ordered by the Physician.

2. Resident #58 was admitted to the facility on 7-11-23 with multiple diagnoses that included

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infection and inflammatory reaction to internal right hip prosthesis.

The 5-day Minimum Data Set (MDS) dated 7-16-23 revealed Resident #58 was cognitively intact and was documented as receiving intravenous (IV) therapy.

Resident #58's care plan dated 8-7-23 revealed Resident #58 was receiving IV antibiotic medication. The goal for Resident #58 was not to have any complications related to his IV therapy. The interventions for the goal were to observe for infection at the IV site and any signs or symptoms of leakage at the IV site.

A review of a Physician order dated 7-11-23 revealed Resident #58 was to receive Cefazolin (antibiotic) in sodium chloride intravenous solution 2-0.9 grams (GM)/100 milliliters (ml) every eight hours for surgical site infection.

Review of Emergency Room documentation dated 7-26-23 revealed Resident #58 arrived in the Emergency Room at 2:07pm for possible infiltration of his IV and was discharged back to the facility at 5:57pm.

Resident #58's Medication Administration Record (MAR) was reviewed from 7-26-23 to 7-27-23. The review revealed documentation of the resident still at the hospital when his 10:00pm dose of IV antibiotic was to be given on 7-26-23 and his 6:00am dose of antibiotic on 7-27-23.

On 8-7-23 at 10:21am, Resident #58 was interviewed. The resident discussed missing two doses of his IV antibiotics on 7-26-23 and 7-27-23. Resident #58 stated he had asked a

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nurse (could not remember name) why he had not received his IV antibiotics and he said the nurse had told him it was because the previous shift nurse did not know he had returned from the hospital. The resident stated he did not believe he suffered any harm from missing the doses of his antibiotic.

An interview with Nurse #1 occurred on 8-8-23 at 4:12pm. Nurse #1 confirmed she was assigned to Resident #58 on 7-26-23 from 7:00am to 7:00pm. She explained she sent the resident to the Emergency Room because "his IV site was red and swollen." The nurse stated when a resident was released from the hospital, the hospital would call with a report and transportation would provide the nurse with paperwork. She said on 7-26-23, the hospital had not called with a report, and she had not received any paperwork, so she was unaware Resident #58 had returned to the facility. The nurse explained when the 7:00pm nurse arrived, she reported to the nurse (Nurse #4) that Resident #58 was still in the hospital.

Nurse #4 was interviewed by telephone on 8-9-23 at 3:34pm. Nurse #4 confirmed she was the nurse assigned to Resident #58 on the 7-26-23 from 7:00pm to 7:00am. She explained when she arrived to work at 7:00pm she was informed by the previous shift nurse (Nurse #1) that Resident #58 was still in the hospital. The nurse stated she had walked down Resident #58's hall several times during the shift but had never checked his room. She confirmed she had not provided his 10:00pm IV antibiotic or his 6:00am IV antibiotic but had documented Resident #58 was in the hospital.

A telephone interview occurred with the Corporate

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medical Director on 8-10-23 at 8:36am. The Corporate Medical Director discussed Resident #58 missing two doses of his IV antibiotic would not have affected the resident or caused the infection to worsen. He stated he did expect staff to provide the residents with their medication as ordered.

The Director of Nursing (DON) was interviewed on 8-10-23. The DON discussed when a resident was returning to the facility from the hospital, the hospital will call with a report and transportation will provide the hospital paperwork to the nurse. She explained on 7-26-23, she had received an email from the facility's hospital liaison, stating the hospital had been trying to reach the facility to provide a report on Resident #58 as he was returning to the facility. The DON stated she informed Nurse #1 that the hospital was trying to contact her, and that Resident #58 was returning to the facility. She stated she went to the nursing station and saw Resident #58's paperwork on the top of the nursing station. She explained she picked up the paperwork and placed it on the desk where Nurse #1 had been sitting. The DON stated on 7-27-23 in the morning (not sure of the time) she had learned Resident #58 had missed two doses of his IV antibiotic. She stated she spoke with Nurse #1 who had told her she did not see the paperwork and was not aware Resident #58 had returned to the facility. The DON said she also spoke with Nurse #4 who stated she also did not know the resident had returned and she had not checked his room during her shift. The DON stated she expected staff to check on their residents and provide medications as ordered.

During an interview with the Administrator on

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F 760	Continued From page 34 8-10-23 at 9:11am, the Administrator stated she was unaware Resident #58 had missed his IV medications and said she expected staff to provide medications to the residents as ordered.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to date opened insulin for 2 of 3 (Hall 200 and Hall 300) medication carts reviewed for medication storage.	F 761	1. Insulins were replaced and dated when opened on 8/10/23. 2. An audit was completed on 8/15/23 to ensure insulin was dated when opened by	8/30/23

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F 761	Continued From page 35 Findings included: 1a. Hall 200 medication cart was observed on 8-9-23 at 8:10am with Certified Medication Aide (CMA) #1, who was working on the 200 Hall medication cart. The observation revealed the following insulins were open with no date. " Aspart 10 cubic centimeter (CC) multi vial insulin bottle. " Novolog Flex pen " Lantus Flex Pen " Glargine Flex Pen CMA #1 was interviewed on 8-9-23 at 8:13am. The CMA explained she had never looked at the insulin because she was not allowed to provide insulin to the residents. She further explained it was the responsibility of the nurse to provide the insulin. The CMA said she did not know who was responsible for checking the medication cart to ensure insulin was dated. 1b. Hall 300 medication cart was observed on 8-9-23 at 8:20am with Nurse #3 who was working on the 300 Hall medication cart. The observation revealed the following insulin had been opened but not dated. " Glargine 5cc multi vial insulin bottle Nurse #3 was interviewed on 8-9-23 at 8:22am. The nurse stated she checked her insulin for opened dates prior to providing insulin to the residents however said she was unaware the above insulin had been opened but not dated. Nurse #3 discussed not knowing who was responsible for checking the medication cart to ensure insulins that had been opened were dated.	F 761	the DON or designee. All insulin was dated, any opened undated insulin was disposed of appropriately. 3. Nurses and Medication Aides were educated to ensure insulin are dated when opened completed by DON or designee on 8/15/23 to be completed by 8/29/23. All new nurse and medication aide hires will be educated during the orientation process. 4. The Director of Nursing or Designee will audit 3 medication carts to ensure insulins are dated when opened weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the DON to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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F 761	Continued From page 36 During an interview with the Director of Nursing (DON) on 8-9-23 at 2:37pm, the DON explained the nurses were responsible for checking their medication carts each shift for any expired medication and to ensure all insulin had an opened date. She further explained a CMA was responsible for their medication cart but expected the nurse to follow up and ensure the medication cart did not have any expired medication and that the insulin was dated with the open date. The DON stated she expected every medication cart to be clean, free from expired medication and have all the opened insulin dated. The Administrator was interviewed on 8-10-23 at 9:33am. The Administrator discussed the Pharmacy Consultant checked the medication carts once a month and stated the DON was responsible for making sure the medication carts did not contain any expired medication and that the opened insulin was dated. She said she expected staff to be dating any insulin once it was opened.	F 761		
F 867 SS=E	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	F 867		8/30/23

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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 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:

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(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 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

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F 867	Continued From page 39 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 resident, staff and physician interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 9/2/20 focused infection control and complaint investigation survey, the 5/19/22 recertification and complaint investigation survey, the 10/19/22 complaint investigation survey, and the 3/8/23 complaint investigation survey. This was for one deficiency in the area of F880 Infection Prevention and Control that was cited on the 9/2/20 focused infection control and complaint investigation survey, 2 deficiencies in the areas of F550 Resident Rights and F677 Activities of Daily Living (ADL) Care that were cited on the 5/19/22	F 867	1. All residents have the potential to be affected by unsustained QAPI 2. A QAPI meeting was completed on 8/25/23 to review deficiencies. 3. The interdisciplinary team was educated by the VP of Clinical services to ensure an effective QAPI meeting is completed monthly on 8/10/23. New department heads will be educated by the VP of Operations during the orientation process. 4. The VP of Operations will ensure an effective QA meeting and compliance with POC is completed monthly for 3 months. Results of these audits will be presented by the DON to the facility Quality Assurance and Performance	

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F 867	Continued From page 40 recertification and complaint investigation survey, 1 deficiency in the area of F745 Medically Related Social Services that was cited on the 10/19/22 complaint investigation survey and 1 deficiency in the area of F550 Resident Rights that was cited on the 3/8/23 complaint investigation survey. These deficiencies were recited on the current recertification and complaint investigation survey of 8/7/23. The continued failure of the facility during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA. Findings included: This tag is cross referenced to: F550: Based on observation, record review, and staff interviews the facility failed to avoid the use of the term 'feeder' to refer to a resident who needed assistance with meals for 1 of 1 dining observations (Resident #22). The reasonable person concept was applied as individuals have the expectation of being treated with dignity and would not want to be labeled 'feeders'. During the recertification and complaint investigation survey on 5/19/22 the facility was cited for failing knock or announce their presence before entering resident's rooms. During the complaint investigation survey of 3/8/23 the facility was cited for failing to keep a resident's catheter bag covered and urine out of view. F677: Based on observations, record review, resident and staff interviews, the facility failed to	F 867	Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	

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provide showers, bed baths, or nail care for 2 of 5 dependent residents reviewed for activities of daily living (Resident #33 & Resident #16).

During the recertification and complaint investigation survey on 5/19/22 the facility was cited for failing to provide showers and failing to keep resident's nails clean and filed or trimmed.

F745: Based on record review, staff and physician interviews, the facility failed to schedule an appointment for a mammogram as ordered by the physician for 1 of 1 resident (Resident #19) reviewed for medically related social services.

During the 10/19/22 complaint investigation the facility was cited for failing to schedule a follow-up oncology appointment.

F880: Based on observation, record review, and staff interviews the facility failed to have a staff member stay out of work following testing positive for COVID-19 per the facility's return to work criteria, and the facility failed to don personal protective equipment (PPE) for 2 of 3 residents reviewed for isolation precautions (Resident #31 and Resident #48).

During the focused infection control and complaint investigation on 9/2/20 the facility was cited for failing to keep a resident under quarantine for COVID-19 after admission and for staff failing to wear the recommended personal protection equipment (PPE) when caring for residents.

On 8/10/23 at 10:04 AM an interview with the Administrator indicated she assumed her position as Administrator for the facility in February 2023

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F 867	Continued From page 42 when the facility ownership changed. She stated she did not have access to any of the previous QAA activity or performance improvement plan information from the previous ownership. She went on to say while she had reviewed the facility's last previous recertification survey deficiency information online, she had not been able to view the plan for correction of the deficiencies listed on it. The Administrator stated since she had started with the facility a lack of ADL care had been identified as an issue, but it was difficult for the facility to put effective measures in place to correct it when there were currently so many new administrative staff. She stated she felt this created a lack of effective leadership. She went on to say none of the other areas of repeated concerns had been identified.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		8/30/23

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providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880	Continued From page 44 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to have a staff member stay out of work following testing positive for COVID-19 per the facility's return to work criteria, and the facility failed to don personal protective equipment (PPE) for 2 of 3 residents reviewed for isolation precautions (Resident #31 and Resident #48). Findings included: 1. Review of the facility's return to work criteria for COVID-19 positive staff, last revised 5/16/23, revealed a staff member could return to work after at least 7 days have passed since symptoms first appeared if a negative viral test is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and at least 24 hours have passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) have improved. Review of a COVID-19 test for the Transport Driver revealed he tested positive 7/24/23. He had no further COVID-19 tests from that date. Review of the Transport Driver's punch in and out times revealed he clocked in to work on 7/24/23	F 880	1. All residents have the potential to be affected by this deficiency. 2. No other staff were off work based on infectious disease. Nursing Assistant #5 was educated on 8/7/23 to ensure appropriate PPE is utilized for isolation completed by NHA. 3. All staff were educated on handwashing and appropriate use of PPE completed on 8/7/23. The Administrator and DON educated staff on requirements for returning to work following illness initiated on 8/23/2023 to be completed by 8/29/23. 4. On 8/25 the Administrator was educated on the company's covid-19 policy by the VP of Operations. All new hire will be educated during the orientation process. 5. The ADON or designee will audit all employees out of work due to infectious disease illnesses to ensure employees return to work appropriately after an infectious disease and The Director of Nursing or Designee will audit 5 staff to ensure staff are utilizing appropriate PPE and effective handwashing weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the ADON to the facility Quality	

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at 10:08 AM and clocked out at 10:34 AM. He then clocked in on 7/26/23 at 6:08 AM and clocked out at 9:30 PM. He transported 3 residents on 7/26/23. He clocked in on 7/27/23 at 6:09 AM and clocked out at 5:03 PM. He transported no residents on 7/27/23. On 7/28/23 he clocked in on 6:13 AM and clocked out at 10:00 PM. He transported three residents on 7/28/23. On 7/31/23 he clocked in at 6:25 AM and clocked out at 10:01 PM. He transported 5 residents on 7/31/23. On 8/1/23 he clocked in at 6:02 AM and clocked out at 3:46 PM. He did not transport any residents on 8/1/23. None of the residents transported during this time tested positive for COVID-19 following transport on these days.

During an interview on 8/9/23 at 8:58 AM the Transport Driver stated on 7/24/23 he was congested and tested positive for COVID-19 at the facility. He left work and went to his primary care physician. The physician told him that he had sinus congestion and gave him some medication and told him if it cleared up, he could return to work. He stated the facility makes workers stay out of work for five days unless they get cleared from the physician. He called the physician's office the next day and told the physician his sinuses were clear, and the medication worked. His primary care physician told him he could go back to work, so he went back to work on 7/26/23. He stated he wore an N95 mask, and the residents also wore a mask as well during transport.

During an interview on 8/9/23 at 9:03 AM the Administrator stated the transport driver tested positive on 7/24/23 and left work. He went to his primary physician that day and got some

Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.

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medication. He reported feeling better on 7/25/23 and the physician told him he could return to work. The transport driver returned to work on 7/26/23 and when she questioned the Transport Driver why he was back, he stated that his primary care provider told him he was okay to return to work. She stated she spoke with the health department who indicated quarantine for COVID-19 should be for five days and was unsure why their policy said seven days must pass and a negative viral test obtained within 48 hours prior to returning to work. She stated she allowed him to return because he was released by his doctor and that that guided her decision.

During an interview on 8/9/23 at 11:23 AM the Director of Nursing stated she was not aware of the situation with the transport driver and coming back to work the day after he had tested positive. She stated had she been involved in this situation she would have asked for documentation that he could return to work from his physician. She stated she was the interim infection preventionist while they were searching for an infection preventionist, but the Administrator had taken over monitoring the COVID-19 outbreak testing log which was why she was not aware of the full story.

During an interview on 8/10/23 at 8:43 AM the Corporate Medical Director stated the staff should be allowed to return to work according to the Centers for Disease Control and Prevention (CDC) recommendations which were the same as the facility's return to work criteria.

2. An observation of Nursing Assistant (NA) #5 on Hall 200 occurred on 8-7-23 from 12:25pm to 12:35pm. NA #5 was observed to enter room 208

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(Resident #31) which had a "Special Droplet Contact Precaution" sign on the door indicating the NA should clean her hands before entering the room, wear a gown when entering the room, wear a N95 or higher mask when entering the room, wear protective eye wear, and wear gloves when entering the room. When NA #5 was observed entering room 208, the NA failed to don a gown or gloves. Upon exiting room 208, NA #5 was observed using hand sanitizer and then entering room 214 (Resident #48), which was also on "Special Droplet Contact Precaution" without donning a gown or gloves.

During an interview with NA #5 on 8-7-23 at 12:35pm, the NA confirmed room 208 and 214 were on precautions due to testing positive for COVID19. She discussed needing to wear a gown, eye protection, and gloves when entering either of the two rooms. NA #5 confirmed she had not donned gloves or a gown prior to entering room 208 or 214. She stated she thought there were circumstances when she did not need to wear a gown or gloves when entering a "Special Droplet Contact Precaution" room. The NA also stated she had not been educated in the different types of precautions.

Nurse #12 was interviewed on 8-7-23 at 1:37pm. The nurse stated with rooms on "Special Droplet Contact Precaution" staff needed to wear a face mask, eye protection, gown, and gloves. She explained that the face mask, eye protection, gown and gloves must be put on prior to entering the room. Nurse #12 stated the items should be worn every time a staff entered the room.

The Director of Nursing (DON) was interviewed on 8-7-23 at 1:43pm. The DON discussed the

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	345339	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR REHABILITATION AND HEALTHCARE CENTER	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 880	Continued From page 48 facility of having on-going monitoring for the proper wearing of protective equipment. She also discussed staff needing to don the appropriate protective equipment (face mask, eye protection, gown, and gloves) each time the staff member entered a "Special Droplet Contact Precaution" room. The DON stated she expected staff to follow the directions on the "Special Droplet Contact Precaution" sign prior to entering the room. The Corporate Medical Director was interviewed by telephone on 8-10-23 at 8:36am. The Corporate Medical Director discussed not wearing the appropriate protective equipment (face mask, eye protection, gown, and gloves) when entering a positive COVID19 room had the potential for the virus to affect other residents and staff. He also stated staff should be following the proper precautions and wearing the proper protective equipment each time they enter a "Special Droplet Contact Precaution" room. The Administrator was interviewed on 8-10-23 at 9:30am. The Administrator discussed the last infection control training was 6-19-23 and stated she believed NA #5 had attended the training. She stated she expected all staff to wear the appropriate protective equipment (face mask, eye protection, gown, and gloves) each time they entered a "Special Droplet Contact Precaution" room.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		8/30/23

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F 883	Continued From page 49	F 883		

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 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

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F 883	Continued From page 50 (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 offer the Pneumococcal 15-valent Conjugate Vaccine (PCV 15) or Pneumococcal 20-valent Conjugate Vaccine (PCV 20) in accordance with nationally recognized standards for 1 of 5 residents reviewed for immunizations (Resident #31). Findings included: Resident #31 was admitted to the facility on 3/16/18 and was over 65 years of age. Review of Centers for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccination last reviewed 4/27/23 read in part that if an individual 65 years or older, "[p]reviously received only PPSV23: 1 dose PCV15 OR 1 dose PCV20 at least 1 year after the PPSV23 dose. If PCV15 is used, it need not be followed by another dose of PPSV23." Review of Resident #31's immunization records revealed he received the pneumococcal polysaccharide vaccine (PPSV23) on 3/19/18 outside of the facility by his primary care provider.	F 883	1. Resident #31 was offered PVC 20 on 8/25/2023. All residents have the potential to be affected by the deficiency. 2. An audit was completed to ensure all residents were offered the appropriate pneumococcal vaccine completed by DON or designee on 8/22/23 a clinic date will be set to provide the appropriate pneumococcal vaccine. 15 orders were obtained to provide pneumococcal vaccine. 3. DON or designee will educate clinical staff to ensure residents are offered the pneumococcal vaccine completed on 8/29/23. All nurse new hires will be educated during the orientation process. 4. The Assistant Director of Nursing or Designee will audit 15 residents to ensure residents receive the pneumococcal vaccine as per CDC recommendations weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the ADON to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if	

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F 883	Continued From page 51 There was no documentation that Resident #31 had been offered the PCV 20. Review of Resident #31's minimum data set assessment dated 7/4/23 revealed he was assessed as moderately cognitively impaired. During an interview on 8/9/23 at 3:28 PM Resident #31 stated he did not remember being offered a vaccine for pneumonia by the facility. During an interview 8/10/23 at 8:26 AM the Director of Nursing stated she was the interim Infection Preventionist and did not know why another dose of the pneumococcal vaccine had not been offered to Resident #31. During an interview on 8/9/23 at 12:37 PM the Area Vice President Clinical Director stated Resident #31 should have been offered the Pneumococcal and it was not offered. During an interview on 8/10/23 at 8:43 AM the Corporate Medical Director stated he did not recall what the most recent CDC recommendations were, but the facility should follow CDC recommendations for pneumococcal immunizations.	F 883	warranted, further action.	