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	345366	A. BUILDING _____ B. WING _____	C 09/01/2022

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GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/29/2022 through 9/1/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 65O611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/29/2022 through 9/1/2022. Event ID# 65O611. The following intakes were investigated: NC00190528 and NC00188214. Two of 4 complaint allegations were substantiated resulting in a 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 must establish and maintain identical policies and	F 550		10/4/22

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

Electronically Signed | 09/26/2022

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F 550	Continued From page 1 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, resident interview and staff interviews, the facility failed to maintain a resident's dignity by not placing a privacy cover on an indwelling urinary catheter bag for 1 of 2 residents reviewed for dignity (Resident #14). Findings included: Resident #14 was admitted to the facility on 2/20/19 with diagnoses which included urinary retention and neuromuscular dysfunction of bladder. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 6/02/22 revealed Resident #14 was cognitively intact and had an	F 550	Greendale Forest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Greendale Forest Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate.	

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F 550	Continued From page 2 indwelling urinary catheter. During an observation on 8/29/22 at 10:30 am Resident #14's indwelling urinary catheter bag was observed attached to the left side of the bed without a privacy cover and urine was visible from the hall. During an interview on 8/29/22 at 10:49 am Resident #14 stated the some of the catheter bags have a privacy cover but the one they used this time did not have a one. Resident #14 stated she had visitors to her room and did not want them to have to see her urine and she was sure they didn't want to see her urine when they visited. During an observation on 8/30/22 at 9:02 am Resident #14's indwelling urinary catheter bag was observed attached to the left side of the bed without a privacy cover and urine was visible from the hall. During an observation on 8/30/22 at 2:37 pm Resident #14 was observed sitting in her power wheelchair in her room with the indwelling urinary catheter bag attached to the left side of the wheelchair. The indwelling urinary catheter bag did not have a privacy cover and urine was visible from the hall. During an interview on 8/30/22 at 2:40 pm Nurse Aide (NA) #2 who was assigned to Resident #14 revealed she was not sure if the indwelling urinary catheter bag required a privacy cover. During an interview on 8/30/22 at 4:11 pm Nurse #6 who was assigned to Resident #14 revealed the indwelling urinary catheter bag required a	F 550	Further, Greendale Forest Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Resident Rights/Exercise of Rights On 8/30/22, the Director of Nursing provided resident #14 a privacy covering for the Foley catheter drainage bag to maintain resident dignity. On 9/20/22, the treatment nurse initiated a 100% audit of all residents with Foley or Supra Pubic catheter to include resident #14. This audit is to ensure all Foley drainage bags were covered with privacy cover to maintain resident dignity. The treatment nurse will address all concerns identified during the audit. Audit will be completed by 10/4/22. On 9/23/22, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants regarding (1) Foley Catheters and (2) Resident Rights/Dignity and Respect with emphasis on ensuring each resident is treated 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 to include ensuring Foley drainage bags are covered with privacy cover to maintain	

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F 550	Continued From page 3 privacy cover. She stated the catheter bag usually came with a cover attached but she stated a privacy cover was available for the catheter bags that did not have the cover attached. Nurse #6 reported the catheter privacy covers were available and could be placed on the indwelling urinary catheter bag by any staff member. During an interview on 8/30/22 at 4:20 pm the Staff Development Coordinator (SDC) revealed indwelling catheter bags were required to have a privacy cover in place. She stated if the catheter bag did not have the attached privacy cover the facility had privacy bags that were to be used. The SDC stated all nursing staff were educated upon hire that an indwelling urinary catheter bag required a privacy cover, and any staff member was able to place the privacy bag on Resident #14's indwelling urinary catheter bag. During an interview on 8/30/22 the Director of Nursing (DON) revealed indwelling urinary catheter bags required a privacy cover and she stated all staff had access to obtain and anyone could place the privacy cover on Resident #14's indwelling urinary catheter bag. During an interview on 9/01/22 at 1:50 pm the Administrator stated Resident #14's indwelling urinary catheter bag was to have a privacy cover.	F 550	resident dignity. In-service will be completed by 10/4/22. After 10/4/22 any nurse or nursing assistant who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding (1) Foley Catheters and (2) Resident Rights/Dignity and Respect The treatment nurse will complete observations of all residents with Foley catheters or Super Pubic catheters to include resident #14 weekly x 4 weeks then monthly x 1 month utilizing the Foley Audit Tool. This audit is to ensure all Foley drainage bags are covered with a privacy cover to maintain resident dignity. The treatment nurse will address all areas of concern identified during the audit. The DON will review and initial the Foley Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will present the findings of the Foley Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Foley Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 561 SS=D	Self-Determination	F 561		10/4/22

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F 561	Continued From page 4 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. §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 observations, record review, resident and staff interviews, the facility failed to honor a dependent resident's request to smoke at the designated times for 1 of 2 residents reviewed for smoking (Resident #70). The findings included:	F 561	F561 Self-Determination On 8/29/22, the nursing assistant assisted resident #70 outside to smoke per resident preference.	

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F 561	Continued From page 5 Resident #70 was readmitted to the facility on 11/9/20 with diagnoses that included stroke with loss of strength on the left non-dominant side and muscle weakness. Resident #70's quarterly MDS dated 7/26/22 revealed he was severely cognitively impaired and was totally dependent on 2 staff persons with transfers. Review of the smoking assessment dated 8/8/22 revealed Resident #70 was assessed as a supervised smoker, and he did not have adequate hand dexterity (skill in performing tasks) or use of his upper extremities (arms, wrists, and hands). The smoking schedule was provided with designated smoking times in the morning of 10:00 AM and 11:30 AM. On 8/29/22 at 10:33 AM, Resident #70 stated he wanted to get out of bed to smoke. He was then instructed to use the call bell for assistance. An interview with nurse aide (NA) #3 on 8/29/22 at 10:47 AM revealed Resident #70 was a supervised smoker. She stated he wanted to go out to smoke, but she was not able to assist him at that time. NA #3 indicated she would get him up last after she attended to the other residents on the 100 hall. During a follow-up interview with NA #3 on 8/31/22 at 9:36 AM, she revealed she was not able to take Resident #70 out to smoke before lunch on Monday 8/29/22 because she had to finish her rounds, she could not find a mechanical	F 561	On 9/20/22, the Social Worker initiated resident questionnaires with all alert and oriented residents regarding Smoking. This audit is to identify any concerns related to staff assisting residents who desire to smoke. The Social Worker and Director of Nursing (DON) will address all concerns identified during the audit. The audit will be completed by 10/4/22 On 9/23/22, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants regarding Resident Preferences with emphasis on staff must attempt to honor resident preferences to include getting out of bed, shower, wake/sleep times, mealtime preferences and activities such as smoke time preference for smokers and notify the DON if preference cannot be honored for any reason. In-service will be completed by 10/4/22. After 10/4/22, any nurse or nursing assistant who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding Resident Preferences. The Social Worker will complete 10 Resident Care Audits-Resident Preferences to include resident #70 weekly x 4 weeks then monthly x 1 month. This audit is to ensure the staff honored resident preferences to include but not limited to preference for smoke time. The Social Worker will address all concerns identified during the audit to include but	

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F 561	Continued From page 6 lift, and then she had to leave for the day. She indicated there were only 2 NA for both 100 and 200 halls that day. During an interview with the Director of Nursing (DON) on 9/1/22 at 9:17 AM, she revealed the facility encouraged teamwork to fulfill resident choices. The DON stated NA #3 could have gotten another staff member to retrieve the mechanical lift and helped Resident #70 out of bed to smoke if that was his desire. An interview was conducted with the Administrator on 9/1/22 at 10:21 AM. She stated Resident #70 should have been able to go out and smoke at the designated smoking times if that was his choice.	F 561	not limited to re-training of staff. The Director of Nursing will review the Resident Care Audits-Resident Preferences weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the Resident Care Audits-Resident Preferences to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Care Audits-Resident Preferences to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		10/4/22

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F 583	Continued From page 7 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview and staff interviews, the facility failed to provide privacy when providing personal care to 1 of 30 residents reviewed for privacy. (Resident #98) Findings included: Resident #98 was admitted to the facility on 6/26/2018. The quarterly Minimum Data Set (MDS) assessment dated 8/5/2022 indicated Resident #98 was moderately cognitively impaired and used a urinary indwelling catheter for urine elimination. On 8/29/2022 at 4:12 p.m., Nurse Aide (NA) #4 entered Resident #98's room to empty the urine collection leg bag. While Resident #98 laid on his	F 583	F583 Personal Privacy/Confidentiality of Records On 9/1/22, the Director of Nursing verbally educated nursing assistant #4 (NA) regarding resident right to privacy with emphasis on pulling curtain and/or shutting door when providing care to include emptying foley drainage bag or observation of secure catheters for foley catheters. On 9/20/22, the Staff Development Coordinator initiated Resident Care Audits (Privacy) with all nurses, nursing assistants and therapy staff. This audit is to ensure staff honored resident right to privacy to include privacy during care and treatment. The Staff Development	

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F 583	Continued From page 8 bed, NA #4 was observed emptying the urinary collection leg bag without closing the door to the hallway and pulling the privacy curtain between Resident #98 and his roommate, Resident #88. After emptying the urinary collection leg bag with the privacy curtain not pulled between the two residents and the door open, NA #4 exposed Resident #98's right groin area for observation of the abdominal urinary suprapubic catheter secure device and exposed the left thigh and penis for observation of a second urinary suprapubic catheter located underneath the penis. Resident #88's bed was observed positioned parallel to Resident #98's bed, and he was observed lying on his back in his bed during the provision of care to Resident #98. On 8/29/2022 at 4:20 p.m. in an interview with NA #4, he stated he should had closed the door to the hallway and pulled the privacy curtain between Resident #98 and Resident #88 before providing care to Resident #98. He stated the reason privacy was not provided was because state surveyor was present in the room. On 8/30/2022 at 9:30 a.m. in an interview with Resident #98, he stated the nursing staff did not always pull the privacy curtain when providing resident care. He stated the nursing staff should have pulled the privacy curtain on 8/29/2022 when emptying the urinary collection leg bag and checking for the urinary secure devices because his roommate did not need to see everything when the nursing staff provided him care. On 9/1/2022 at 3:18 p.m. in an interview with the Director of Nursing, she stated resident #98's door should be closed and privacy curtains should be pull between residents to provide	F 583	Coordinator will address all concerns identified during the audit to include providing resident privacy and education of staff. Audit will be completed by 10/4/22. On 9/23/22, the Staff Development Coordinator initiated an in-service with all nurses, nursing assistants and therapy staff regarding Resident Rights/Dignity and Respect with emphasis on right to privacy during care and treatment. In-service will be completed by 10/4/22. After 10/4/22 any nurse or nursing assistant who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses, nursing assistants and therapy staff will be in-serviced during orientation regarding Resident Rights/Dignity and Respect. The Unit Managers will complete 10 Resident Care Audits (Privacy) to include resident #98 weekly x 4 weeks then monthly x 1 month. This audit is to ensure staff honored resident right to privacy to include privacy during care and treatment. The Unit Managers will address all concerns identified during the audit to include providing resident privacy and education of staff. The Director of Nursing will review Resident Care Audits (Privacy) weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the Resident Care Audits (Privacy) to the Executive Quality Assurance Performance	

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F 583	Continued From page 9 privacy during resident care.	F 583	Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Care Audits (Privacy) to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a Minimum Data Set (MDS) Significant Change in Status Assessment within 14 days of being admitted to hospice for 1 of 1 resident reviewed for Hospice (Resident #10). The findings included: Resident #10 was readmitted to the facility on 5/21/22 with a diagnosis of heart failure and hypertension.	F 637	F637 Comprehensive Assessment After Significant Change On 8/30/22, the Minimum Data Set Nurse (MDS) completed resident #10 MDS assessment for significant change related to hospice services. On 9/20/22, the MDS Consultant along with the MDS nurse initiated an audit of all residents MDS assessments for significant change to include resident #10	10/4/22

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F 637	Continued From page 10 The Annual Minimum Data Set (MDS) dated 5/27/22 revealed Resident #10 had severe cognitive impairment. A physician order was dated 8/11/22 and read, "hospice consult per decline." A review of a "Patient Comfort Care Kit" form from the hospice service revealed Resident #10 was admitted to Hospice on 8/12/22. A MDS Significant Change in Status Assessment dated 8/18/22 was observed with an Assessment Reference Date (ARD) of 8/18/22 was not completed and was in process. On 8/31/22 at 1:07 PM the MDS nurse was interviewed, and she stated they had 14 days from the ARD to complete the MDS. She stated Resident #10 was admitted to hospice on 8/12/22 and the ARD should have been 8/12/22 and not 8/18/22. She stated the MDS was late and should have been completed and processed. An interview was conducted with the Administrator on 9/1/22 at 3:06 PM and she stated she expected the MDS to be completed when due.	F 637	and residents receiving hospice services. This audit is to ensure assessments were completed within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition to include but not limited to residents receiving hospice services. The Director of Nursing (DON) and MDS consultant will address all concerns identified during the audit. Audit will be completed by 10/4/22. On 9/23/22, the MDS consultant initiated an in-service with the MDS nurse regarding MDS Assessment for Significant Change with emphasis on ensuring assessment is completed within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. All newly hired MDS nurses will be in-serviced during orientation regarding MDS Assessment for Significant Change. In-service will be completed by 10/4/22. The Unit Manager will audit all new MDS assessments related to significant change to include assessments for resident #10 weekly x 4 weeks then monthly x 1 month utilizing the MDS Audit Tool. This audit is to ensure assessments were completed within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition to include but not limited to residents receiving hospice services. The	

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F 637	Continued From page 11	F 637	Unit Manager will address all concerns identified during the audit to include completion of the assessment and/or re-training of staff. The DON will review the MDS Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the MDS Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the MDS Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code Minimum Data Set (MDS) assessments accurately for 3 of 32 residents reviewed in the areas of elimination (Resident # 97), nutrition (Resident #95), and mental illness (Resident #79). Findings included: 1. Resident #97 was admitted to the facility on 1/14/2022.	F 641	F641 Accuracy of Assessments On 09/01/22 The Minimum Data Set Coordinator (MDS) completed a modification to prior comprehensive assessment for Resident # 97 to reflect accurate coding for colostomy. On 09/21/22 The MDS Coordinator completed a modification to prior comprehensive assessment for Resident	10/4/22

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F 641	Continued From page 12 The admission Minimum Data Set (MDS) assessment dated 1/21/2022 indicated Resident #97 was cognitively intact and required extensive assistance with toileting. The MDS indicated bowel elimination was not rated and ostomy was not indicated. The care plan dated 1/27/2022 revealed Resident #97 had a diverting colostomy due to a stage IV sacral ulcer. Interventions included Resident #97 performing ostomy care and changing the colostomy bag. In an interview with the MDS Nurse #1 on 9/1/2022 at 9:10 a.m., she stated Resident #97 had a colostomy and missed coding the admission MDS for a colostomy. She stated she would need to modify the admission MDS for presence of a colostomy. In an interview with the Administrator on 9/1/2022 at 3:35 p.m., she stated MDS assessments should be coded accurately. 2. Resident #95 was admitted to the facility on 3/29/2016, and diagnoses included dysphagia and gastrostomy. A review of the physician orders dated 5/17/2022 revealed Resident #95 was ordered enteral feedings if she ate less than fifty percent of her meals and water flushes every six hours, and physician orders dated 7/13/2022 revealed Resident #95 was ordered a bolus enteral feeding once a day via gastrostomy tube. A review of July 2022 and August 2022 Medication Administration Record revealed Resident #95 was administered bolus enteral	F 641	# 95 to reflect accurate coding of diagnosis of dysphagia and gastrostomy. On 09/23/22 The MDS Coordinator completed a modification to prior comprehensive assessment for Resident # 79 to reflect accurate coding of mental illness to include diagnosis of Schizophrenia and PASARR level II. On 08/31/22 the Social Worker submitted for review of level II PASARR for resident #79. Resident was determined to be level II. On 09/23/22 the MDS consultant initiated an audit of section H for all residents most current MDS assessment, to include resident #97 to ensure all MDS assessments completed are coded accurately for bowel to include colostomy. The MDS completed modifications for all concerns identified during the audit. Audit will be completed by 10/04/22. On 09/23/22 the MDS consultant initiated an audit of section K for all residents most current MDS assessment, to include resident #95 to ensure all MDS assessments completed are coded accurately for enteral feedings (gastrostomy). The MDS completed modifications for all concerns identified during the audit. Audit will be completed by 10/04/22. On 09/23/22 the MDS consultant initiated an audit of section A for all residents most current comprehensive MDS assessment,	

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F 641	Continued From page 13 feedings daily after meals and at bedtime and received water flushes every six hours. The quarterly Minimum Data Set (MDS) assessment dated 8/3/2022 indicated Resident #95 was severely cognitively impaired and required extensive assistance with eating. Active diagnoses included a gastrostomy. There was no documentation on the MDS that indicated Resident #95 received enteral feedings for nutrition via gastrostomy tube. In an interview on 9/1/2022 at 9:18 a.m. with MDS Nurse #1, she stated Resident #95 was not using the gastrostomy tube for nutrition and was the reason feeding tube was not marked on the MDS. After reviewing the physician orders and July and August 2022 medication administration records, she stated nutrition by feeding tube should had been marked and would modify the MDS for Resident #95. In an interview with the Administrator on 9/1/2022 at 3:35 p.m., she stated MDS assessments should be coded accurately. 3. Resident #79 was admitted to the facility on 11/11/2019, and his diagnoses included Schizophrenia. The care plan dated 6/25/2020 revealed Resident #79 was receiving psychotropic drugs due to diagnosis of Schizophrenia, and interventions included observing his interactions with others and monitoring his mental status. The annual Minimum Data Set (MDS) assessment dated 7/1/2022 indicated Resident #79 was severely cognitively impaired and had an	F 641	to include resident #79 to ensure all MDS assessments completed are coded accurately for Level II PASARR when resident has level II qualifying diagnosis to include but not limited to Schizophrenia. The MDS completed modifications for all concerns identified during the audit. Audit will be completed by 10/04/22 On 09/20/22 the Social Worker initiated an audit of diagnosis for all residents with a Level I PASARR. This audit is to identify any resident with a newly added Level II PASARR qualifying diagnosis to ensure resident assessed for need to re-submit PASARR for evaluation. The Social Worker and/or Admission Director will address all concerns identified during the audit to include submission of Level II PASARR evaluation/re-evaluation. Audit will be completed by 10/04/22. On 09/23/22 the MDS Consultant completed an in-service with the MDS Coordinator and MDS nurse regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely. All newly hired MDS Coordinator and/or MDS nurse will be in-serviced by the Director of Nursing during orientation regarding MDS Assessments and Coding. On 09/23/22 the MDS Consultant initiated an in-service on Level II PASARRs with the Admission Director, Social Worker, Minimum Data Set Nurse (MDS), Director of Nursing with emphasis on referral for	

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F 641	Continued From page 14 active diagnosis of Schizophrenia with no display of unusual behaviors. There was no indication of mental illness for the Preadmission Screening and Resident Review (PASARR). In an interview with MDS Nurse #1 on 9/1/2022 at 9:21 p.m., she stated Resident #79 had a severe mental illness (SMI) diagnosis, Schizophrenia, and was not coded with a SMI because she did not have a PASARR Level II. She stated Resident #79 should had been coded with a mental illness, and she should have questioned Resident #79 not having a PASARR Level II screening with a diagnosis of Schizophrenia. In an interview with the Administrator on 9/1/2022 at 3:35 p.m., she stated MDS assessments should be coded accurately.	F 641	evaluation/re-evaluation of PASARR following changes in mental health status or newly Level II qualifying diagnosis. All newly hired Admission Director, Social Worker, Minimum Data Set Nurse (MDS), and Director of Nursing will be in-serviced during orientation on PASARRs regarding referral for re-evaluation following changes in mental health status. 10% audit of all resident□s most recent MDS assessments section A, section H, and section K will be completed by the Director of Nursing, Quality Assurance Nurse and/or Facility Consultant utilizing the MDS Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure accurate and complete coding of the MDS assessment to include section H for bowel continence to include colostomy, section K for enteral feedings (gastrostomy), section A for level II PASARR when a resident has a level II PASARR qualifying diagnosis. The MDS Coordinator, Administrator and/or Director of Nursing will address all areas of concern identified during the audit to include completion of resident assessment and/or retraining of the Social Worker/ MDS nurses when indicated. The Administrator will review and initial the MDS Accuracy Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns were addressed. The Administrator will forward the results of MDS Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months.	

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F 641	Continued From page 15	F 641	The Executive QAPI Committee will meet monthly x 2 months and review the MDS Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to obtain a physician order for finger-stick blood sugar checks for 1 of 1 resident reviewed for insulin (Resident #73). Findings included: Record review of the hospital discharge record dated 8/01/22 revealed Resident #73 had an order to continue at the facility for Insulin Lantus (long-acting insulin) 100 units/milliliter (mL) inject 0.4 mL/40 units under the skin at noon. Resident #73 was admitted to the facility on 8/01/22 with diagnoses which included diabetes and dementia. A physician order dated 8/01/22 for Lantus Solution 100 unit/mL inject 40 units subcutaneously one time a day for Diabetes management. Give at noon. The order was	F 658	F658 Services Provided Meet Professional Standards On 08/31/22 the Unit Manager clarified order for Lantus insulin for resident #73 to include parameter instructions on holding insulin and finger stick glucose monitoring. The medication administration record (MAR) was updated by the Unit Manager On 08/31/22 the Unit Manager completed an audit of all residents receiving diabetic medications to include insulin. This audit is to ensure all residents receiving diabetic medications to include insulin have clearly defined orders for blood glucose monitoring. The Unit Manager will address all concerns identified during the audit to include clarifying with the physician the	10/4/22

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F 658	Continued From page 16 discontinued on 8/10/22. Record review of the Minimum Data Set (MDS) Admission Assessment dated 8/08/22 revealed Resident #73 had moderate cognitive impairment and received insulin injections. A physician order dated 8/10/22 for Lantus Solution 100 unit/mL inject 40 units subcutaneously one time a day for Diabetes management. Give at noon hold if blood sugar (BS) is 150 or below. Record review of the Pharmacy Consultant Medication Regimen Review dated 8/17/22 revealed Resident #73 had an order for Lantus and required clarification of orders for finger-stick blood sugar (FSBS) check frequency. Record review of the Blood Sugar Summary report for Resident #73 revealed the FSBS was documented as obtained on 8/9/22 with a BS of 114, 8/15/22 with a BS of 186, and 8/31/22 with a BS of 287. Record review of the Medication Administration Record (MAR) note dated 8/11/22 revealed Nurse #2 obtained a FSBS of 138 for Resident #73. Record review of the Medication Administration Record (MAR) note dated 8/12/22 revealed Nurse #2 obtained a FSBS of 148 for Resident #73. Record review of the Medication Administration Record (MAR) note dated 8/16/22 revealed Nurse #2 obtained a FSBS of 140 for Resident #73. Record review of the Medication Administration Record (MAR) note dated 8/17/22 revealed Nurse	F 658	need for blood glucose monitoring for any resident receiving diabetic medications to include insulin. Audit will be completed by 10/04/22 On 09/23/22 the SDC initiated an in-service with all nurses regarding Blood Glucose Monitoring with emphasis on clarifying with the physician the need for blood glucose monitoring for any resident receiving diabetic medications to include insulin and/or any order that does not clearly define frequency/parameters of blood glucose monitoring. In-service will be completed by 10/04/22. After 10/04/22 any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Blood Glucose Monitoring. The Unit Manager will audit all newly admitted/readmitted residents three x a week x 4 weeks then monthly x 1 month utilizing the Blood Glucose Monitoring Audit Tool. This audit is to ensure residents receiving diabetic medications to include insulin have clearly defined orders for blood glucose monitoring. The Unit Manager will address all concerns identified during the audit to include clarifying with the physician the need for blood glucose monitoring for any resident receiving diabetic medications. The Director of Nursing will review the Blood Glucose Monitoring Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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F 658	Continued From page 17 #2 obtained a FSBS of 124 for Resident #73. Record review of the Medication Administration Record (MAR) note dated 8/18/22 revealed Nurse #2 obtained a FSBS of 120 for Resident #73. Record review of Physician Standing orders for Physician #1 and Physician #2 revealed no standing order for finger-stick blood sugar check was in place. During a telephone interview on 8/31/22 at 7:26 pm Nurse #4 revealed she completed the admission for Resident #73. She stated she entered the Lantus order as written from the hospital discharge record. Nurse #4 stated there was not an order for FSBS or hold parameters on the discharge record. She stated Lantus insulin was a long-acting insulin that did not usually have a parameter or FSBS checks associated with the medication. Nurse #4 stated Nurse Manager #1 reviewed admission orders and would clarify if there were any concerns. During an interview on 8/31/22 at 1:05 pm Nurse Manager #1 revealed that they usually have an order to obtain FSBS but not all physicians write them, and the nurse was able to use her judgement to obtain a FSBS. She stated the nurse that completed the admission should have confirmed with the physician if they wanted a FSBS. The Nurse Manager #1 stated she contacted Physician #1 and notified him of the admission and that Resident #73 was ordered Lantus at noon with no FSBS and he did not order a FSBS. She stated she reviewed admission orders the day after the admission but did not review again until the end of the month. Nurse Manager #1 stated she received the	F 658	The Director of Nursing will forward the results of Blood Glucose Monitoring Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Blood Glucose Monitoring Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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Pharmacy Consultant Medication Regimen Review dated 8/17/22 and corrected the recommendation for FSBS check frequency on 8/30/22 by adding a prompt to enter the FSBS but did not enter an order for blood sugar checks for Resident #73.

During an interview on 8/31/22 at 1:01 pm Nurse #2 revealed she notified Physician #2 on 8/10/22 that Resident #73 BS was low and requested to add a hold parameter to the insulin order to hold if BS less than 150. She stated she added the hold parameter to the order but did not add the order to obtain FSBS before administering the medication. Nurse #2 stated she completed the FSBS for Resident #73 each time she administered the insulin without a physician order because it was her safety net to ensure the BS was not too low. She stated it was her nursing judgement to check a blood sugar without a physician order. Nurse #2 stated she did not ask for the FSBS order from Physician #2 but should have clarified to get the order to check Resident #73 ' s blood sugar when the order was changed to hold for the parameter.

During a telephone interview on 8/31/22 at 6:56 pm Nurse #3 revealed she was assigned to provide care for Resident #73 on the weekends during the day shift. She stated she checked Resident #73 ' s blood sugar before she administered insulin without a physician order because she would not give insulin without checking blood sugar first. Nurse #3 stated the admission nurse or Nurse Manager should have clarified with the physician to obtain the order to check the blood sugar. Nurse #3 stated she did not call the physician to obtain an order to check Resident #73 ' s blood sugar before

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F 658	Continued From page 19	F 658		

administration of the Lantus.

During an interview on 8/31/22 at 1:24 pm the Director of Nursing (DON) revealed the nurses were expected to enter physician orders and to clarify if the FSBS check was needed. The DON stated admission orders were reviewed the next day in the clinical meeting and the Nurse Manager would clarify any orders that were needed. The DON was unable to state how the order for the finger stick blood sugar check was missed for Resident #73.

During a telephone interview on 8/31/22 at 3:49 pm Physician #1 revealed he would not have added a hold parameter to Resident #73 ' s Lantus order because it was a long-acting insulin. He stated an order for FSBS checks should have been obtained from the ordering physician or if the facility had standing orders the order could be entered into the medical record. Physician #1 stated the nurse should have clarified with him or Physician #2 for the order to obtain FSBS for Resident #73.

During a telephone interview on 8/31/22 at 4:48 pm Physician #2 revealed she spoke with Nurse #2 who reported Resident #73 ' s blood sugar was running low, and she requested a hold parameter for the Lantus. Physician #2 thought there was an existing order in place for the FSBS check but she did not confirm. She stated the nurse should have clarified with her when there was not an order for FSBS checks with the hold parameter for Lantus.

During an interview on 9/01/22 at 1:47 pm the Administrator revealed the nursing staff was responsible to obtain a physician order for FSBS

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F 658	Continued From page 20 check for Resident #73.	F 658		
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 record review, observations and staff interviews the facility failed to provide oral care and nail care for 1 of 5 residents (Resident #46) reviewed who were dependent on facility staff for activities of daily living (ADL). The findings included: Resident #46 was admitted to the facility 11/30/20 with diagnoses that included stroke with loss of strength/paralysis to the right dominant side, epilepsy, and diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated 7/6/22 revealed Resident #46 had severely impaired vision and was severely cognitively impaired with no rejection of care behaviors. He was totally dependent on 1 staff person for personal hygiene and bathing. An observation on 8/29/22 at 11:55 AM revealed Resident #46 had a yellow, dried coating on his bottom lip. During a phone interview with Resident #46's Responsible Party (RP) on 8/29/22 at 4:13 PM, she revealed she had observed Resident #46's mouth was not clean and had an odor during her	F 677	F677 ADL Care Provided for Dependent Residents On 8/31/22, the nursing assistant provided oral care to resident #46. On 08/31/22 the NA cleaned and trimmed resident #46 nails. On 09/22/22 the Medical Records Director, Central Supply Clerk, Scheduler, and NA/Transporter initiated an audit of activities of daily living (ADLs) for all residents to include resident #46. This audit is to ensure staff provide assistance to any resident who is unable to carry out activities of daily living to include but not limited to oral hygiene and nail care to maintain good nutrition, grooming and personal/oral hygiene. The DON will address all concerns identified during the audit. On 09/23/22 the SDC initiated an in-service with all nurses and nursing assistants regarding Activities of Daily Living (ADL) with emphasis on staff responsibility to provide assistance to any	10/4/22

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visit on 8/28/22. She stated his fingernails were too long, and she was afraid he would scratch himself.

An observation on 8/30/22 at 8:36 AM revealed Resident #46's bottom lip had a yellow, dried coating.

An interview was conducted with Nurse #2 on 8/30/22 at 2:06 PM. She revealed Resident #46 was a total assist and required daily ADL care from his head to his toes. She stated sponges were used to clean out his mouth, but sometimes he refused oral care. Nurse #2 indicated nursing staff were informed of daily care needs by the resident care plan.

An observation on 8/31/22 at 8:36 AM revealed Resident #46's face and lips were cleaned, and all 10 of his fingernails were at least ¾ inch long.

During an interview with Nurse Aide (NA) #5 on 8/31/22 at 8:45 AM, she revealed she had given Resident #46 a full bed bath yesterday (8/30/22) around 11:45 AM. She indicated she did notice the yellow, dried substance on his lips prior to his bath yesterday. NA #5 stated she normally trimmed and cleaned his nails when bed baths were provided, but she had forgotten to do so the day prior.

An observation on 9/1/22 8:43 AM revealed Resident #46's 10 fingernails were at least ¾ inches long.
During a follow-up interview with Nurse #2 on 9/1/22 at 9:03 AM, she revealed she had not cut his nails this week because she had not even thought about it. Nurse #2 stated podiatrists cut toenails for diabetics and nurses assist with

resident who is unable to carry out activities of daily living to include but not limited to oral hygiene and nail care to maintain good nutrition, grooming and personal/oral hygiene. In-service will be completed by 10/04/22. After 10/04/22 any nurse or nursing assistant who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding Activities of Daily Living.

The Medical Records Director, Central Supply Clerk, Scheduler and NA/ Transporter will review ADL care for 10 residents to include resident #46 weekly x 4 weeks then monthly x 1 month utilizing the ADL Audit Tool. This audit is to ensure the staff provide assistance to any resident who is unable to carry out activities of daily living to include but not limited to oral hygiene and nail care to maintain good nutrition, grooming and personal/oral hygiene. The DON will address all concerns identified during the audit to include but not limited to assisting residents with ADL care when indicated and/or re-training of staff. The Director of Nursing will review the ADL Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.

The DON will present the findings of the ADL Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet

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F 677	Continued From page 22 fingernails. An interview was conducted on 9/1/22 at 9:28 AM with NA #6, who had worked with Resident #46 from 7:00 AM - 3:00 PM on 8/29/22. She revealed her morning routine was to give all residents on her hall a full bed bath, perform incontinence care, and change their bed sheets if necessary. On 8/29, NA #6 stated she had cleaned Resident #46's shoulders, groin and bottom areas, and his face. She indicated the yellow, dried substance was on his lips daily, and if she wiped his lips too hard then they would bleed. NA #6 stated she was not able to give Resident #46 a full bed bath on 8/29 because she was the only NA on the 200 hall and did not have time. An interview was conducted on 9/1/22 at 9:00 AM with Nurse #7, who had worked with Resident #46 from 7:00 AM - 3:00 PM on 8/29/22. She revealed she did not even notice his nails that day. Nurse #7 indicated she usually assisted with nail care for diabetic residents. During an interview with the Director of Nursing (DON) on 9/1/22 at 9:13 AM, she revealed whenever a resident displayed a dirty face/mouth, nursing staff should have provided cleaning assistance. She indicated there should never be any yellow, dried substance on Resident #46's mouth, and daily cleaning should have been performed throughout all shifts. The DON stated fingernails should have been cut by the nurse whenever they appeared long, and the nurse should have checked Resident #46's nails daily because he is a diabetic. If any staff member did not feel comfortable cutting nails, they should notify the nurse manager.	F 677	monthly for 2 months and review the Resident ADL Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 677	Continued From page 23 An interview was conducted with the Administrator on 9/1/22 at 010:22 AM. She revealed her expectation was for Resident #46's face/mouth to be cleaned daily and as needed. The Administrator stated nail care should be monitored by nursing staff and attended to as needed.	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 by: Based on record review and staff interview the facility failed to complete dressing changes on 1 of 2 resident reviewed for wound care (Resident #44). Findings included: Resident #44 was admitted to the facility on 3/31/20 with diagnoses including cerebral infarction and type 2 diabetes mellitus. A review of the quarterly Minimum Data Set (MDS) dated 7/2/22 revealed Resident #44 had moderate cognitive impairment. He required extensive assessment with bed mobility and toilet use. He needed supervision for transfers and	F 684	F684 Quality of Care On 09/23/22 the hall nurse assessed resident #44 skin/wounds. The treatment nurse notified the physician of all concerns identified during the assessment, initiated treatment per facility protocol and/or physician order and updated the treatment administration record (TAR) for all new orders. On 09/20/22 the Treatment Nurse initiated a 100% audit of all TARs from for the past 14 days to ensure treatments were completed per physician□s order. The DON will address all areas of concern	10/4/22

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F 684	Continued From page 24	F 684		

was independent with eating after set-up assistance. Resident #44 was not coded for refusal of care.

Record review for Resident #44 revealed the following physician order:

Hydrogen Peroxide Solution 3% apply to left hand topically two times a day for
wound healing. Soak entire hand in half hydrogen peroxide and half warm water solution for 30 minutes. After soaking hand, dry the area and place dry gauze
over the incisions and wrap with dry kerlix. The order started on 2/23/22 and was discontinued on 3/9/22. This order was scheduled 2 times a day at 8:00 AM and 8:00 PM.

Record review revealed Resident #44 was diagnosed with Methicillin Staph Aureus (MRSA) with cellulitis to the left hand.

A review of the Treatment Administration Record (TAR) for March 2022 revealed the order was not documented as completed on 3/1/22, 3/2/22, 3/4/22, 3/7/22, and 3/8/22 at 8:00 PM.

Record review revealed Medication Aid #3 was scheduled to work at the facility on 3/1/22 from 3:00 PM until 11:00 PM and assigned to Resident #44.

Medication Aid #3 was interviewed on 9/1/22 at 10:16 AM and she stated she was from an agency and worked at the facility a few times. She stated she does not do dressing changes and doesn ' t recall if she looked to see if Resident #44 had a treatment ordered.

identified during the audit to include assessment of the resident, notification of MD of treatment omission for further instructions and education of the nurse. Audit will be completed by 10/04/22.

On 09/23/22 the SDC initiated an in-service with all nurses regarding TAR Documentation/Treatments with emphasis on nurse□s responsibility on initiating treatments or completing treatments per physician order with documentation in the electronic treatment record. In-service will be completed by 10/04/22 After 10/04/22 any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding TAR Documentation/Treatments

The DON will review TAR documentation 5 times a week x 4 weeks then monthly x 1 month to include weekends utilizing the Medication Administration Audit Report for treatments. This audit is to ensure all treatments are completed per physician□s order with documentation in the electronic record. The DON will address all concerns identified during the audit. The Director of Nursing will review the Medication Administration Audit Report for treatments 5 times a week x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed.

The DON will present the findings of the Medication Administration Audit Report to the Executive Quality Assurance

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F 684	Continued From page 25 On 9/1/22 at 9:53 AM an interview was conducted with MA #4 who worked from 3:00 PM until 11:00 PM on 3/4/22 and 3/7/22 and was assigned to Resident #44. She stated she did not recall Resident #44 having hand soaks or a dressing change. MA #4 stated she doesn ' t complete treatments and doesn ' t look to see if a resident has a treatment ordered. She also stated some of the medication aids are trained to complete treatments, but she had not been trained to do them. On 09/01/22 at 10:05 AM an interview was conducted with MA #5 who stated she was assigned to work from 3:00 PM until 11:00 PM on 3/2/22 and 3/8/22 and assigned to Resident #44. She stated she does not do treatments and she does not look to see if Resident #44 needed a treatment. The wound nurse was interviewed on 09/01/22 at 10:36 AM and was asked about Resident #44 not getting his dressing changed as scheduled at 8:00 PM. She stated Resident #44 was very social and wouldn't stay in his room for long periods of time. She stated she had to encourage him to let her do the dressing changes. The wound nurse stated she felt like the evening dressing changes were not being charted because Resident #44 was not letting the nurses do the dressing change. She stated she remembered talking to Resident #44 ' s physician who was taking care of his hand and telling her about Resident #44 ' s resistance to care. The wound nurse recalled the physician had stated to keep doing what you are doing and just monitor him for signs of infection. On 09/01/22 at 10:56 AM an interview was	F 684	Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Medication Administration Audit Report to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 684	Continued From page 26 conducted with Nurse Manager #1, and she stated the nurse would be responsible for doing wound treatments on Resident #44 if the medication aids could not do them. She stated she does not track treatments to make sure they are being completed. Nurse #10 was interviewed on 9/1/22 at 11:07 AM. She stated if she was working 3/1/22 and was supervising MA #3. She stated she remembers Resident #44 having a problem with his hand but doesn ' t remember if she did a dressing change for him. She stated if she had completed a dressing change on Resident #44, she would have documented it. Nurse #4 was interviewed on 9/1/22 at 11:51 AM and she stated she was working on 3/4/22 from 3:00 PM until 11:00 PM. She stated she was supervising MA#4 who was assigned to Resident #44. Nurse #4 stated she remembered doing one soak and dressing change for Resident #44 but could not remember what day. Record review revealed there were no negative outcomes related to the missed dressing changes. On 09/01/22 at 12:34 PM the DON was interviewed, and she stated it is her expectation wounds treatments get completed and charted in the electronic record.	F 684		
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	F 761		10/4/22

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F 761	Continued From page 27 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 observations, record review and staff interviews, the facility failed to label medications with resident information and with the date the medication was opened and an expiration date on 2 of 7 medication carts (800-hall and 700-hall medication cart) and failed to discard expired medications on 2 of 7 medication carts (300-hall and 400-hall medication cart) and in 1 of 2 medication storage rooms (300-400 hall medication storage room) inspected for storage of medications. Finding included: 1. An observation of the 800-hall medication cart	F 761	F761 Label/Store Drugs and Biologicals On 08/31/22 the DON removed and destroyed all medications that were not labeled with an open date and/or expiration date and any expired medications from the 300, 400, 700 and 800 hall medication carts and 300-400 hall medication storage room per facility protocol. On 09/22/22 the Unit Manager and QI Nurse an audit of all medication carts to include 300, 400, 700 and 800 hall medication carts and medication rooms to	

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F 761	Continued From page 28 on 8/31/2022 at 3:17 p.m. was conducted in the presence of Medication Aide (MA) #1. The observation revealed a Soliqua Insulin pen for Resident #11 with a label that read expires twenty-eight days after opening. There was no open date or expiration date observed written on the Soliqua Insulin pen label. In an interview with MA#1 on 8/31/2022 at 3:19 p.m. she stated she did not administer insulin to residents. She stated she did not know when the Soliqua Insulin pen was opened, and there was not a date written on the pharmacy label indicating when the Soliqua Insulin pen was opened. She stated the label indicated the Soliqua Insulin pen expired twenty-eight days after opening and there was no date written on the label indicating when the Soliqua Insulin pen would expire. On 8/31/2022 at 3:21 p.m., the Director of Nursing (DON) was present for the continuation of the 800-hall medication cart observation. There was an observation of an opened Lantus Insulin pen for Resident #11 with an open date of 7/28/2022 on the label and there was no expiration date observed written on the label. The label on the Lantus Insulin pen stated the Lantus Insulin pen expired twenty -eight days after opening. An opened Basaglar Insulin pen for Resident #7 was observed with no open date and no expiration date written on the pharmacy label. On 8/31/2022 at 3:23 p.m., the DON stated the Lantus Insulin pen was expired based on the date opened and discarded the Lantus Insulin pen in the sharp disposal. She stated there was no date written on the pharmacy label when the Basaglar was opened and discarded the Basaglar Insulin	F 761	include 300-400 medication storage room. This audit is to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed per facility protocol, and that all carts were locked when not supervised by assigned nurse. The DON will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility protocol and locking medication cart. The audit will be completed by 10/04/22. On 09/23/22 the Staff Development Coordinator (SDC) initiated an in-service with all nurses and medication aides regarding Medication Storage with emphasis on (1) labeling medications with an open date/expiration date per facility protocol (2) nurse/medication aid responsibility to check medication cart/medication storage room daily for expired medications and discarding expired medications per pharmacy policy and (3) storage of medication/securing medication cart when not directly supervised by assigned nurse. In-service will be completed by 10/04/22. After 10/04/22 any nurse or medication aide who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses or medication aides will be in-serviced during orientation regarding Medication Storage. The Unit Manager and QI Nurse will audit	

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pen in the sharp disposal. The DON stated nurses were to write the date Inulin pens were opened on the pharmacy label and an expiration date based on the number of days for expiration provided on the pharmacy label.

On 8/31/2022 at 3:27 p.m., Unit Manager #1 stated to the DON she was on the 800-medication cart on 8/29/2022, and she opened the Soliqua Insulin pen on 8/29/2022. Unit Manager #1 was observed writing 9/26/2022 as an expiration date on the label for the Soliqua Insulin pen and did not write a date the Soliqua pen was opened on the label.

On 8/31/2022 at 3:33 p.m., Nurse #8 stated she was on the 800-hall medication cart on 8/31/2022 for the 7:00 a.m. to 3:00 p.m. shift. She stated none of the residents received insulin coverage for that shift, and Resident #11 received her regular dose of Soliqua Insulin. She stated she did not recall checking for an expiration date prior to administrating the Soliqua Insulin.

2. On 8/31/2022 at 3:35 p.m., an observation of the 700-hall medication cart was conducted with the Director of Nursing (DON) and Nurse #9 present. An opened Lantus Insulin pen was observed with no resident identification and no opening date and expiration date was written on the pharmacy label. Nurse #9 disposed the Lantus Insulin pen into the sharp disposal.

On 8/31/2022 at 3:37 p.m., in an interview with the DON and Nurse #9, Nurse #9 stated she was beginning the 3:00 p.m. to 11:00p.m. shift and had not checked the 700-medication cart. They stated the date Lantus Insulin pen was opened and the expiration date, that was based on the

all medication carts and medication storage rooms weekly x 4 weeks then monthly x 1 month utilizing the Medication Cart/Medication Storage Room Audit Tool. This audit is to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed per facility protocol, and that all carts were locked when not supervised by assigned nurse. The DON will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility protocol and locking medication cart. The Director of Nursing (DON) will review Medication Cart/Medication Storage Room Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. for completion and to ensure all areas of concerns were.

The DON will present the findings of the Medication Cart/Medication Storage Room Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Medication Cart/Medication Storage Room Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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days indicated on the label from pharmacy, should be written on the pharmacy label when opened. They also stated the Lantus Insulin pen should be labeled with resident information.

3. On 8/31/2022 at 3:49 p.m., an observation of the 300-hall medication cart was conducted with the Director of Nursing (DON). An opened Lantus Insulin pen was observed with 8/16/2022 written as the expiration date. The DON stated the nurse probably wrote the opened date on the wrong line. An opened vial of Lantus Insulin was observed on the 300-hall medication cart with an expiration date 8/18/2022 written on the vial. The DON discarded the Lantus Insulin pen and the Lantus Insulin vial into the sharp disposal container.

4. On 8/31/2022 at 4:00 p.m., an observation of the 300-400 hall medication storage room was conducted with the Director of Nursing (DON). In the refrigerator, a bottle of magic mouth wash with an expiration date 8/11/2022 was observed and two intravenous antibiotic bulbs were observed dated with an expiration 8/8/2022. The DON stated the residents were no longer receiving the medications and discarded the medications in the medication disposal container. She stated the antibiotics should had been sent back to the pharmacy.

5. On 8/31/2022 at 4:03 p.m., an observation of the 400-hall medication cart was conducted with Unit Manager #2. Seven Acetaminophen 650 milligram suppositories with an expiration date 7/2022 were observed on the 400-medicaiton cart. Unit Manger #2 disposed of the suppositories into the medication waste container. She stated medication carts were

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F 761	Continued From page 31 checked by the Unit Managers for expired items once a week, and she checked her medications carts on Monday. On 8/31/2022 at 4:19 p.m. in an interview with Nurse #6, she stated before administration of medications, the medication was checked to assure the medication was the right medication, for the right resident, the right dose, right route and was not expired. She stated the medication carts were checked weekly for expiration of stock medications by the unit managers, and Insulin was administered in high doses that resulted in opening new vials more frequently. She stated when opening new Insulin pens or vials, the opening date and expiration date were written on the pharmacy label on the insulin. On 9/1/2022 at 9:00 a.m. in an interview with Nurse #2, she stated the Unit Managers were responsible for checking the medication carts for expirations weekly, and she checked for expirations of medications on her assigned medication cart daily. On 9/1/2022 at 3:11 p.m. in an interview with the Director of Nursing, she stated the pharmacy checked the medication monthly for expirations and did not have a date when the pharmacy last checked the medication carts. She stated assigned nurses of medication carts were to check the medication cart and medications for expiration dates before administering medication to the residents. She stated Unit Managers were responsible for checking their assigned medication carts and medication storage rooms for expired medications on Mondays.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		10/4/22

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F 812	Continued From page 32 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to 1) label and date leftover food items and 2) remove expired food stored for use in 1 of 2 nourishment refrigerators located in between the 700 and 800 resident halls. Findings included: An observation of the nourishment room in between the 700 and 800 halls was conducted on 8/31/22 at 9:14 AM, and the refrigerator/freezer were inspected. The following items were found inside the refrigerator: a plastic container of mixed fruit not labeled or dated with a sell by date of 8/29/22, 2 expired 2% milk cartons dated 8/12/22 and 8/15/22, 3 vanilla flavored high	F 812	F812 Food Procurement, Store/Prepare/Serve On 8/31/22, the housekeeping staff removed all expired items and/or items not labeled per facility protocol from the 700/800 nourishment room refrigerator. On 09/22/22 the Activities Director initiated an audit of all nourishment room refrigerators and refrigerators in resident rooms to ensure all food items were dated and/or expired items were discarded per facility protocol. The Activities Director will address all concerns identified during the audit to include removing all expired items	

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F 812	Continued From page 33 protein/high calorie nutritional supplement containers in a plastic bag that appeared to be spoiled and were not labeled/dated, 1 plastic bag of cut pineapple fruit without a name or date, 1 plastic fast food cup ½ filled with water without a name or date, and 2 opened bottles of salad dressing that were not labeled or dated. Also, an unlabeled plastic bag with lunch items (spaghetti, chips, and crackers) was found on top of the fridge. During an interview with the Dietary Manager on 8/31/22 at 9:21 AM, she revealed it was the responsibility of housekeeping/nursing staff to manage the content of nourishment room refrigerators. On 8/31/22 at 9:25 AM, accompanied by the Director of Nursing (DON), the 700/800 hall nourishment refrigerator was inspected a second time. All expired and unlabeled contents were no longer in the refrigerator. The DON revealed the nourishment rooms were managed by nursing staff. She stated if families brought outside food for a resident, it should have been labeled and dated. The DON indicated her expectation was that the fridge/nourishment rooms be monitored and cleaned daily by housekeeping. Housekeeping Attendant #1 was interviewed on 8/31/22 at 9:30 AM, and she revealed that she had just discarded all expired/unlabeled items from the 700/800 hall nourishment refrigerator. During an interview with the Administrator on 9/1/22 at 10:19 AM, she revealed there was a process in-place for cleaning out expired/unlabeled foods from the nourishment room refrigerators performed by housekeeping	F 812	and/or items not labeled per facility protocol and education of staff. Audit will be completed by 10/04/22. On 09/23/22 the SDC initiated an in-service with all nurses, nursing assistants, dietary staff and housekeeping staff regarding Monitoring Nourishment and Resident Refrigerators with emphasis on nurse, nursing assistant, dietary and housekeeping staff responsibility for monitoring nourishment room refrigerators and refrigerators in resident rooms to ensure items are dated per facility protocol and all expired items removed and discarded. In-service will be completed by 10/04/22. After 10/04/22 any nurse, nursing assistant, dietary staff and/or housekeeping staff who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses or medication aides will be in-serviced during orientation regarding Monitoring Nourishment and Resident Refrigerators. The Activities Director will audit all nourishment room refrigerators and 5 resident room refrigerators weekly x 4 weeks then monthly x 1 month utilizing the Nourishment Room Audit Tool. This audit is to ensure all food items in nourishment room and resident rooms were dated and/or expired items were discarded per facility protocol. Activities Director will address all concerns identified during the audit to include removing all expired items and/or items not labeled per facility	

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F 812	Continued From page 34 daily. She stated all food in nourishment room fridges should have been labeled and dated appropriately.	F 812	protocol and education of staff/residents. The Administrator will review the Nourishment Room Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing (DON) will present the findings of the Nourishment Room Audit Tool. to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Nourishment Room Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		10/4/22

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F 842	Continued From page 35 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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F 842	Continued From page 36 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain accurate Treatment Administration Records (TAR) for 1 of 2 residents reviewed for wound care (Resident #7) and failed to document blood sugar results in medical record for 1 of 1 resident reviewed for insulin use (Resident #73). The findings included: 1. Resident #7 was re-admitted to the facility on 9/2/21. Her diagnoses included stroke and hypertension. The quarterly Minimum Data Set (MDS) dated 5/20/22 revealed Resident #7 was cognitively impaired. She required extensive assistance with bed mobility and toilet use and total assistance with transfers. Resident #7 had no pressure ulcers at the time of the assessment. She was coded at risk for developing pressure ulcers. Resident #7 was care planned for risk of skin breakdown or development of pressure ulcers. A review of the physician orders for Resident #7 revealed the following orders:	F 842	F842 Resident Records - Identifiable Information On 09/20/22 the DON initiated a 100% audit of all TARs to include TAR for resident #7 for the past 14 days to ensure treatments were completed per physician□s order. The DON will address all areas of concern identified during the audit to include assessment of the resident, notification of MD of treatment omission for further instructions and education of the nurse. Audit will be completed by 10/04/22. On 08/31/22 the Unit Manager completed an audit of all residents to include resident #73 with orders for blood glucose monitoring. This audit is to ensure the nurse is completing blood glucose monitoring per physician order with documentation of finger stick blood sugar (FSBS) in the electronic record and notification of the physician when FSBS is outside of ordered parameters for further recommendations. The Unit Manager will address all concerns identified during the audit to include but not limited to assessment of the resident, updating	

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F 842	Continued From page 37 a. Buttock: Cleanse with normal saline and pat dry with 4x4 gauze. Apply skin prep and allow to dry thoroughly. Cover with 4x4 foam dressing. This order started on 6/14/22 and was discontinued on 7/11/22. A review of the Treatment Administration Record (TAR) from July 1, 2022, through July 11, 2022, revealed no documentation of completing the dressing change on 7/1/22 and 7/3/22. b. Buttock: Cleanse with normal saline and pat dry with 4x4 gauze. Apply Medi honey (a gel to promote wound healing) to wound bed and cover with 4x4 foam dressing every day shift for healing. This order started on 7/12/22 and was discontinued on 8/4/22. A review of the Treatment Administration Record (TAR) from July 12, 2022, through July 31, 2022, revealed no documentation of completing the dressing changes on 7/16/22 and 7/29/22. An interview was conducted with the Medication Aid # who was assigned as the Treatment Aid on 7/1/22, 7/3/22, 7/16/22, and 7/29/22. She stated she did the dressing change for Resident #7 on 7/1/22, 7/3/22, 7/16/22, and 7/29/22 but she failed to document them as being completed on the TAR. She stated she could not remember why she didn ' t complete the documentation. On 09/01/22 at 12:34 PM the Director of Nursing was interviewed, and she stated her expectation was the wound treatments get completed and if it's done it needs to be charted in the electronic record.	F 842	electronic record for FSBS and/or notification of the physician when FSBS is outside of ordered parameters. Audit will be completed by 10/04/22. On 09/23/22 the Staff Development Coordinator (SDC) initiated an in-service with all nurses regarding TAR Documentation/Treatments with emphasis on nurse□s responsibility on initiating treatments or completing treatments per physician order with documentation in the electronic treatment record. In-service will be completed by SDC. After 10/04/22 any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding TAR Documentation/Treatments On 09/23/22 the SDC initiated an in-service with all nurses regarding Blood Glucose Monitoring with emphasis on obtaining FSBS per physician order with documentation of FSBS in the electronic record and notification of the physician when FSBS is outside ordered parameters for further recommendations. In-service will be completed by 10/04/22. After 10/04/22 any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Blood Glucose Monitoring. The DON will review TAR documentation	

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F 842	Continued From page 38 2. Resident #73 was admitted to the facility on 8/01/22 with diagnoses which included diabetes and dementia. A physician order dated 8/10/22 for Lantus Solution 100 unit/mL inject 40 units subcutaneously one time a day for Diabetes management. Give at noon hold if blood sugar (BS) is 150 or below. Record review of the August 2022 MAR revealed Resident #73 ' s Lantus insulin was administered on 8/14/22, 8/19/22, 8/20/22, 8/21/22, 8/23/22, 8/24/22, 8/25/22, 8/26/22, 8/27/22, 8/28/22, 8/29/22, and 8/30/22 without record of blood sugar check completed and documented in the medical record. During an interview on 8/31/22 at 1:01 pm Nurse #2, who administered insulin to Resident #73 on 8/19/22, 8/22/22, 8/23/22, 8/24/22, 8/25/22, 8/26/22, and 8/30/22 stated she completed the FSBS for Resident #73 each time she administered the insulin, but she did not document in the medical record because there was not a spot to enter the blood sugar. Nurse #2 reported that she obtained and entered the physician order, but she forgot to add the prompt to enter the blood sugar result. During an interview on 8/31/22 at 1:05 pm Nurse Manager #1 revealed she corrected the order and added the prompt to document Resident #73 ' s blood sugar on 8/31/22. She stated she reviewed orders upon admission and again monthly. During an interview on 8/31/22 at 1:24 pm the	F 842	5 times a week x 4 weeks then monthly x 1 month to include weekends utilizing the Medication Administration Audit Report for treatments. This audit is to ensure all treatments are completed per physician□s order with documentation in the electronic record. The DON will address all concerns identified during the audit. The Director of Nursing will review the Medication Administration Audit Report for treatments 5 times a week x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Unit Manager will audit all residents with orders for FSBS monitoring to include resident #73 three times a week x 4 weeks then monthly x 1 month utilizing the Blood Glucose Monitoring Audit Tool. This audit is to ensure the nurse is completing blood glucose monitoring per physician order with documentation of finger stick blood sugar (FSBS) in the electronic record and notification of the physician when FSBS is outside of ordered parameters for further recommendations. The Unit Manager will address all concerns identified during the audit to include but not limited to assessment of the resident, updating electronic record for FSBS and/or notification of the physician when FSBS is outside of ordered parameters. The Director of Nursing will review the Blood Glucose Monitoring Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the	

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F 842	Continued From page 39 Director of Nursing (DON) revealed the nurses were expected to enter physician orders correctly. The DON stated the nurses were able to document Resident #73 ' s blood sugar in the vital sign section of the medical record if no prompt was added to the order. During a telephone interview on 8/31/22 at 6:56 pm Nurse #3 revealed she administered insulin to Resident #73 on 8/13/22, 8/14/22, 8/20/22, 8/21/22, 8/27/22, and 8/28/22. She reported she checked his blood sugar before administering the insulin but did not document the blood sugar in the medical record because the order did not have a prompt to enter the information. Nurse #3 stated she kept a record of the blood sugar obtained in her notebook but did not enter the information into the medical record. During an interview on 9/01/22 at 1:47 pm the Administrator revealed the nurse was expected to document Resident #73 ' s blood sugar in the medical record.	F 842	Medication Administration Audit Report and Blood Glucose Monitoring Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Medication Administration Audit Report and Blood Glucose Monitoring Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, and physician interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain and	F 867	F867 QAPI/QAA Improvement Activities On 09/23/22 The Facility Consultant	10/4/22

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F 867	Continued From page 40 implement procedures and monitor interventions the committee put into place following the recertifications and complaint surveys conducted on 5/20/21, 10/4/19, and 10/16/20. This was for five deficiencies cited in resident rights (F550), self-determination (F561), personal privacy and confidentiality (F583), discharge summary (F661), and infection control (F880). The duplicate citations during four federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag was cross-referenced to: 1. F550 Based on observation, record review, resident interview and staff interviews, the facility failed to maintain a resident's dignity by not placing a privacy cover on an indwelling urinary catheter bag for 1 of 2 residents reviewed for dignity (Resident #14). During the recertification survey that concluded on 10/4/19, the facility failed to assist the resident with feeding when the meal tray was delivered to the room in 1 of 1 resident observed who required assistance with feeding. The Administrator was interviewed on 9/1/22 at 3:56 PM, and she revealed the QAA committee met monthly to discuss various issues that did not include dignity related to privacy covers on catheters. 2. F561 Based on observations, record review, resident and staff interviews, the facility failed to honor a dependent resident's request to smoke at the designated times for 1 of 2 residents reviewed	F 867	initiated an audit of previous citations and action plans within the past two years to include F550 Dignity and Respect, F561 resident right to smoke, F583 providing privacy during care, F661 recapitulation of stay and F880 infection control to ensure the QA committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by the Administrator for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to education of staff. Audit will be completed by 10/04/22. On 09/23/22 the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Quality Assurance (QA) Nurse regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 9/26/22. All newly hired Administrator, DON and QA nurse will be educated during orientation regarding the QA Process.	

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F 867	Continued From page 41 for smoking (Resident #70). During the recertification and complaint survey that concluded on 5/20/21, the facility failed to allow independent/safe smokers to smoke without supervision and whenever they wanted for 2 of 2 residents reviewed for choices. The Administrator was interviewed on 9/1/22 at 3:56 PM, and she revealed the QAA committee met monthly to discuss various concerns in the facility that did not include resident choice. 3. F583 Based on record review, observation, resident interview and staff interviews, the facility failed to provide privacy when providing personal care to 1 of 30 residents reviewed for privacy (Resident #98). During the COVID-19 focused survey that concluded on 10/16/20, the facility failed to provide privacy to Resident #1 during a sacral pressure ulcer dressing change by leaving the resident's hallway door open when the resident was exposed from the waist down and not covered for 1 of 1 residents observed during care. The Administrator was interviewed on 9/1/22 at 3:56 PM, and she revealed the QAA committee met monthly to discuss various concerns in the facility that did not include privacy. 4. F661 Based on record review and staff interviews, the facility failed to complete a recapitulation of stay at the facility for 1 of 1 resident reviewed for discharges (Resident #103). During the recertification and complaint survey	F 867	All data collected for identified areas of concerns to include dignity and respect, resident rights, privacy, recapitulation of stay and infection control will be taken to the Quality Assurance committee for review monthly x 6 months by the Administrator. The Quality Assurance committee will review the data and determine if plan of corrections is being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include coding accuracy of Minimum Data Set Assessments, environmental services, activities of daily living care and posted staffing requirements and all current citations and QA plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Quality Assurance Nurse to the Executive Committee Quarterly x 2 for review and the identification of trends,	

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F 867	Continued From page 42 that concluded on 5/20/21, the facility failed to provide a discharge summary that included a recapitulation of the resident's stay for 1 of 1 resident reviewed for discharges. On 9/1/22 at 3:56 PM an interview was conducted with the Administrator. She stated the nurse who was assigned the discharge for Resident #103 forgot to enter/document the discharge note because she was at lunch when transportation took Resident #103 out of the facility. The Administrator further stated the nurse got distracted and forgot to enter the note when she returned from break. Re-education with documentation will be provided to the nurse. 5. F880 Based on observations, record review, staff and resident interviews, the facility failed to (1) implement the Centers for Disease Control & Prevention (CDC) guidance to initiate isolation precautions for those residents that were not up to date with the COVID-19 vaccine when following the broad-based approach for outbreak testing (Resident #94, Resident #44, Resident #77, Resident #80, Resident #5, Resident #16, and Resident #45) and (2) failed to remove isolation gown and gloves before exiting an isolation room (Nurse Aide #7). The facility was in COVID-19 outbreak status as of 6/06/22. Record review of the prior four-week period of COVID-19 facility testing revealed two residents and five staff members had tested positive during the month of August 2022. The dates of the most recent staff and resident positive COVID-19 results were 8/08/22 and 8/27/22. During the COVID-19 focused survey and complaint investigation that concluded on 10/16/20, the facility failed to prevent cross	F 867	development of action plans as indicated to determine the need and/or frequency of continued monitoring.	

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F 867	Continued From page 43 contamination when a nurse took a bottle of wound cleanser, (that was used during a resident's dressing change and placed on the resident's bed-not on the clean field barrier), off a resident's bed and did not clean the bottle prior to placing it in back into the treatment cart for 1 of 5 residents reviewed for infection control. During the recertification survey that concluded on 5/20/21, the facility failed to screen two state surveyors who entered the building after hours for signs and symptoms of COVID-19. The Administrator was interviewed on 9/1/22 at 3:56 PM, and she revealed the QAA committee met monthly and infection control was discussed. The Administrator stated that change of staffing had impacted the repeated citation of infection control. The plan of correction was implemented immediately after last year's survey and ended 1 month after the state follow-up survey.	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:	F 880		10/4/22

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F 880	Continued From page 44 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment 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	F 880		

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F 880	Continued From page 45 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of 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 observations, record review, staff and resident interviews, the facility failed to (1) implement the Centers for Disease Control & Prevention (CDC) guidance to initiate isolation precautions for those residents that were not up to date with the COVID-19 vaccine when following the broad-based approach for outbreak testing (Resident #94, Resident #44, Resident #77, Resident #80, Resident #5, Resident #16, and Resident #45) and (2) failed to remove isolation gown and gloves before exiting an isolation room (Nurse Aide #7). The facility was in COVID-19 outbreak status as of 6/06/22. Record review of the prior four-week period of COVID-19 facility testing revealed two residents and five staff members had tested positive during the month of August 2022. The dates of the most recent staff and resident positive COVID-19 results were 8/08/22 and 8/27/22. Findings included: The CDC guidance "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" dated 2/02/22 stated outbreak testing should be	F 880	FF880 Infection Prevention & Control On 08/29/22 the DON initiated isolation precautions for residents #94, resident #44, resident #77, resident #80, resident #5, resident #16, and resident #45 per Centers for Disease Control & Prevention (CDC) guidance for residents that were not up to date with the COVID 19 vaccine. Appropriate signage for isolation required placed on each resident door. On 09/16/22 the DON verbally educated nurse aide #7 regarding donning/doffing PPE with emphasis on removing PPE prior to exiting resident room and removal/changing N95 mask between isolation rooms. On 09/20/22 the Administrator initiated an audit of all residents not up to date on COVID 19 vaccine. This audit is to ensure the facility implemented isolation precautions for those residents that were not up to date with the COVID-19 vaccine	

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F 880	Continued From page 46 conducted in response to newly identified infections through broad-based approach those residents that are not up to date on vaccination should generally be restricted to their rooms, even if testing is negative and cared for by staff using an N95 or higher-level respirator, eye protection, gloves, and gown. Record review of the facility policy titled "Guideline for Testing and Quarantine for Close Contact Exposure, and Community Visits" dated July 2022 stated the outbreak response when a new facility-onset case of Covid-19 was identified utilizing the broad-based approach for residents not up to date on all COVID-19 vaccinations should be generally restricted to their rooms, even if testing was negative, and care for by staff using N95 or higher-level respirator, eye protection, gown, and gloves. During the entrance conference on 8/29/22 at 9:40 am the Administrator revealed the facility had been in COVID-19 outbreak status since 6/06/22. 1. Record review of the Resident Vaccination log revealed the following rooms were required to be on isolation during the facility outbreak when utilizing the broad-based approach for outbreak response. a. An observation on 8/29/22 at 10:00 am revealed Room #804 did not have isolation signage or PPE supplies in place. Resident #94 and Resident #44, who resided in Room #804, declined the COVID-19 vaccinations. b. An observation on 8/29/22 at 10:30 am revealed Room #311 did not have isolation	F 880	when following the broad-based approach for outbreak testing. The Administrator will address all concerns identified during the audit to include but not limited to implementing isolation precautions per CDC guidance and education of staff. Audit will be completed by 10/04/22. On 9/23/22, the Facility Consultant initiated an in-service the Director of Nursing, Administrator and Infection Preventionist on facility Guidelines for COVID Testing and Quarantine and the responsibility of the Administrator, Director of Nursing and Isolation Preventionist to initiate new guidance timely, educated facility staff on all updated guidance and to ensure appropriate monitoring of infection control practices are in place. In-service will be completed by 10/4/22. On 09/23 22 the Director of Nursing and Infection Preventionist initiated an in-service with all staff to include nurses, nursing assistants, accounts payable, accounts receivable, social worker, dietary staff, therapy staff, administrator, activity staff, maintenance staff, receptionist, medical records director and housekeeping staff. regarding Guidelines for COVID Testing and Quarantine with emphasis on initiating appropriate isolation for residents not up to date on COVID vaccine during outbreak testing status per CDC guidance. In-service will be completed by 10/04/22. After 10/04/22 any nurse, nursing assistant, dietary staff and/or housekeeping staff who has not worked or received the in-service will	

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F 880	Continued From page 47 signage or PPE supplies in place. Resident #77, who resided in Room #311, declined the COVID-19 vaccinations. c. An observation on 8/29/22 at 10:30 am revealed Room #402 did not have isolation signage or PPE supplies in place. Resident #80, who resided in Room #402, declined the COVID-19 vaccinations. d. An observation on 8/29/22 at10:40 am revealed Room #710 did not have isolation signage or PPE supplies in place. Resident #5, who resided in Room #710, was partially vaccinated with one dose of the primary vaccination series administered on 6/05/21. e. An observation on 8/29/22 at 10:30 am revealed Room #410 did not have isolation signage or PPE supplies in place. Resident #16, who resided in Room #410, was eligible to receive the second COVID-19 booster vaccination on 8/19/22 but declined the vaccination. f. An observation on 8/29/22 at 12:15 pm revealed Room #206 did not have isolation signage or PPE supplies in place. Resident #45, who resided in Room #206, declined the COVID-19 vaccinations. During an interview on 8/29/22 at 11:36 am Nurse #1 revealed she was not sure why Room #311 was placed on isolation but stated possibly related to COVID-19 vaccination status but would find out the reason. Nurse #1 returned and reported Room #311 was placed on isolation because the facility was in	F 880	complete in-service prior to next scheduled work shift. All newly hired nurses nursing assistants, accounts payable, accounts receivable, social worker, dietary staff, therapy staff, administrator, activity staff, maintenance staff, receptionist, medical records director and housekeeping staff, will be in-serviced during orientation regarding Guidelines for COVID Testing and Quarantine. On 09/23/22 the Infection Preventionist initiated an in-service with return demonstration with all nurses, nursing assistants, therapy staff, dietary staff, housekeeping staff, Accounts Receivable, Administrator, Accounts Payable, medical records, receptionist, screener, social worker and maintenance staff in regard to facility Guidelines for PPE Use. Emphasis is on appropriate donning/doffing PPE to include but not limited to gowns/gloves and use of PPE when enter resident rooms and/or quarantine rooms based on CDC guidelines. In-service will be completed by 10/04/22. After 10/04/22 any staff who has not received the in-service will be in-serviced upon next scheduled work shift. All newly hired staff will be in-serviced with return demonstration during orientation regarding facility Guidelines for PPE Use. The Administrator will monitor all residents not up to date with COVID 19 vaccines and boosters weekly x 4 weeks then monthly x 1 month utilizing the	

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F 880	Continued From page 48 outbreak status and the resident had declined the COVID-19 vaccinations. During an interview on 8/30/22 at 12:11 pm the Infection Preventionist (IP) revealed the Administrator and Director of Nursing (DON) were responsible for the COVID-19 vaccination monitoring. She stated the updated guidance was not discussed with her, but she recalled hearing the DON talking about the isolation requirement for residents that were not up to date with the COVID-19 vaccine with someone. The IP was unable to state why the Administrator and DON did not implement the changes. During an interview on 8/30/22 at 11:57 am the Corporate Clinical Director revealed the facility utilized the broad-based testing during a COVID-19 outbreak and that residents that were not up to date on the COVID-19 vaccinations were required to be on isolation. She stated she instructed the facility to implement isolation precautions for the residents that were not up to date with COVID-19 vaccinations when she arrived at the facility on 8/29/22. The Corporate Clinical Director revealed the facility was not following CDC guidelines and the corporation had missed the updated guidance from the CDC. The Corporate Clinical Director reported an updated policy was provided to the facility in July 2022 which included the current CDC recommendations but was unable to state why the facility had not implemented the updated policy regarding isolation requirements based on vaccination status during an outbreak when it was received. During an interview on 8/30/22 at 11:47 am with the Administrator, DON, and Corporate Clinical	F 880	Quarantine/Isolation Audit Tool to ensure the facility implemented isolation precautions for those residents that were not up to date with the COVID-19 vaccine when following the broad-based approach for outbreak testing. The Administrator will address all concerns identified during the audit to include but not limited to implementing isolation precautions per CDC guidance and education of staff. The Director of Nursing will review the Quarantine/Isolation Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will complete 10 staff observations to include staff on all shifts weekly x 4 weeks then monthly x 1 month utilizing a PPE Audit Tool. This audit is to ensure staff donned/doffed PPE appropriately when entering/exiting resident room when isolation precautions were required. The DON will address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will review the PPE Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing (DON) will present the findings of the Quarantine/Isolation Audit Tool and the PPE Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Quarantine/Isolation Audit Tool and the	

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F 880	Continued From page 49 Director the Administrator revealed she and the DON were responsible for the COVID-19 vaccination effort and monitoring the status of immunization eligibility. During an interview on 8/30/22 at 12:03 pm the Administrator revealed the facility received the updated policy in July and was working on implementing it, but they attempted to encourage all residents to accept the COVID-19 vaccine so they would not have to be placed on isolation. 2. On 8/30/22 at 9:26 am an observation was made of Nurse Aide (NA) #7 entering Room 804 which had signage posted on the door that alerted staff that the resident was on room restrictions and required the following PPE to be utilized when providing care. Staff were instructed to wear a gown, N95 mask, gloves, and eye protection upon entry. NA #7 was observed wearing a gown, N95, gloves and eye protection. NA #7 was observed exiting the room with gown, gloves, N95 mask, and eye protection on and taking the gown and gloves off in the hallway and placing them in a trash can located in the hallway. NA #7 was interviewed on 8/30/22 at 9:26 am and she stated she was not educated to take her mask and gown off inside a room at the doorway before coming out into the hallway. She also stated she was not educated on disposing of the N95 mask and getting a new one when coming out into the hall. During an interview on 8/31/22 at 9:21 am the Infection Preventionist (IP) revealed the staff was educated on donning and doffing PPE for isolation rooms upon hire, annually, and random	F 880	PPE Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 880	Continued From page 50 individual education when observations of non-compliance occurred. The IP stated she was available if a staff member had a question regarding the proper procedure for the use of PPE. During an interview on 9/01/22 at 9:01 am the Administrator revealed the facility had provided education for proper use of PPE which included donning/doffing of PPE as in person education as well as computer training for PPE use.	F 880		
F 881 SS=C	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interviews, the facility failed to implement an Antibiotic Stewardship Program. Findings included: Record review of the Antibiotics Stewardship Policy dated 9/2014 and revised 1/22/2018 revealed the facility was responsible to utilize the pharmacy consultant and/or others regarding the appropriate use of antibiotics, provide prescribing practitioners with verbal or written feedback on their antibiotic prescribing practices quarterly, and	F 881	F881 Antibiotic Stewardship Program On 09/23/22 the Director of Nursing and Infection Preventionist initiated an audit of all current residents with orders for antibiotic therapy for the past 30 days. This audit is to ensure the facility monitored antibiotic use per the Antibiotic Stewardship Protocol. The DON and Staff Facilitator will address all concerns identified during the audit to include notification of the physician for all concerns related to repeated antibiotic	10/4/22

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F 881	Continued From page 51 education offerings on antibiotic stewardship and any developed antibiotic use protocols will occur bi-annually to prescribing practitioners and facility ' s staff. During an interview on 8/31/22 at 9:21 am the Infection Preventionist (IP) revealed she was the IP for the past 5-6 years at the facility. The IP reported she was responsible for the monitoring of antibiotic use at the facility and she reported the facility infection rate and infection trends at the quarterly Quality Assurance (QA) meetings. She stated the pharmacy consultant reported the antibiotics ordered monthly, but she has not met with the pharmacy consultant to discuss appropriateness of antibiotics and did not recall the pharmacy consultant attending the QA meetings. The IP reported she did was not familiar with the quarterly antibiotic prescribing practices of prescribing practitioners report and she had not discussed antibiotic prescribing with any physicians or providers in the facility. She stated antibiotic stewardship education was not provided to prescribing practitioners or facility staff. During a telephone interview on 8/31/22 at 10:18 am the Pharmacy Consultant revealed she did not know the details of the facility ' s Antibiotic Stewardship Program. She stated she had not attended QA meetings or discussed antibiotic stewardship and antibiotic usage and monitoring with the IP. The Pharmacy Consultant stated was able to assist with the program at the request of the facility. During an interview on 8/31/22 at 10:55 am the Medical Director revealed he was not familiar with the Antibiotic Stewardship Program and had	F 881	use, organisms identified and education of the nurse. Audit will be completed by 10/04/22 On 09/23/22 the Facility Consultant initiated an in-service with the Director of Nursing, Medical Providers and Infection Preventionist regarding Antibiotic Stewardship. Emphasis is on monitoring and tracking antibiotic use within the facility. In-service will be completed by 10/04/22. All newly hired DON, Medical Providers and Infection Preventionist will be in-serviced during orientation regarding Antibiotic Stewardship. The Director of Nursing will review all antibiotic use within the facility weekly x4 weeks then monthly x 1 month utilizing the Antibiotic Audit Tool. This audit is to ensure the facility maintained a system for monitoring and tracking antibiotic use within the facility. The DON will address all concerns identified during the audit to include retraining of the Infection Preventionist. The Administrator will review the Antibiotic Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the Antibiotic Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Antibiotic Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

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F 881	Continued From page 52 never discussed it with the facility. He stated he was not aware of a policy or procedure pertaining to antibiotic usage. The Medical Director stated the Antibiotic Stewardship Program was not discussed in the QA meeting. During an interview on 9/01/22 at 9:00 am the Director of Nursing (DON) revealed the IP tracked antibiotics and infections. She stated the IP reported on the facility infection rate and trends at the quarterly QA meeting. During an interview on 9/01/22 at 9:01 am the Administrator reported the infection rate and infection trends were reported by the IP, but no other antibiotic information was reviewed during the QA meetings.	F 881	frequency of monitoring.	
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 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:	F 883		10/4/22

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F 883	Continued From page 53 (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 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include documentation in the medical record of education regarding the	F 883	F883 Influenza and Pneumococcal Immunizations	

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F 883	Continued From page 54 benefits and potential side effects of the influenza and pneumococcal immunizations for 2 of 5 residents reviewed for influenza and pneumococcal immunizations (Resident #44 and Resident #77). Findings included: Record review of the facility policy titled Immunization Policy dated 1/2009 and revised on 10/18/2017 revealed that prior to offering the influenza or pneumococcal vaccines, residents or resident ' s legal representative will be provided education regarding the benefits and potential side effects of these immunizations with documentation in the medical record. 1. Resident #77 was admitted to the facility on 3/04/2019. Record review of the Minimum Data Set (MDS) Annual Assessment dated 7/29/22 revealed Resident #77 received the influenza vaccination on 12/15/21 at the facility and was offered and declined the pneumococcal vaccine. Record review of Resident #77 ' s medical record revealed no documentation of the education provided regarding the benefits and potential side effects of the influenza or pneumococcal immunizations. During an interview on 8/31/22 at 9:21 am the Infection Preventionist (IP) revealed education was to be provided to Resident #77 for the influenza and the pneumococcal vaccines. She stated the education was to be provided when the vaccine was offered regardless of consent or declination of the vaccines. The IP reported the	F 883	DON and Infection preventionist will clarify immunization history to include flu, pneumonia, and COVID for residents #44 and resident #77. The resident or resident representative will be education on the risk and benefits of receiving/declining vaccine, consent obtained when indicated, and MD notified to obtain order per resident preference. Vaccines will be provided per physician□s order and/or documentation of resident refusal following education of risk/benefits of the vaccine by 10/4/22. . On 09/23/22 the DON and Infection Control Preventionist initiated an audit of Influenza and Pneumonia immunizations for all current residents. This audit was to identify any resident who had not been provided the Influenza or Pneumonia vaccine or have a documented refusal of immunization per facility protocol and to ensure residents/resident representative was educated on the risk/benefits of receiving/refusing vaccine with documentation in the electronic record. The Don and Infection Preventionist will address all concerns identified during the audit to include education of the resident/resident representative of risks/benefits of receiving/refusing of vaccine with documentation in the electronic record, providing vaccine per resident preference and/or education of staff. Audit will be completed by 10/04/22. On 09/23/22 the SDC initiated an in-service with all nurses regarding Immunizations. Emphasis is on educating	

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F 883	Continued From page 55 education was documented in the medical record. 2. Resident #44 was admitted to the facility on 3/31/20. Record review of the MDS Quarterly Assessment dated 7/02/22 revealed Resident #44 was offered and declined the influenza and pneumococcal immunizations. Record review of Resident #44 ' s medical record revealed he was provided education on the influenza vaccination. There was no documentation of the education provided regarding the benefits and potential side effects of the pneumococcal immunization. During an interview on 8/31/22 at 9:21 am the Infection Preventionist (IP) revealed the education was provided to all residents even if the vaccine was declined. She stated the education was documented as provided in the medical record. During an interview on 8/31/22 at 11:30 am the Director of Nursing (DON) revealed the education was to be provided to all residents and documented in the medical record as provided. She stated the documentation could be in a progress note or marked on the immunization tracking section in the medical record. The DON was unable to state why the education was not documented in the medical record as provided for Resident #44 or Resident #77. During an interview on 9/1/22 at 3:07 pm the Administrator stated Resident #44 and Resident #77 wase to receive education on the influenza and pneumococcal immunizations and the	F 883	resident/resident representative on the risks/benefits or receiving/refusing vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. In-service will be completed by 10/04/22. After 10/04/22 any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Immunizations. The DON and Infection Control Preventionist will audit 10% of resident immunization record weekly x4 weeks then monthly x 1 month utilizing the Immunization Audit Tool. This audit is to ensure residents were educated on risks/benefits of receiving/refusing Influenza and Pneumonia vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined following education. The DON and Infection Control Preventionist will address all concerns identified during the audit. The DON will review the Immunization Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Immunization Audit Tool to	

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F 883	Continued From page 56 documentation was to be entered in the medical record that the education was provided.	F 883	the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Immunization Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 887 SS=E	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	F 887		10/4/22

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F 887	Continued From page 57 additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the	F 887	F887 COVID-19 Immunization DON and Infection Control Preventionist will clarify immunization history to include	

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F 887	Continued From page 58 COVID-19 immunization for 5 of 5 residents reviewed for COVID-19 immunizations (Resident #44, Resident #77, Resident #80, Resident #92, and Resident #94). Findings included: Record review of the policy titled Immunization Policy dated 1/2009 and revised on 10/18/2017 revealed that prior to offering immunizations, the residents or resident ' s legal representative will be provided education regarding the benefits and potential side effects of these immunizations with documentation in the medical record. a. Resident #44 was admitted to the facility on 3/31/20. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 7/02/22 revealed Resident #44 was offered and declined the COVID-19 immunization. Record review of Resident #44 ' s medical record revealed there was no documentation of the education provided regarding the benefits and potential side effects of the COVID-19 immunization. b. Resident #77 was admitted to the facility on 3/04/19. Record review of the MDS Annual Assessment dated 7/29/22 revealed Resident #77 was offered and declined the COVID-19 immunization. Record review of Resident #77 ' s medical record revealed no documentation of the education provided regarding the benefits and potential side	F 887	flu, pneumonia, and COVID for residents #44, resident #77, resident #80, resident #92 and resident #94. The resident or resident representative will be education on the risk and benefits of receiving/declining vaccine, consent obtained when indicated, and MD notified to obtain order per resident preference. Vaccines will be provided per physician□s order and/or documentation of resident refusal following education of risk/benefits of the vaccine by 10/04/22. . On 09/23/22 the DON, Unit Manger and QI Nurse initiated an audit of COVID vaccination status for all current residents. This audit was to identify any resident who not up to date on COVID vaccine or have a documented refusal of vaccine per facility protocol and to ensure residents/resident representative was educated on the risk/benefits of receiving/refusing vaccine with documentation in the electronic record. The QI Nurse will address all concerns identified during the audit to include education of the resident/resident representative of risks/benefits of receiving/refusing of vaccine with documentation in the electronic record, providing vaccine per resident preference and/or education of staff. Audit will be completed by 10/04/22. On 09/23/22 the SDC initiated an in-service with all nurses regarding Immunizations. Emphasis is on educating resident/resident representative on the risks/benefits or receiving/refusing	

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F 887	Continued From page 59 effects of the COVID-19 immunization. c. Resident #80 was admitted to the facility on 5/22/14. Record review of the MDS Quarterly Assessment dated 8/05/22 revealed Resident #80 was offered and declined the COVID-19 immunization. Record review of Resident #80 ' s medical record revealed no documentation of the education provided regarding the benefits and potential side effects of the COVID-19 immunization. d. Resident #92 was admitted to the facility on 2/28/19. Record review of the MDS Annual Assessment dated 8/09/22 revealed Resident #92 was offered and declined the COVID-19 immunization. Record review of Resident #92 ' s medical record revealed no documentation of the education provided regarding the benefits and potential side effects of the COVID-19 immunization. e. Resident #94 was admitted to the facility on 3/18/21. Record review of the MDS Quarterly Assessment dated 8/02/22 revealed Resident #94 was offered and declined the COVID-19 immunization. Record review of Resident #94 ' s medical record revealed no documentation of the education provided regarding the benefits and potential side effects of the COVID-19 immunization. During an interview on 8/31/22 at 9:21 am the	F 887	vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. In-service will be completed by 10/04/22. After 10/04/22 any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Immunizations. The QI Nurse will audit 10% of resident immunization record weekly x4 weeks then monthly x 1 month utilizing the Immunization Audit Tool. This audit is to ensure residents were educated on risks/benefits of receiving/refusing COVID vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined following education. The QI Nurse will address all concerns identified during the audit. The DON will review the Immunization Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Immunization Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review	

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F 887	Continued From page 60 Infection Preventionist (IP) revealed the COVID-19 immunization education was to be provided to the residents regardless of consent or declination of the immunization. The IP reported the education was documented in a progress note in the medical record. During an interview on 8/31/22 at 11:30 am the Director of Nursing (DON) revealed the immunization education was required for all residents and documented in the medical record as provided. She stated the documentation could be in a progress note or marked on the immunization tracking section in the medical record. The DON was unable to state why the COVID-19 immunization education was not documented in the medical record as provided. During an interview on 9/1/22 at 3:07 pm the Administrator stated the COVID-19 immunization education should have been provided to the residents and the documented in the medical record that it was provided.	F 887	the Immunization Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	