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	345539	A. BUILDING _____ B. WING _____	C 01/10/2024

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THE ARBOR	300 CLYNELISH CLOSE PITTSBORO, NC 27312

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E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		2/7/24

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

Electronically Signed | 02/01/2024

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a comprehensive facility specific Emergency Preparedness (EP) plan. The EP manual did not include a system to track staff and residents' during an emergency, arrangements with other facilities, names and contact information for facility staff, residents ' physicians, other facilities, and/or volunteers, emergency officials contact information, local surroundings, evacuation site, potential emergency specific situations related to the facility's location, or information regarding local resources such as the fire department in the event of an emergency. Findings included: A review completed of the facility's Emergency Preparedness plan material on 01/09/24 revealed: A. The supplied EP plan provided by the facility did not provide facility specific information, such as information about the facility staff, local surroundings, evacuation site, potential emergency specific situations related to the facility's location, or information regarding local resources such as the fire department in the event of an emergency. B. The facility provided EP plan did not provide information regarding a system to track the	E 001	The Emergency Preparedness plan will be updated by the Director of Safety and Security and the Administrator to include: Facility staff information Local surrounding information System for tracking the location of on-duty staff and sheltered residents Evacuation site Emergency specific situations related to facility location Local resource information and contacts The Administrator, Director of Security and Safety, or designee will complete random weekly audits for 4 consecutive weeks beginning on 2/5/24 of the Emergency Preparedness plan to ensure all pieces remain up to date. Specifically, the audit will review that the following are up to date: Facility staff information Local surrounding information System for tracking the location of on-duty staff and sheltered residents Evacuation site Emergency specific situations related to facility location Local resource information and contacts If in compliance, audits will then be done quarterly and audited records reviewed by the Risk Management/Quality Assurance	

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E 001	Continued From page 2 location of on-duty staff and sheltered residents in the facility's care during an emergency including the specific name and location of a receiving facility or other location. C. The supplied EP plan did not provide specific information for arrangements with other facilities and who would provide transportation. D. There were no names nor contact information for facility specific staff, residents' physician, other facilities, and/or volunteers in the supplied EP plan. E. The names and contact information for emergency officials contained in the EP plan was not facility specific. An interview was conducted on 01/09/24 at 8:51 AM with Life Safety Specialist. He stated the EP binder had not been updated since 2010 that he was aware of. He indicated the Director of Security and Safety had recently completed an update and that he was currently waiting for it to be reviewed. An interview was conducted on 01/10/24 at 2:14 PM with the Director of Security and Safety. He indicated the EP manual did not provide facility specific information such as local emergency information, community information, facility contact information, and other information specific to the facility. He stated he took over the responsibility of the EP manual in 2020 and the EP manual had not been updated since 2018. He verified the manual had not been updated with specific facility information due to him trying to manage staffing concerns and other obligations. He indicated other departments within the	E 001	Committee.	

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E 001	Continued From page 3 community had merged several positions which had made it challenging for him. He then stated that the EP manual was currently being updated. An interview was conducted on 01/10/24 at 2:59 PM with the Administrator. The Administrator indicated the EP manual had not been updated and was missing components. She stated the Director of Security and Safety was responsible for updating the EP manual and she was unaware it was not done. She further stated the EP manual was currently being updated.	E 001		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 01/08/24 through 01/10/24. Event ID# 0IPS11. The following intakes were investigated NC00199438 and NC00197808. 3 of the 3 complaint allegations did not result in deficiency.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of Hospice for Resident #7 and #5. This was for 2 of 8 residents reviewed for MDS accuracy. The findings included: 1. Resident #7 was admitted to the facility on	F 641	The MDS assessments for resident #7 and resident #5 were updated on 1/16/24 to indicate that they have a condition or chronic disease that may result in a life expectancy of less than 6 months. The facility has determined that of the 9 residents, no other residents have the potential to be affected. All 8 were	2/7/24

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F 641	Continued From page 4 01/24/23 with diagnosis that included chronic systolic congestive heart failure (CHF), and nonrheumatic aortic stenosis. Record review revealed Resident #7 started receiving Hospice services on 02/13/23. The quarterly Minimum Data Set (MDS) assessment dated 11/23/23 indicated Resident #7's cognition was severely impaired. Resident #7 was coded as not having a condition or chronic disease that may result in a life expectancy of less than 6 months although she was coded as receiving Hospice services while being a resident. Resident #7's active care plan, last reviewed on 11/24/23, included a focus area that read Resident #7 had a terminal prognosis. The interventions included for staff to work with Hospice team to ensure the residents spiritual, emotional, intellectual, physical and social needs are met. An interview was conducted on 01/10/24 at 11:51 AM with the Minimum Data Set (MDS) nurse. She verified Resident #7's Section J1400 was coded as "No". She stated she was unaware she was to look at the Hospice physician's notes and that she only looked at the facility physician's notes for Resident #7's life expectancy diagnosis. She then indicated she had not been doing MDS that long and it was an oversight (Had been in the MDS position since April of 2023). She further stated it was an oversight that she miscoded this question. She verified the resident was covered by Hospice and had a life expectancy of 6 months or less. An interview was conducted on 01/10/24 at 1:49	F 641	audited by the Administrator on 1/29/2024 and determined that #7 and #5 referenced in the 2567 were the only two currently receiving Hospice care. All MDS/Care planning nurses will be in-serviced regarding the facility policy for coding the MDS assessment accurately on 2/2/24 by Dianne Armstrong, Administrator. The DON, Administrator, or designee will complete random weekly audits beginning 2/5/2024 for 4 consecutive weeks of MDS accuracy for coding of residents receiving Hospice services. If in compliance, audits will be done quarterly and audit records reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 641	Continued From page 5	F 641		

PM with the Director of Nursing (DON). She stated the Minimum Data Set (MDS) assessment should have been coded to reflect Resident #7's Hospice status accurately.

2. Resident #5 was admitted to the facility on 10/26/23 with diagnosis that included chronic systolic congestive heart failure (CHF), and nonrheumatic aortic stenosis.

Record review revealed Resident #5 started receiving Hospice services on 11/24/23.

The significant change Minimum Data Set (MDS) assessment dated 11/24/23 indicated Resident #5's cognition was moderately impaired. Resident #5 was coded as not having a condition or chronic disease that may result in a life expectancy of less than 6 months although she was coded as receiving Hospice services while being a resident.

Resident #5's active care plan, last reviewed on 11/24/23, included a focus area that read Resident #5 had a terminal prognosis. The interventions included for staff to work with Hospice team to ensure the residents spiritual, emotional, intellectual, physical and social needs are met.

An interview was conducted on 01/10/24 at 11:51 AM with the Minimum Data Set (MDS) nurse. She verified Resident #5's section J under prognosis was coded as "No". She stated it was an oversight that she miscoded this question. She verified the resident was covered by Hospice and had a life expectancy of 6 months or less.

An interview was conducted on 01/10/24 at 1:49

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F 641	Continued From page 6 PM with the Director of Nursing (DON). She stated the Minimum Data Set (MDS) assessment should have been coded to reflect Resident #5 ' s Hospice status accurately.	F 641		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff resident interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 1 resident reviewed for respiratory care (Residents #64). The findings included: Resident #64 was admitted to the facility on 01/05/24 with diagnoses which included acute respiratory failure with hypoxia, vascular dementia, and hypertension. Resident #64's admission summary dated 01/05/24 indicated he had cognitive impairment and was using oxygen. A review of the physician orders for Resident #64 indicated an order dated 01/05/24 to apply 2 liters of oxygen for shortness of breath or for oxygen saturations of 90% or less as needed for	F 695	The oxygen for resident #64 was turned up to 2.0 liters on 1/10/24 at 2:09pm by the nurse on duty (Nurse #1). The facility has determined that of the 9 residents on Juniper, one (1) other residents has the potential to be affected. The other resident receiving oxygen was on the prescribed amount of oxygen and no further action was required. The audit was done by the ADON on 1/29/24. All licensed nurses will be educated on the proper administration of oxygen and how to set the rate of oxygen by Kelsey Shaw, ADON, by 2/7/2024. The DON, Administrator, or designee will complete random weekly audits for 4 consecutive weeks beginning 2/5/2024 of	2/7/24

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F 695	Continued From page 7 shortness of breath. Resident #64's care plan dated 01/08/24 indicated a focus area of Resident #64 had oxygen therapy related to congestive heart failure and respiratory illness. The goal indicated Resident #64 would have no signs or symptoms of poor oxygen absorption through the review date. Interventions included, in part, oxygen settings were to be at 2 liters continuously via nasal cannula. Resident #31's oxygen saturations were documented in his Electronic Medical Chart as followed: 01/08/24 at 6:24 PM - 98% via nasal cannula 01/09/24 at 9:48 AM - 96% via nasal cannula 01/09/24 at 7:45 PM - 96% via nasal cannula On 01/08/24 at 2:08 PM Resident #64 was observed to be sitting in his wheelchair with his eyes open. He did not appear to be in distress. The oxygen regulator on the concentrator was set to 1.5 liters flow when viewed horizontally at eye level. On 01/09/24 at 8:41 AM Resident #64 was observed to be sitting in a chair, awake, and eating breakfast. He did not appear to be in distress. The oxygen regulator on the concentrator was set to 1.5 liters flow when viewed horizontally at eye level. On 01/09/24 at 10:13 AM Resident #64 was observed to be lying in bed, with his eyes open, and watching TV. He did not appear to be in distress. The oxygen regulator on the concentrator was set to 1.5 liters flow when	F 695	the rate of oxygen administration. If in compliance, audits will be done quarterly and audit records reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 695	Continued From page 8	F 695		

viewed horizontally at eye level.

On 01/10/24 at 8:55 AM Resident #64 was observed to be sitting in a chair, awake, and eating breakfast. He did not appear to be in distress. The oxygen regulator on the concentrator was set to 1.5 liters flow when viewed horizontally at eye level.

On 01/10/24 at 12:51 PM Resident #64 was observed to be sitting in a chair, awake, and eating lunch. He did not appear to be in distress. The oxygen regulator on the concentrator was set to 1.5 liters flow when viewed horizontally at eye level.

On 01/10/24 at 2:00 PM Resident #64 was observed to be sitting upright in his chair with his eyes closed. He did not appear to be in distress. The oxygen regulator on the concentrator was set to 1.5 liters flow when viewed horizontally at eye level.

During an observation and interview on 01/10/24 at 2:09 PM with Nurse #1 she stated she was Resident #64's assigned nurse during the duration of the survey and checked the setting on the concentrator once a shift. She stated she viewed the settings at eye level. She stated she thought it was set at 2 liters because the top of the ball was touching the 2-liter line. She then adjusted the flow to administer 2 liters of oxygen as ordered. Resident #64 did not appear to be in distress during the observation. Nurse #1 checked his oxygen saturation during the observation, and it was 100% via nasal cannula.

During an interview with the Director of Nursing on 01/10/24 at 2:40 PM, she indicated Nurse #1

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F 695	Continued From page 9 was a new nurse; however, it was her expectation for oxygen to be delivered at the ordered rate.	F 695		
F 760 SS=E	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 Medical Director, Psychiatrist, Director of Nursing, and Consultant Pharmacist interviews, and record reviews, the facility failed to identify the need to clarify a physician's medication order for crushing Bupropion HCl SR (a sustained release antidepressant) for 1 of 6 residents reviewed for significant medication errors (Resident #65). This resulted in Resident #65 receiving 11 crushed doses of the medication over a 6-day period. Findings included: Resident #65 was admitted to the facility on 02/02/23 with diagnoses which included major depressive disorder, vascular dementia, and cognitive communication deficit. Resident #65's admission Minimum Data Set (MDS) assessment dated 02/09/23 indicated her cognition was moderately impaired and she received an antidepressant 7 out of 7 days since admission. Resident #65 care plan initiated on 02/15/23 indicated she used antidepressant medication related to diagnoses of anxiety disorder. The goal included, in part, that she would be free from	F 760	There was no corrective action to be taken for the affected resident as the medication in question was discontinued in February of 2023. The facility has determined that of the 9 residents, no other residents have the potential to be affected. All 9 were audited by the Administrator on 1/29/2024 and determined that no residents have orders to crush any of their medications. All licensed nurses will be in-serviced regarding crushing of medications and specifically the risks of crushing extended release medications, and instructed to clarify crushing orders for any extended release medication prior to implementation by 2/7/2024 by Kelsey Shaw, ADON. The DON, Administrator, or designee will complete random weekly audits for 4 consecutive weeks beginning 2/5/2024 of new orders to ensure medications ordered to be crushed are not extended release, and that if there was an order, that it was clarified with the physician prior to	2/7/24

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F 760	Continued From page 10 discomfort or adverse reactions related to antidepressant therapy. The intervention included, in part, to administer antidepressant medication as ordered by physician. A physician order dated 02/02/23 with an end date dated 03/08/23 indicated she would receive Bupropion HCl Extended Release (XL) 300 milligrams 1 time a day by mouth for depression. Another physician order dated 03/03/23 with an end date dated 03/08/23 indicated she would receive Bupropion HCl Sustained Release (SR) 100 milligrams by mouth two times a day for depression for 1 week and may crush in applesauce then increase to 150 milligrams. Review of the March 2023 Medication Administration Record indicated she received the following doses of the crushed Bupropion HCl SR: - 03/03/23 at 8:00 PM - 03/04/23 at 8:00 AM - 03/04/23 at 8:00 PM - 03/05/23 at 8:00 AM - 03/05/23 at 8:00 PM - 03/06/23 at 8:00 AM - 03/06/23 at 8:00 PM - 03/07/23 at 8:00 AM - 03/07/23 at 8:00 PM - 03/08/23 at 8:00 AM - 03/08/23 at 8:00 PM A physician note by the Medical Director dated 03/03/23 indicated Resident #65 was not taking Bupropion regularly and suggested to titrate Bupropion HCl SR so it could be crushed. A psychiatrist note dated 03/07/23 indicated	F 760	administration. If in compliance, audits will be done quarterly and audit records reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 760	Continued From page 11	F 760		

Bupropion Extended Release (XL) was changed to the SR formulation with an order to crush. The noted stated neither the XL nor SR formulation should be crushed. Doing so would destroy the slow-release mechanism and can create a "rush" or other side effects.

A review of the nurses notes from 03/03/23 through 03/08/23 indicated her mood was pleasant and there was no documentation of increased sadness or adverse side effects.

During a telephone interview with the Consultant Pharmacist on 01/09/24 at 10:42 AM, she stated she would not recommend delayed release medications to be crushed. She stated even though Bupropion SR was being crushed for 6 days, she would not expect there be adverse side effects because it was a short amount of time.

In a telephone interview with the Psychiatrist on 01/09/24 at 10:36 AM she stated prior to Resident #65 being admitted to the facility, she was hospitalized after a fall and hit her head without loss of consciousness. Prior to her admission to the facility, she was on a different antidepressant, but it was discontinued before her admission. She stated Bupropion was started at the time of her admission to the facility. She stated the XR nor SR formulation should be crushed because it could cause adverse side effects. She stated she did not know if any adverse side effects occurred when the Bupropion SR was being crushed because Resident #65 was already decompensating after her most recent hospitalization.

During a telephone interview with the Medical Director on 01/10/24 at 11:44 AM, she stated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 12 Resident #65 had dementia and her health had been declining prior to her admission to the facility. She stated she was notified of Resident #65 not taking the Bupropion XR regularly because she was spitting it out. She stated she changed the order to Bupropion SR with the order to be crushed. She stated she was notified by the pharmacy that the medication should not be crushed. She stated the crushed doses that she received would not have caused any adverse side effects. Attempts to reach the nurses who administered the crushed Bupropion SR were not successful. The Director of Nursing (DON) was interviewed on 01/10/24 at 2:50 PM. She stated she was not the DON at that time. She stated if she noticed an order to crush a medication that should not have been crushed, she would have notified the Medical Director and would have sought clarification.	F 760		
F 761 SS=D	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	F 761		2/7/24

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	345539	A. BUILDING _____ B. WING _____	C 01/10/2024

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F 761	Continued From page 13 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 observations, record review and staff interviews, the facility failed to discard expired medications in 1 of 1 medication storage room (Juniper Hall Med Storage Room). Findings included: An observation was conducted on 01/08/24 at 10:11 AM of the Juniper Hall medication storage room in the presence of Nurse #1. The observation revealed 9 unopened bottles of aspirin Enteric Coated (EC) 81mg tablets with an expiration date of 12/2023 marked on each bottle. Nurse #1 verified the bottles of aspirin were expired, removed them from the cabinet and put them in a basket to return to pharmacy. Nurse #1 confirmed the medications should not have been in the medication storage room. An interview was conducted on 01/10/24 01:49 PM with the Director of Nursing (DON). She stated the facility stopped ordering bottles of over the counter (OTC) medications a long time ago and the pharmacy had been sending all OTC medications to each resident in bubble cards.	F 761	The expired bottles of aspirin were disposed of on 1/10/24 by Margaret Clark, LPN. The medication storage room was inspected on 1/29/24 by Dianne Armstrong, Administrator, for expired medications and none were found. All licensed nurses will be in-serviced regarding expired medications by 2/7/24 by Kelsey Shaw, ADON. The DON, Administrator, or designee will complete random weekly audits for 4 consecutive weeks beginning 2/5/2024 of the medication storage room to ensure there are no expired medications. If in compliance, audits will be done quarterly and audit records reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the	

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F 761	Continued From page 14 The medications that were expired in the medication room were overlooked as they have not stored any OTC medications in the storage room for a long time now. The night shift supervisor checks the medication carts nightly for expired medications.	F 761	committee.	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a	F 887		2/7/24

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F 887	Continued From page 15 COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, the resident's representative and staff, the facility failed to educate and offer the COVID-19 vaccine on admission and failed to maintain a resident's record of COVID-19 vaccine history. This was for 1 of 5 residents reviewed for immunizations (Resident #2). Findings included: Review of the undated facility policy revealed in part:	F 887	The resident in question, #2, was reviewed for her vaccine status on 1/9/24 and immunizations downloaded from the UNC record and scanned into the facility electronic medical record. There were 9 residents identified to potentially be affected. All 9 had their records audited on 1/29/24 by Dianne Armstrong, Administrator, for documentation of COVID-19 vaccine administration and all were found to be in	

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F 887	Continued From page 16 · The facility will educate and offer the COVID-19 vaccine to residents, resident representative, or staff and maintain documentation of such. · The resident's medical record will include documentation of the following: a. Education to the resident or resident representative regarding the risks, benefits, and potential side effects of the COVID-19 vaccine. b. Each dose of COVID-19 vaccine administered to the resident. c. If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. Resident #2 was admitted to the facility on 12/04/23. Resident #2's admission Minimum Data Set (MDS) assessment dated 12/12/2023 indicated she was cognitively intact. Review of Resident #2's medical record revealed no documentation that the COVID-19 vaccine was offered, contraindicated, administered, or refused. No documentation that the COVID-19 vaccine education was provided, and no documentation of previous COVID-19 vaccines received. An interview was conducted on 01/10/24 at 9:59 AM with Resident #2 and her representative. They both stated that Resident #2 had not been offered a COVID-19 vaccine nor had the facility asked for proof of vaccinations on admission.	F 887	compliance. Immunization status, including COVID-19, will be discussed and vaccines offered as indicated at the initial care plan meeting which includes the social worker and MDS/Care plan nurse. The resident's vaccine record will be updated in the EMR as needed. Licensed nurses and the social worker will be in-serviced regarding immunization status, and specifically COVID-19 vaccination status, and the requirement to educate and offer vaccines upon admission to the facility by 2/7/24 by Kelsey Shaw, ADON. The DON, Administrator, or designee will complete random weekly audits for 4 consecutive weeks beginning 2/5/2024 of the immunization records of new admissions to ensure that immunization records are complete and that COVID-19 vaccines were offered if the resident has not previously received the COVID-19 vaccine. If in compliance, audits will be done quarterly and audit records reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 887	Continued From page 17	F 887		

Resident #2 and her representative both indicated they thought she had received all doses of the COVID-19 vaccine.

An interview was conducted on 01/09/24 at 11:05 AM with the Infection Control Preventionist/Assistant Director of Nursing (ICP/ADON). She indicated that vaccines should be discussed and offered on admission to the facility by the admitting nurse. If the resident has had some or all vaccines that information should be obtained and entered into the resident's medical record. Refusals should be documented in the nurses notes and under the immunization tab. She stated the COVID-19 vaccine was not offered to Resident #2 on admission. She further stated that prior to Resident #2's admission she was scheduled to receive a COVID-19 vaccine on 10/25/23, but she did not show up to the clinic to do so. The COVID-19 vaccine had not been offered or administered to Resident #2 as of 01/09/24.

An interview was conducted on 01/10/24 at 1:14 PM with the Infection Control Preventionist/Assistant Director of Nursing (ICP/ADON). She stated she spoke to Resident #2 and her representative related to the COVID-19 vaccine in which they stated the resident had previously received them. She then stated upon further investigation Resident #2 had not received the COVID-19 vaccine and was not offered the vaccine upon admission. She confirmed Resident #2's medical record did not include her COVID-19 vaccine history, nor did it include documentation that the COVID-19 vaccine was discussed or offered on admission to the skilled facility. She felt it was an oversight that her COVID-19 status had not been discussed on

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F 887	Continued From page 18 admission. An interview was conducted on 01/10/24 at 1:49 PM with the Director of Nursing (DON). She indicated that vaccines should be discussed and offered on admission to the facility. If the resident has had some or all vaccines that information should be obtained and entered into the resident's medical record. She was unaware Resident #2's vaccination information was not in her medical record. She felt it was an oversight that Resident #2's COVID-19 status was not addressed on admission.	F 887		