STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/24/23 through 4/27/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #TD8R11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/24/23 through 4/27/23. Event ID# TD8R11. The following intakes were investigated NC00197137, NC00192338, NC00198847, NC00196716, NC00192677, NC00194597, NC00193413, NC00189985, NC00189376, and NC00194295. 7 of the 44 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to determine whether the self-administration of medications was clinically appropriate for 1 of 1 sampled resident (Resident #10) observed to have medications at bedside. Findings included: Resident #10 was admitted to the facility on 10/28/11 with re-entry from a hospital on 6/25/20. Her diagnoses included stroke, chronic pain,	F 554	F554 Resident Self Admin Meds-Clinically Appropriate On 4/26/23, the Unit Manager immediately verbally educated medication aide #1 on ensuring resident takes medications as prescribed and not leaving medications at resident bedside unless a Self-Administration of Medications assessment has been completed and physician order obtained for resident to self-administer medications. Medication	5/25/23

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

Electronically Signed | 05/13/2023

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F 554	Continued From page 1 hyperlipidemia, and diabetes mellitus. Review of Resident #10's annual comprehensive Minimum Data Set (MDS) dated 2/24/23 revealed resident was cognitively intact. The MDS showed Resident #10 required supervision from one staff member with eating. Resident #10's care plan dated 3/17/23 noted she resisted treatment/care related to refusing medications. The resident was not care planned for the self-administration of medications. Resident #10's current physician orders included the following medications scheduled for 8:00 A.M. administration each morning as follows: - Allopurinol Tablet 100 milligrams (mg) (used to treat gout); 2 tablets - Amlodipine Besylate Tablet 5mg (used to treat high blood pressure); 1 tablet - Docusate Sodium Capsule 100mg (used to treat occasional constipation); 1 capsule - Ezetimibe Tablet 10mg (used to treat high cholesterol); 1 tablet - Ferrous Sulfate tablet 325mg (supplement); 1 tablet - Aspirin Enteric Coated tablet delayed release 81mg (used for mild pain); 1 tablet - Atenolol Tablet 50mg (used to treat high blood pressure); 1 tablet - Furosemide tablet 40mg (used to treat swelling); 1 tablet - Polyethylene Glycol give 17 grams by mouth (used to treat constipation); 15 grams powder - Sodium Bicarbonate tablet 650mg (used to treat acid indigestion); 1 tablet - Linagliptin Tablet 5mg (used to treat diabetes); 1 tablet - Icosapent Ethyl Capsule 1gram (used to treat	F 554	Aide no longer works at the facility. On 4/26/23, resident #10 took medications as prescribed under the supervision of the medication aide #1. On 4/26/23, the Unit Manager educated resident #10 on the risks of not taking medications as prescribed by the physician to include risks of saving medications and taking at times not recommended by the physician. Resident #10 verbalized understanding of risks. On 5/10/23, the Director of Nursing initiated an audit of all resident rooms. This audit is to ensure medications were not left at the resident bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. The audit will be completed 5/24/23. On 5/10/23, the Unit Managers, Assistant Director of Nursing, Treatment Nurse and Director of Nursing initiated Med Pass Audits with all nurses and medication aides. This audit is to ensure the nurse and/or medication aid administered medications following the rights to medication administration and to ensure that the nurse and/or medication aid did not leave medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. The Unit Managers, Assistant Director of Nursing, Treatment Nurse and Director of Nursing will address all concerns identified during the audit to	

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F 554	Continued From page 2	F 554		

high levels of fat in the blood); 1 capsule
- Isosorbide Mononitrate Extended-Release Tablet 60mg (used to treat high blood pressure); 1 tablet
- Omeprazole Capsule delayed release 40mg (used to treat acid reflux); 1 capsule
- Vitamin D3 Tablet 2000 Unit (supplement); 1 tablet
- Metformin Extended Release 1000mg tablet (used to treat diabetes); 1 tablet
The physician orders did not include an order for the resident to self-administer any of his medications.

An observation was conducted on 4/26/23 at 8:27 A.M. of Medication Aide #1 entering Resident #10's room. On 4/26/23 at 8:30 A.M. the Medication Aide #1 exited Resident #10's room.

A continuous observation was conducted on 4/26/23 from 8:32 AM to 9:00 A.M. with Resident #10 sitting in her bed with a bed side table within resident's reach beside the bed. A medicine cup containing multiple tablets and capsules (1 tan tablet, 2 copper-colored tablets, 1 orange capsule, and multiple white tablets) was observed on the bedside table within reach of Resident #10. Also, a plastic cup containing approximately 4 ounces of clear liquid was sitting on the table next to the medication cup.

An interview was conducted on 4/26/23 at 8:50 A.M. with Resident #10. During the interview, when asked about the cup of medication on her bedside table, Resident #10 indicated staff normally wait until she has taken the pills. Resident #10 indicated he was new a new staff member, "he usually leaves the pills on my table

include but not limited to the education of staff. The audit will be completed by 5/24/23. After 5/24/23, any nurse or medication aid who has not completed the audit will complete upon next scheduled work shift.

On 5/12/23, the Unit Managers, Assistant Director of Nursing, Treatment Nurse and Director of Nursing initiated an in-service with all nurses and medication aides regarding Rights of Medication Administration with emphasis on administering medication per physician order to include right medication at the right time and not leaving medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. In-service will be completed by 5/24/23. After 5/24/23, any nurses or medication aid who have not worked or received the in-service will be educated prior to the next scheduled work shift. All newly hired nurses and or medication aides will receive the in-service during orientation regarding Rights of Medication Administration.

The Unit Managers, Assistant Director of Nursing, Treatment Nurse will complete 5 Med Pass Audits with nurses and medication aides weekly x 4 weeks then monthly x 1 month. This audit is to ensure the nurse and/or medication aid administered medications following the rights to medication administration and to ensure that the nurse and/or medication aid did not leave medication at bedside

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F 554	Continued From page 3 and leaves the room." An interview was conducted on 4/26/23 at 9:02 A.M. with Medication Aide #1. At that time, Medication Aide #1 was standing at the medication cart approximately six resident rooms away from Resident #10's room (Resident #10 was out of his line of sight). Medication Aide #1 was immediately asked to walk to Resident #10's room where the medication cup filled with capsules and tablets was still observed on Resident #10's bed side table. Medication Aide #1 indicated he had put Resident #10's scheduled 8:00 A.M. medication into a medication cup, went to Resident #10's room, and left the medications on the bedside table. During the interview, Medication Aid #1 stated he was not trained to remain present with a resident during medication administration until the resident had taken all the medication and staff were not to leave unattended medication at a resident's bedside. An observation was conducted on 4/26/23 at 9:05 A.M. of Resident #10 began to take the medications in the medication cup on her bedside table with Mediation Aide #1 present in room. An interview was conducted on 4/26/23 at 9:14 A.M. with the Cooperate Clinical Director. During the interview, the Cooperate Clinical Director indicated medications should never be left at a resident's bedside for the resident to self-administer unless the resident had been assessed to self-administer their own medications. The Cooperate Clinical Director indicated Resident #10 had not been assessed for self-administration of medication and the staff should have stayed with her until the medication was taken.	F 554	unless the resident had been assessed to safely self-administer medications and physician order obtained. Audits will include all shifts and weekends. The Unit Managers, Assistant Director of Nursing, Treatment Nurse will address all concerns identified during the audit to include but not limited to re-education of staff. The Director of Nursing will review the Med Pass Audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Unit Managers will audit all resident rooms 3 times a week x 4 weeks then monthly x 1 month utilizing a resident census sheet. This audit is to ensure no medications are left at bedside unless resident assessed per facility protocol and physician order obtained. The Unit Managers will address all concerns identified during the audit to include removing medications when indicated and re-training staff. The Director of Nursing will review the room audits 3 times a week x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Quality Assurance Nurse will present the findings of the Med Pass Audits and room audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Med Pass Audits and room audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency	

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F 554	Continued From page 4 An interview was conducted on 4/26/23 at 10:35 A.M. with the Administrator. The Administrator indicated she expected staff to wait for residents to take their medication prior to the staff member leaving the resident's room. During the interview, the Administrator further indicated staff were provided medication administration training that included not leaving medication unattended by their corporation and at the facility prior to being assigned to work on the floor unsupervised with residents.	F 554	of monitoring.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §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.	F 561		5/25/23

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F 561	Continued From page 5 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff, and resident interviews the facility failed to honor a resident choice when to have wound care completed for 1 of 2 resident (Resident #45) reviewed for choices. Findings included: Resident #45 was admitted to the facility on 12-4-15 with multiple diagnoses that included a pressure ulcer of left buttock, stage 4. The quarterly Minimum Data Set (MDS) dated 1-25-23 revealed Resident #45 was cognitively intact and was documented for one stage four pressure ulcer. The MDS also documented Resident #45 required total assistance with one person for transfers. During an interview with Resident #45 on 4-24-23 at 11:28am, the resident stated she would have liked to have her wound care completed in the morning. Resident #45 discussed staff not wanting to get her out of bed until her wound care was completed and she stated when her wound care was not completed until the afternoon, she was unable to attend activities. Resident #45 explained she had spoken to the wound care nurse and the floor nurses as to her preference of when her wound care was completed but she said when the wound care nurse was not working (days off during the week and on weekends) her	F 561	F561 Self Determination On 4/25/23, resident #45 was provided wound care per resident preference. On 5/4/23, the social worker initiated Resident Preference Questionnaire with all alert and oriented residents regarding preference to include but not limited to wound care. All areas of concern will be immediately addressed by the assigned nurse/Director of Nursing (DON) and/or Minimum Data Set Nurse (MDS) to include providing care per resident preference and updating all care plans to reflect resident preferences. Audit will be completed by 5/24/23. On 5/12/23, the Director of Nursing initiated an in-service with all nurses and nursing assistants regarding (1) Resident Preferences with emphasis on resident right to make choices about aspects of life to include but not limited to wound care. In-service will be completed by 5/24/23. After 5/24/23, any nurse or nursing assistant who has not completed the in-service will be educated prior to the next scheduled work shift. All newly hired nurses and nursing assistants will be in service during orientation regarding Resident Preferences.	

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F 561	Continued From page 6 wound care was not being completed until the afternoon. The resident was observed to not have her wound care completed at the time of the interview. An interview with the Wound Care Nurse occurred on 4-25-23 at 9:47am. The Wound Care nurse discussed starting her position 3 months ago and stated she kept the schedule the previous Wound Care nurse had to perform wound care. She stated she spoke with Resident #45 in February 2023 who had informed her, she liked to have her wound care completed in the morning. The Wound Care nurse explained she worked Monday through Friday and ensured Resident #45 her daily wound care treatment would be completed by 10:00am. She discussed not working on 4-24-23 and the floor nurses were responsible for Resident #45's wound care. The Wound Care nurse stated she was unable to state why resident #45's wound care was not completed in the morning. Observation of Resident #45's wound care on 4-25-23 at 9:55am revealed Resident #45 had her wound care treatment completed within her preferred time frame. During an interview with Nurse #3 on 4-26-23 at 9:40am, the nurse confirmed he had been responsible for Resident #45's wound care treatment on 4-24-23. The nurse explained when he was responsible for completing wound care on his residents, he completed the treatments when he could and that sometimes he was not able to complete the wound care treatments so he would have to have the next shift (3:00pm to 11:00pm) complete the treatments. Nurse #3 stated he was aware of Resident #45's preference to have her	F 561	The social worker and Activities Director will complete Resident Preference Questionnaire with alert and oriented residents to include resident #45 weekly x 4 weeks, then monthly x 1 month to ensure resident preferences to include wound care is being honored appropriately. All areas of concern will be immediately addressed by the Unit Managers to include providing care per resident preference, updating the care plan/care guide as indicated for changes or new resident preferences and/or re-education of staff. The Director of Nursing will review questionnaires weekly for 4 weeks, then monthly for one month to ensure all areas of concern are addressed. The Administrator will forward the results of the Resident Preference Questionnaire to the Quality Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Resident Preference Questionnaire 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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F 561	Continued From page 7 wound care completed in the morning but said he was not always able to "cater" to the resident's preference. He stated on 4-24-23 he was not able to complete Resident #45's wound care until 2:00pm because of his other duties. Nurse #3 discussed not having any support that was available to assist him in completing his tasks. NA #4 was interviewed on 4-26-23 at 2:45pm. The NA discussed Resident #45 preferring to be up out of bed by 12:00pm so the resident could attend activities. NA #4 stated she was willing to get Resident #45 out of bed without her wound care treatment being completed but said she was told by the floor nurse (the NA could not remember a name) Resident #45 could not get up until her wound care treatment was completed. An interview occurred with the Corporate Clinical Director on 4-26-23 at 4:10pm. The Corporate Clinical Director discussed how the facility tried to honor resident preferences and if the staff could not, it was expected that staff would speak with the resident and arrange an agreeable alternative for the day. She explained it was difficult for the floor nurses to complete wound care due to their other duties but stated there were alternatives to ensure the resident's choice was honored. The Administrator was interviewed on 4-27-23 at 1:25pm. The Administrator stated she expected staff to honor resident choices per the resident request and/or care plan. She also discussed expecting staff to request help if needed to try and accommodate a resident's preference.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		5/25/23

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F 582	Continued From page 8	F 582		

§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any

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F 582	Continued From page 9 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a complete Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) by omitting the estimated cost for 1 of 3 residents reviewed for beneficiary notices (Resident #46). Findings included: Resident #46 was admitted to the facility on 10/4/21 diagnoses to include stroke, hypertension, and heart failure. The quarterly Minimum Data Set assessment (MDS) dated 1/21/23 revealed Resident # 46 was cognitively intact. Review of Resident # 46's record indicated the SNF ABN dated 3/24/23 had no estimated cost documented on the form. During an interview on 4/26/23 at 8:09 AM the Social Worker stated she was not informed of the estimated cost needing to be included in the SNF	F 582	F582 Liability Notice On 5/12/23, the Social Worker completed liability notice for resident #46 to include estimated cost of services and provided a written copy to the resident representative. On 5/12/23, Accounts Receivable initiated an audit of all NOMNCs issued for the past 30 days. This audit was to ensure all Notifications of Medical Non-Coverage (NOMNC) were completed appropriately to include but not limited to listing estimated cost of services. All areas of concern were addressed by the Social Worker and Accounts Payable to include completing an appropriate notification of non-coverage to include the estimated cost of services and that a copy is provided to the resident/resident representative. The audit will be completed by 5/24/23.	

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F 582	Continued From page 10 ABN. She concluded she would begin to include the estimated cost in the future. During an interview on 4/26/23 at 8:17 AM the Administrator stated if estimated costs was to be included in the SNF ABN then it should have been completed for Resident #46.	F 582	On 5/12/23, the Administrator initiated an in-service with the Social Worker and Medical Records regarding Notifications of Medical Non-Coverage (NOMNC) with emphasis on providing appropriate notification related to non-coverage of Medicare A to include estimated cost of services. In-service will be completed by 5/24/23. After 5/24/23, any Social Worker who has not received the in-service will complete it prior to the next scheduled work shift. All newly hired Administrator, Accounts Receivable and/or Social Workers will be in-serviced during orientation regarding Notifications of Medical Non-Coverage (NOMNC). 10% audit of all Medicare A discharges will be reviewed by the Accounts Receivable and Medical Records weekly x 4 weeks then monthly x 1 month utilizing the NOMNC Audit Tool to ensure the appropriate notification of medical non-coverage was provided to the resident/resident representative to include but not limited to estimated cost of services. Accounts Receivable will address all areas of concern identified during the audit. The Staff Facilitator will re-educate staff for any concerns identified. The Administrator will review the NOMNC Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Administrator will forward the NOMNC Audit Tool to the Quality Assurance and Performance	

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F 582	Continued From page 11	F 582	Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the NOMNC 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 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing	F 607		5/25/23

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F 607	Continued From page 12 retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy for protection, reporting and investigation. This was for 1 of 1 resident (Resident #90) with an allegation of abuse. Findings included: The facility's policy titled "Abuse, Neglect, or Misappropriation of Resident Property Policy" last revised on 10/15/22 read in part, "Any employee who witnesses or suspects that abuse, neglect, exploitation, or misappropriation of resident property has occurred will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator. Allegations of abuse, neglect, exploitation, or misappropriation of resident property and injuries of unknown origin will be investigated by the facility. Employees accused of being directly involved in allegations of abuse, neglect, exploitation, or misappropriation of resident property will be suspended immediately pending the outcome of the investigation. The resident will be examined for any sign of injury as appropriate and emotional support will be provided as needed. The Administrator will ensure for all allegation that involves abuse or results in serious bodily injury, the Division of Health Service Regulation, Health Care Personnel Section, and Adult Protective Services are notified immediately but not later than 2 hours after the allegation is received, and determination of abuse is made."	F 607	NA #1 and NA #3 no longer work at the facility. On 4/25/23, the Administrator initiated an investigation for an allegation of abuse for resident #90 to include completion of initial report, notification of police and Adult Protective Services (APS), and removal of alleged perpetrator nursing assistant #3 (NA) pending investigation. On 4/25/23, resident #90 was assessed by the nurse for signs and symptoms of abuse with no negative findings. Resident #90 denied abuse while residing in the facility. On 4/25/23, nurses from sister facilities and floor nurses initiated 100% skin assessments on all non-alert and oriented residents for signs and symptoms of abuse, including but not limited to bruising, skin tears, and signs/ symptoms of pain. There were no residents identified with signs and symptoms of abuse. The audit was completed on 4/25/23. On 4/25/23, the Social Worker interviewed all alert and oriented residents regarding abuse. There were no allegations of abuse voiced during the interviews. The interviews were completed on 4/25/23. On 4/25/23, the Unit Manager audited progress notes for the past 14 days. This	

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Resident #90 was admitted to the facility on 4/13/21.

A review of her quarterly Minimum Data Set (MDS) assessment dated 4/2/23 revealed she was severely cognitively impaired.

In an interview on 4/25/23 at 2:46 PM Nurse Aide (NA) #1 stated approximately 2 to 2 and 1/2 weeks ago, she could not recall the exact date, she and NA #3 had been working with Resident #90. She indicated she observed NA #3 swear at Resident #90 and being rough with her during care. She believed NA #3 was physically and verbally abusive to Resident #90.

In a follow-up telephone interview on 4/26/23 at 9:38 AM NA #1 stated NA #2 came to Resident #90's room following the incident with NA #3, and she informed her of what happened. NA #1 stated NA #2 told her she would go let the Director of Nursing (DON) know what happened. NA #1 stated she herself did not report the incident to Nurse #2 (the assigned nurse), the DON, or the Administrator that day although she knew she should have. She went on to say she looked for the DON a couple of times that day but couldn't find her. She further indicated NA #3 continued to work the rest of that shift. NA #1 stated while she knew from her abuse training that NA #3 should not have continued to work with residents after the incident, she had not wanted to overstep her authority. She stated she felt that it would have been the DON's responsibility to deal with NA #3. NA #1 stated she did follow up with the DON the next day to make sure NA #2 reported to her. She went on to say she described the incident to the DON and the DON told her the incident had already been reported to her. NA #1 further

audit was to identify any residents with documentation of signs and symptoms of abuse. There was no documentation of signs and symptoms of abuse. The audit was completed on 4/25/23.

On 4/25/23, the Administrator audited resident concerns for the past 14 days. This audit was to ensure identified allegations were reported per protocol. There were no identified allegations. The audit was completed on 4/25/23.

On 4/25/23, the facility consultant completed an audit of all reportable investigative folders for the past 30 days. This audit is to ensure all required reportable events were investigated, alleged perpetrator immediately removed from care and allegation reported timely and per state guidelines. There were no additional concerns identified.

On 4/25/23, the Administrator initiated staff questionnaires with all staff, including Nurses, Nursing Assistants, Medication Aides, Dietary Staff, Housekeeping Staff, Therapy Staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and Receptionist regarding abuse. This questionnaire ensures that any incidents of abuse were immediately reported, the perpetrator was removed from resident care areas, and the incident was investigated per facility protocol. The Administrator will address all concerns

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indicated the DON told her she would be doing some observations of NA #3's interactions with residents.

In a telephone interview on 4/25/23 at 6:41 PM NA #2 verified approximately 2 to 2 and a half weeks ago NA #1 informed her she observed NA #3 swear at Resident #90 and being rough with her during care and that she believed this was abuse. She indicated she had immediately gone to the DON and reported to her what NA #1 told her regarding the allegation of NA #3 abusing Resident #90. NA #2 stated the DON told her she would do some observations of NA #3. She went on to say NA #3 did continue to work with residents that day, but she felt like she had done her duty in reporting the incident to the DON, so she did not question it.

Record review revealed no evidence this allegation of abuse involving NA #3 and Resident #90 was reported to the state agency.

During an interview with the Administrator on 4/25/23 at 4:01 PM she revealed she had not been made aware of any allegation of abuse involving NA #3 and Resident #90. She verified this allegation had not been reported to the state agency and had not been investigated by the facility.

On 4/25/23 at 4:07 PM a telephone interview with the DON indicated she did not recall ever receiving any report from NA #1 or NA #2 related to an allegation of resident abuse involving NA #3 and Resident #90.

On 4/26/23 at 3:10 PM an interview with the Administrator indicated she had no idea why NA

identified during the audit, including but not limited to an assessment of the resident, removal of the perpetrator from all care areas, and notification per facility protocol. The questionnaires will be completed by 4/25/23. After 4/25/23, any staff who still needs to complete the questionnaire will complete it before the next scheduled work shift.

On 4/25/23, the Administrator initiated an in-service with all staff, including Nurses, Nursing Assistants, Medication Aides, Dietary Staff, Housekeeping Staff, Therapy Staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and the Receptionist on (1) Abuse with emphasis on the definition of abuse, immediately removing the perpetrator from resident care and verbally reporting abuse, notification of Administrator if staff feel concerns are not addressed immediately (2) Effective Communication with an emphasis on verbal interactions and providing care at resident's pace. All in-services will be completed by 4/25/23. After 4/25/23, any Nurse, Nursing Assistants, Medication Aides, Dietary Staff, Housekeeping Staff, Therapy Staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and Receptionist who has not worked or completed the in-service will complete

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F 607	Continued From page 15 #1 and NA #2 would both recount reporting to the DON that NA #3 had abused Resident #90, but the DON denied this had been reported to her. She stated her concern was that if a staff member reported to the DON a potential incident of abuse by an employee, the first thing that needed to happen was to ensure the resident was safe, the accused employee immediately removed, and an investigation begun.	F 607	before the next scheduled work shift. All newly hired Nurses, Nursing Assistants, Housekeeping Staff, Therapy Staff, Medical Records, Admission Staff, Accounts Payable/Receivable, Receptionist, Social Worker, Dietary Staff, and Maintenance staff will be in-serviced during orientation regarding Abuse, and Effective Communication. On 4/25/23, the facility nurse consultant completed an in-service with the Administrator and Assistant Director of Nursing regarding reportable events to include but not limited to abuse and that all allegations must be investigated, alleged perpetrator immediately removed from care areas for the safety of residents and reported to the state, police and APS per state guidelines. In-service will be completed with the Director of nursing upon return to work. On 4/25/23, the Administrator initiated Abuse Quizzes with all staff to include Nurses, Nursing Assistants, Medication Aides, Dietary Staff, Housekeeping Staff, Therapy Staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker (SW), and Receptionist. This quiz is to validate staff knowledge and understanding of the education/in-services on abuse including what constitutes abuse, immediate removal of the perpetrator from all care areas, and reporting abuse immediately.	

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F 607	Continued From page 16	F 607	Quizzes will be completed by 4/25/23. After 4/25/23, any staff who still needs to complete the quiz will complete it before the next scheduled work shift. Any staff that does not pass the quiz after three attempts will be allowed to work once, they are re-educated and successfully pass. 10 Staff-to-resident interactions with aides will be completed utilizing the Staff to Resident Interaction Audit Tool by the treatment nurse, nurse supervisor, and Unit Manager weekly to include all shifts and weekends x 4 weeks then monthly x 1 month. This audit ensures that staff interact with residents appropriately during care and that there are no signs and symptoms of abuse, including verbal abuse. The treatment nurse, nurse supervisor, and Unit Manager will address all concerns identified during the observations, including immediately removing the perpetrator from resident care, initiating an investigation, and reporting per facility protocol, resident assessment, and physician notification. The Administrator will review the staff interactions weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Social Worker will complete 5 questionnaires with alert and oriented residents and 5 questionnaires with staff regarding Abuse weekly x 4 weeks then monthly x 1 month. This questionnaire is to identify concerns related to staff interactions with residents and/or abuse to	

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F 607	Continued From page 17	F 607	ensure all incidents of abuse are immediately reported, the alleged perpetrator immediately removed from care for the safety of residents and an investigation initiated with notification of state, police and APS. The Social Worker will address all concerns identified during the audit, including notification of the Administrator and/or DON for any allegations of abuse for further investigation. The Administrator will review the questionnaires weekly x 4 weeks to ensure all concerns are addressed. The facility consultant will review the investigative folder for all reportable events to include but not limited to allegations of abuse weekly x 4 weeks then monthly x 1 month. This audit is to ensure the facility initiated an investigation per facility protocol to include immediate removal of alleged perpetrator from care for the safety of residents, and timely reporting to the state, APS and police per state guidelines. The facility consultant will address all concerns identified during the audit to include initiating investigation when indicated, removing alleged perpetrator from care and re-training of staff. Administrator will forward the results of the resident/staff questionnaires, audit of reportable events, and staff to resident interactions to the QAPI (Quality Assurance Performance Improvement) Committee monthly x 2 month. The QAPI Committee will meet monthly x 2 month to review the progress note audit and	

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F 607	Continued From page 18	F 607	staff-to-resident interaction audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F 645		5/25/23

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F 645	Continued From page 19 §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident had received a Preadmission Screening and Resident Review (PASRR) prior to admission to the facility for 1 of	F 645	F645 Coordination of PASARR and Assessments On 4/25/23 the Admission Director	

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F 645	Continued From page 20 1 resident (Resident #50). Findings included: Resident #50 was admitted to the facility on 12/02/22 with diagnoses which included depression and a history of schizoid personality disorder. Review of Resident #50's electronic medical record revealed a time limited PASRR level II dated 5/24/16 with an expiration date of 7/23/16. Further review revealed, in part, a placement determination of nursing facility placement was appropriate for a 60-day period. Review of Resident #50's North Carolina Medicaid Uniform Screening Tool (NC MUST) PASRR Program detail history revealed his most recent PASRR number dated 9/12/16 ended in the letter "X" which meant authorization was cancelled and no longer seeking placement/consent not granted. An interview on 4/25/23 at 1:21 PM with the Admissions Director revealed she was unaware Resident #50 did not have a current PASRR. She stated he had been in living in assisted living at the facility and when he moved to a skilled nursing bed on 12/2/22 she had not checked for a current PASRR for him. An interview on 4/25/23 at 2:29 PM with the Administrator revealed Resident #50 should have had another PASRR requested when he moved from assisted living to skilled nursing, and it had just fallen through the cracks.	F 645	submitted a preadmission screening and Resident Review (PASARR) for Resident # 50. On 5/10/23, the PASARR returned as a level II and the care plan was updated. On 5/4/23, the Assistant Director of Nursing (ADON) and Medical Records Director initiated an audit of all residents to ensure each resident had current and accurate PASARR. The Assistant Director of Nursing and the Admission Director will address all concerns identified during the audit will address all concerns identified during the audit to include submitting information for PASARR evaluations for any resident who does not have a current PASSAR, has an expired PASARR or who has a need for Level II PASARR review following changes in mental health status or newly Level II qualifying diagnosis. Audit will be completed by 5/24/23. On 5/12/23 the Administrator initiated an in-service regarding PASARRs with the Admission Director, Social Worker, Minimum Data Set Nurse (MDS), ADON and Director of Nursing with emphasis on referral for evaluation/re-evaluation of PASARR on admission, when PASARR expires, following changes in mental health status or newly Level II qualifying diagnosis. In-service will be completed by 5/24/23. After 5/24/23, any Admission Director, Social Worker, Minimum Data Set Nurse (MDS), ADON and Director of Nursing who has not worked or received the in-service will complete upon next scheduled work shift. All newly hired	

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F 645	Continued From page 21	F 645	Admission Director, Social Worker, Minimum Data Set Nurse (MDS), and Director of Nursing will be in-service during orientation regarding PASARRs. The Medical Records Director will review 10 resident charts to include new admissions weekly x 4 weeks then monthly x 1 month utilizing the PASARR Audit Tool. This audit is to ensure the resident has a current and accurate PASARR. The ADON, MDS nurse and/or Admission Director will address all concerns identified during the audit to include referral for evaluation/re-evaluation of PASARR for any resident without a current PASARR, an expired PASARR or following changes in mental health status or newly Level II qualifying diagnosis. The Administrator will review the PASARR Audit Tool weekly for 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Administrator will forward the results of the PASARR Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the PASARR 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 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		5/25/23

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§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be

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F 655	Continued From page 23 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to initiate a baseline care plan on admission for 1 of 4 residents (Resident #115) for care planning. Findings included: Resident #115 was admitted to the facility on 12/2/22 with diagnoses that included hip fracture, cancer, heart failure, and dysphagia (difficulty swallowing foods or liquids). Resident #115's medical record revealed no baseline care plan. An interview was conducted on 4/27/23 at 8:59 A.M. with the Activities Assistant. During the interview, the Activities Assistant indicated the nurse who admitted Resident #115 was responsible to initiate the baseline care plan. Resident #115's medical record was reviewed with the Activities Assistant at the time of the interview. The Activities Assistant indicated Resident #115's care plan showed his care plan was started by herself on 12/7/23. She indicated the baseline care plan for Resident #115 was required to be completed within 48 hours from his admission on 12/2/23. The Activities Assistant indicated the care plan was not completed on time and she is unsure why nursing staff had not initiated the care plan when he arrived in the facility.	F 655	F655 Baseline Care Plan Resident #115 no longer resides in the facility. On 5/11/23, the Assistant Director of Nursing (ADON) initiated an audit of all admissions and/or readmissions for the past 30 days. This audit is to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and that the resident and/or resident representative was provided a copy of the care plan. All areas of concern were immediately addressed by the MDS nurse and Unit Managers. Audit will be completed by 5/24/23. On 5/12/23, the Assistant Director of Nursing initiated an in-service with all nurses, MDS Coordinator, and MDS nurse regarding Baseline Care Plans. Emphasis includes guidelines to develop and implement a baseline care plan for each new admission and/or readmission within 48hrs that includes instructions needed to provide effective and person-centered care of the resident,	

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F 655	Continued From page 24 An interview was conducted on 4/27/23 at 11:23 A.M. with the Unit Manager. The Unit Manager indicated the admitting nurse, or a manager were responsible to complete a resident's initial baseline care plan. The Unit Manager indicated every resident required an initial care plan to be completed the day they were admitted. During the interview, the Unit Manager indicated Resident #115 not having a base line care plan was an oversite and she was unsure how it was missed by staff. An interview was conducted on 4/27/23 at 11:44 A.M. with the Cooperate Clinical Director. During the interview, the Cooperate Clinical Director indicated staff were expected to begin the initial baseline care plan for residents within 48 hours of their admission.	F 655	minimum healthcare information necessary to properly care for a resident, and that the facility must provide the resident and their resident representative with a summary of the baseline care plan. In-service will be completed by 5/24/23. After 5/24/23, any nurse who has not worked or completed the in-service will complete it prior to the next scheduled work shift. All newly hired will be in-service regarding Baseline Care Plans during orientation. 10% audit of all admissions and/or readmissions will be completed by the MDS nurses and Unit Managers utilizing the Baseline Care Plan Audit Tool 3 times a week x 4 weeks then monthly x 1 month. This audit is to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and that the resident and/or resident representative was provided a copy of the care plan. All areas of concern will be immediately addressed by the MDS nurse and Unit Managers to include retraining of staff as indicated. The Director of Nursing (DON) will review and initial the Baseline Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns have been addressed. The Director of Nursing will forward the results of Baseline Care Plan Audit Tool to	

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F 655	Continued From page 25	F 655	the Quality Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Baseline Care Plan 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		5/25/23

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F 656	Continued From page 26 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to care plan diabetes mellitus for 1 of 6 residents reviewed for medications (Resident #114). Findings included: Resident #114 was admitted to the facility on 7/7/22. Her active diagnoses included diabetes mellitus. Resident #114's quarterly Minimum Data Set (MDS) assessment dated 10/17/22 revealed she was assessed as severely cognitively impaired. She received insulin injections 7 days of the 7 day lookback period. Review of Resident #114's care plan dated 8/15/22 and revised 10/27/22 revealed she was	F 656	F656 Develop/Implement Comprehensive Care Plan Resident #114 no longer resides in the facility. On 5/4/23, the Minimum Data Set Nurse, Assistant Director of Nursing (ADON) and Director of Nursing (DON) initiated an audit of all resident□s care plans. This audit is to ensure residents are care planned for current medical diagnoses to include but not limited to diabetes. The MDS nurse, ADON, DON and/or Unit Managers will address all areas of concern identified during the audit to include updating care plans when indicated. Audit will be completed by 5/24/23.	

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F 656	Continued From page 27 not care planned for diabetes mellitus. During an interview on 4/25/23 at 2:29 PM the MDS Coordinator stated diabetes and insulin should be care planned and she did not know why it was not done for Resident #114. During an interview on 4/25/23 at 2:41 PM the Cooperate Clinical Director stated diabetes and insulin should be care planned.	F 656	On 5/12/23, the DON, ADON and Unit Managers initiated an in-service with all nurses regarding Comprehensive Care Plans with emphasis on ensuring care plan is resident centered and goal oriented and to ensure that the care plans reflect the resident□s most current information all aspects of care to include but not limited to diagnoses. In-service will be completed by 5/24/23. After 5/24/23, any nurse who has not worked or completed the in-service will be educated prior to the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Comprehensive Care Plans. The Interdisciplinary Team members to include the Minimum Data Set Nurse (MDS), Unit Managers, and ADON will review all admissions/readmissions and newly added diagnoses for residents 5 times a week x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure care plan is resident centered and goal oriented and to ensure that the care plans reflect the resident□s most current information all aspects of care to include but not limited to diagnoses. The Director of Nursing (DON) will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns are addressed. The DON will forward the results of the Care Plan Audit Tool to the Quality Assurance Performance Improvement	

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F 656	Continued From page 28	F 656	(QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months to review the Care Plan 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 677 SS=E	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, observation, staff, and resident interviews the facility failed to provide (1) incontinence care hygiene (Resident #13), (2) nail care (Resident #264) and failed to (3) rinse soap from a resident (Resident #88) during a bath for 3 of 3 residents who were dependent on staff for activities of daily living care. Findings included: 1. Resident #13 was admitted to the facility on 5-17-21 with multiple diagnoses that included protein-calorie malnutrition. The quarterly Minimum Data Set (MDS) dated 2-10-23 revealed Resident #13 was cognitively intact and required extensive assistance with bed mobility, total assistance with one for dressing and personal hygiene and total assistance with two for toileting. Resident #13's care plan dated 3-5-23 revealed a	F 677	F677 ADL Care Provided for Dependent Residents On 5/5/23, a skin check was completed by the nurse for resident #13 with no skin concerns identified. On 5/12/23 resident #13 was provided incontinent care by the nursing assistant under the oversight of the Assistant Director of Nursing to ensure appropriate technique was used. There were no concerns noted during care. Resident #264 no longer resides in the facility. On 5/13/23, resident #88 was provided a full bed bath by the assigned nursing assistant (NA) with oversight of the Unit Manager to ensure staff utilized appropriate technique to include but not limited to rinsing soap from resident skin. There was no redness or skin irritation	5/25/23

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F 677	Continued From page 29 goal of activities of daily living/personal care would be completed with staff support. The interventions included personal hygiene/grooming required total care for wash and dry face, skin, nails, hands, and perineum. Resident #13 was interviewed on 4-24-23 at 10:55am. The resident discussed being left in urine and feces half the day and not being washed thoroughly when staff changed his brief. An observation of incontinence care occurred on 4-25-23 at 2:38pm with Nursing Assistant (NA) #5. Resident #13's brief was noted to be wet but not saturated with no bowel movement. The resident's skin was observed to be intact with no redness present. NA #5 was observed to use pre-moistened wipes to clean the resident's peri-area. She was observed to not lift the resident's penis but instead wipe one time over the shaft of his penis. The NA then placed the resident on his side and washed his bottom and placed a new brief on the resident. NA #5 was interviewed on 4-25-23 at 2:45pm. The NA discussed how she washed a male's peri-area by cleaning the shaft of the penis, pulling back the foreskin and/or wiping around the opening of the penis. NA #5 acknowledged she did not perform those steps when providing incontinence care to Resident #13. The NA stated she forgot because she was nervous. An interview with Nurse #4 occurred on 4-25-23 at 3:05pm. The nurse explained when performing peri-care on a male resident the NA should remove the brief, pull back the foreskin and clean the area including the head of the penis and around the opening.	F 677	noted during care. On 5/12/23, the hall nurses initiated an audit of nail care (fingernails and toenails) for all residents to ensure all residents were provided nail care/cleaning/trimming per resident preference. The hall nurse, treatment nurse, and Unit Managers provided nail care for all identified concerns during the audit. The audit will be completed by 5/24/23. On 5/4/23, the Social Worker initiated Resident Preference Questionnaire with all alert and oriented residents regarding resident preferences to include but not limited to preferences for care/treatment times, nail care/length, and getting in or out of bed. The Social Worker, Unit Managers and Assistant Director of Nursing will update the care plan for all newly identified or changes in resident preferences. Questionnaires will be completed by 5/24/23. On 5/12/23, the Unit Managers, Director of Nursing (DON) and Assistant Director of Nursing (ADON) initiated return demonstrations with all nursing assistants regarding Activities of Daily Living (ADL) care to include but not limited to (1) Incontinent Care with emphasis on cleaning the entire perineal area during incontinent care (2) Baths with emphasis on rinsing soap from resident skin to prevent skin irritation and (3) Nail Care with emphasis on cleaning and trimming nails per resident preference. This was to ensure staff used appropriate techniques	

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F 677	Continued From page 30 The Corporate Clinical Director was interviewed on 4-25-23 at 3:07pm. The Corporate Clinical Director stated she would have expected NA #5 to perform good peri-care on all male residents. The Administrator was interviewed on 4-27-23 at 1:25pm. The Administrator stated she would have expected staff perform appropriate peri-care on male residents. 2. Resident #264 was admitted to the facility on 4-17-23 with multiple diagnoses that included chronic kidney disease stage 4. The admission documentation noted Resident #264 as alert and oriented to person, place, and time. Resident #264's care plan dated 4-18-23 revealed a goal that his activities of daily living/personal care would be completed with staff support. There were no interventions documented for the goal. Resident #264 was interviewed on 4-24-23 at 11:10am. The resident's fingernails were noted to be an inch long and caked with a brown and yellow substance underneath the nail. Resident #264 stated he did not like long fingernails, and he had asked staff (could not remember who) to cut them. He explained he was informed by staff that they were not allowed to cut residents' fingernails in the facility. A Nursing Assistant (NA) #5 was interviewed on 4-25-23 at 2:45pm. The NA was observed completing incontinence care to Resident #264. NA #5 confirmed she was assigned to Resident	F 677	when providing ADL care. Return demonstrations will be completed by 5/24/23. After 5/24/23, any nursing assistant who has not completed the return demonstration will complete prior to the next scheduled work shift. On 5/12/23, the Unit Managers, Director of Nursing (DON) and Assistant Director of Nursing (ADON) initiated an in-service with all nurses and nursing assistants regarding (1) Resident Preferences with emphasis on resident right to make choices about aspects of life to include but not limited to wound care, nail care and times to get in or out of bed (2) ADL Care with emphasis on rinsing soap from skin when providing bath/showers and cleaning/trimming nails per resident preference and (3) Incontinent Care with emphasis on cleaning the entire perineal area to prevent skin irritation. In-services will be completed by 5/24/23. After 5/24/23, any nurse or nursing assistant who has not completed the in-services will be educated prior to the next scheduled work shift. All newly hired nurses and nursing assistants will be in service during orientation regarding Resident Preferences, ADL care and Incontinent Care. The Unit Managers and treatment nurse will complete 15 resident care audits weekly x 4 weeks then monthly x 1 month. This audit is to ensure that staff provide ADL care per resident preference utilizing appropriate techniques to include but not limited to perineal care, baths, nail care.	

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F 677	Continued From page 31 #264 today (4-25-23) and had provided the resident a full bed bath earlier in the day. She also confirmed she had noticed Resident #264's fingernails were long and dirty but stated she did not have time to clean or cut his nails today. Observation of Resident #264 on 4-25-23 at 2:48pm revealed the resident's fingernails remained long and had a brown/yellow substance caked under the nails. During an interview with Nurse #4 on 4-25-23 at 3:05pm, the nurse explained a nurse, or a NA can cut and clean resident fingernails. She further explained the NA would provide nail care during the bathing process of a resident and she could not explain why Resident #264 had not had his fingernails cut and cleaned. Observation of bathing occurred on 4-26-23 at 10:08am with NA #6. Resident #264's fingernails were observed to be long and dirty. The resident was observed asking NA #6 to cut and clean his nails. NA #6 was heard responding to Resident #264 stating she did not have fingernail clippers to cut his nails. Observation of the bath also revealed NA #6 did not clean under Resident #264's fingernails. During an interview with NA #6 on 4-26-23 at 11:00am, NA #6 explained she did not clean under Resident #264's nails because the matter under the nails was caked in under the fingernails and she was afraid it may hurt the resident to try and clean the fingernails. NA #6 explained she would obtain nail clippers and cut Resident #264's fingernails first and then clean underneath the nails.	F 677	The Unit Managers and treatment nurse will address all areas of concern identified during the audit to include providing care per resident preference and/or re-training of staff. The DON will review the Resident Care Audits weekly for 4 weeks, then monthly for one month to ensure all areas of concern are addressed. The Social Worker and Activities Director will complete 5 Resident Preference Questionnaires with all alert and oriented residents regarding resident preferences to include but not limited to preferences for care/treatment times, nail care/length, and getting in or out of bed. The Social Worker, Activities Director and Unit Managers will address all concerns identified during the questionnaires to include but not limited to updating the care plan for all newly identified or changes in resident preferences and/or re-training of staff. The DON will forward the results of the Resident Care Audits and Resident Questionnaires to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review 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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Resident #264 was interviewed on 4-27-23 at 8:41am. The resident stated no one had come and cut or cleaned his fingernails. He stated he asked staff yesterday to cut and clean them, but no one did.

Observation of Resident #264's fingernails revealed they were still long with a brown and yellow substance caked underneath the fingernails.

The Corporate Clinical Director was interviewed on 4-27-23 at 9:08am. She explained when a NA provided a bath to a resident, she would expect the NA to clean and/or cut the residents fingernails.

The Corporate Clinical Director stated she did not know why the NAs were not cleaning and/or cutting Resident #264's fingernails especially if he had requested his fingernails to be cut.

The Administrator was interviewed on 4-27-23 at 1:25pm. The Administrator stated she expected resident fingernails to be cleaned and/or cut during the bathing process.

3. Resident #88 was admitted to the facility on 12/28/2022 with a diagnosis of diabetes.

A review of her quarterly Minimum Data Set (MDS) assessment dated 1/2/23 revealed she was cognitively intact. She required the total assistance of one person for bathing.

A review of Resident #88's current comprehensive care plan revealed a focus area of activities of daily living preferences. The goal was for her preferences to be provided through the next review. An intervention last revised on

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1/26/23 was prefers a bed bath.

In an interview on 4/24/23 at 3:38 PM Resident #88 stated there were times when she received a bath that some nurse aides (NAs) didn't rinse off the soap. She went on to say when she asked about this, the NAs told her it was the kind of soap that didn't need to be rinsed off. She further indicated it sometimes made her itchy, but she did not have any rash. Resident #88 stated the soap the NAs used for her bath was orange liquid soap.

On 4/25/23 at 9:47 AM an observation of bathing was conducted for Resident #88 with NA #1 and NA #7. The soap used for Resident #88's bath was observed to be orange liquid. The instructions on the bottle indicated to moisten the washcloth, lather, and rinse. NA #7 was observed to prepare a single basin of warm water. During the bathing, NA #7 was observed to squeeze a small amount of orange liquid soap onto a wet washcloth and use this to wash Resident #88. Lather was observed on Resident #88's skin. NA #7 was then observed to use a towel to dry Resident #88 without rinsing her.

An interview with NA #7 at that time indicated she knew she should have rinsed the soap from Resident #88's skin before she dried her, but she had been nervous and forgotten.

On 4/25/23 at 12:41 PM an interview with the Wound Care Nurse indicated the soap used during Resident #88's bath was not a no rinse soap and should have been rinsed off her skin before she was dried. She stated not rinsing this soap off Resident #88's skin before drying her could cause skin irritation.

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F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to ensure the continued application of a left resting hand splint after discharge from therapy services for 1 of 1 residents (Resident #40) reviewed for range of motion. This placed Resident #40 at risk for pain and progression of her contracture (muscle tightening). Findings included: Resident #40 was admitted to the facility on 2/5/21 with a diagnosis of flaccid hemi-paresis (weakness) affecting the left non-dominant side. A review of her quarterly Minimum Data Set (MDS) assessment dated 3/21/23 revealed she	F 688	F688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) On 5/12/23, the order for resting hand splint for resident #40 was clarified and updated in the electronic record. Resting hand splint was applied to left wrist per therapy recommendation and physician order. On 5/10/23, the Minimum Data Set Nurse initiated an audit of all residents with orders for splints and/or care planned for use of splint to include resident # 40. This audit is to ensure that splint was applied per resident plan of care to prevent	5/25/23

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was cognitively intact. She had functional limitation of range of motion on one side of both her upper and lower extremities. She received 207 minutes of Occupational Therapy (OT) beginning on 3/13/23. Her OT was still ongoing. She had not received any restorative nursing.

A review of the In-Service Training Report for Resident #40 dated 3/27/23 revealed OT #1 completed training with nursing staff on placing Resident #40's left resting hand splint every day for at least 6 hours to prevent pain and progressive contracture. It further revealed documentation that Nurse #8 and Nurse Aide #1 had been trained.

A physician's order for a left resting hand splint to be placed every day for at least 6 hours to prevent pain and progression of contracture was entered by OT #1 on 3/29/23. The duration of the order was indefinite. The order was discontinued on 3/31/23.

A review of the OT Therapist Progress and Discharge Summary for Resident #40 dated 4/13/23 revealed Resident #40's OT therapy began on 3/13/23. She was seen by OT for contracture (muscle tightening) of her left non-dominant side, pain in her left hand and abnormal posture. The discharge plan and instructions included nursing staff were to facilitate Resident #40's splinting program. She was discharged from OT on 4/13/23.

On 4/24/23 at 3:30 PM an observation and interview with Resident #40 revealed she was not wearing a left resting hand splint. The splint was observed to be present in her room on her dresser. An interview revealed she was not able

decrease in ROM. The therapy staff, Administrative Nurses and/or assigned hall nurse will address all areas of concern identified during the audit. Audit to be completed by 5/24/23.

On 5/10/23, the Minimum Data Set Nurse initiated an audit of all residents to include resident #40 care planned for use of splints. This audit is to ensure splint application was identified on the Point of Care (POC) Task Listing for nursing assistant to document application of splint when indicated. Audit will be completed by 5/24/23.

On 5/12/23, the Assistant Director of Nursing initiated an in-service with all nurses and nursing assistants to include regarding Range of Motion/Splints with emphasis on applying splints per resident plan of care to prevent a decrease in ROM ability. In-service to be completed by 5/24/23. After 5/24/23, any nurse or nursing assistant who has not received the in-service will complete prior to the next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced by the Staff Facilitator during orientation regarding Range of Motion/Splints.

5 residents care planned for use of splints, to include resident # 40 will be audited by the Unit Managers utilizing Splints Audit Tool weekly x 4 weeks then monthly x 1 month to ensure that splint is applied per the plan of care to prevent a decrease ROM ability with documentation

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F 688	Continued From page 36 to put the splint on herself. She stated her therapist had been putting her splint on, but since her therapy ended no one had been doing it. She stated when she asked NAs about it, she had been told therapy did that. She stated she was not having any pain in her hand and did not feel like it was stiffer. On 4/25/23 at 2:33 PM Resident #40 was not observed to be wearing her left resting hand splint. The splint was observed on her dresser. She stated no one had offered to put her splint on that day. On 4/25/23 at 2:35 PM an interview with NA #1 indicated she received training from therapy on applying Resident #40's left resting hand splint. She stated she was not caring for Resident #40 that day but when she cared for Resident #40 last week, she had put her splint on. She went on to say there was no place for her to document the application of Resident #40's hand splint. She further indicated she had not passed on the information or training she received regarding Resident #40's left resting hand splint to any other NAs. NA #1 stated she had not been told she was supposed to. On 4/25/23 at 2:41 PM an interview with NA #3 indicated he was caring for Resident #40 that day. He stated he was familiar with her and had cared for her before. He went on to say he had never put a left hand splint on Resident #40. He further indicated if he needed to put a splint on for a resident there would be a place for him to document putting the splint on and taking it off. He stated Resident #40 did not have this. On 4/27/23 at 9:20 AM an interview with OT #1	F 688	in POC. The MDS nurse will address all areas of concern identified during the audit to include application of splint per plan of care and re-education of staff. The Director of Nursing (DON) will review and initial the Splints Audit Tool weekly x 4 weeks then monthly x 1 month to ensure completion and that all areas of concern are addressed. The DON will forward the results of the Splints Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Splints 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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indicated Resident #40 had been having some pain and stiffness in her left hand when she began OT services. She went on to say Resident #40 was good at doing her range of motion exercises for her left hand to decrease the pain and stiffness. She stated Resident #40 was able to do these exercises herself. She further indicated the discharge recommendation had been for Resident #40 to continue wearing a left resting hand splint after her OT therapy had finished. OT #1 stated she completed the training with the nursing staff and the continued application of this splint was to be done by them. She went on to say Resident #40 liked to wear her left resting hand splint but could not place it on herself. She further indicated she entered the physician's order for the left resting hand splint to be placed on Resident #40 daily for 6 hours after she completed the training with nursing staff. OT #1 stated she had not discontinued the physician's order and Resident #40 should still be wearing her splint daily. She went on to say the main risks to Resident #40 from not having her left resting hand splint applied would be pain and increased stiffness although Resident #40 had complained of pain and stiffness in her left hand at times even when she had regularly been working with her. She further indicated Resident #40's left hand contracture was not severe and pain and stiffness in an affected limb were typical after a stroke (damage to the brain from lack of blood flow).

On 4/27/23 at 9:46 AM Resident #40 was not observed to have her left resting hand splint in place. The splint was observed on her dresser.

On 4/27/23 at 11:18 AM an interview with Nurse #7 indicated she was familiar with Resident #40

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F 688	Continued From page 38	F 688		

and frequently cared for her 3 days a week on the 3PM-11PM shifts. She stated she had never applied a left resting hand splint on Resident #40. She went onto say she did not know anything about one. She further indicated if a resident needed a splint applied it would show up on the resident's Medication Administration Record (MAR) or Treatment Administration Record (TAR) to let the nurse know it was needed. She stated Resident #40 did not have this on her MAR or TAR.

Attempts to reach Nurse #8 for a telephone interview were not successful.

On 4/27/23 at 11:30 AM an interview with Nurse #9 indicated she was Resident #40's assigned nurse that day. She stated Resident #40 had not had a left resting hand splint on that day that she knew of. She went on to say when a resident needed to have a splint applied, there would be a physician's order for it, and it would appear on the resident's MAR or TAR to let the nurse know it was needed. Nurse #7 stated Resident #40 did not have this on her MAR or TAR.

On 4/27/23 at 11:46 AM an interview with the Unit Manager indicated when a resident needed to continue wearing a splint after therapy was completed the therapist would conduct training with staff and would enter a physician's order for the resident. She went on to say this would ensure the splint would show up on the MAR or TAR for the nurses to know it was needed because in the past these had gotten missed. She stated she could not tell who had discontinued Resident #40's physician's order for her splint.

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F 688	Continued From page 39 On 4/27/23 at 12:45 PM an interview with the Corporate Clinical Director indicated Resident #40's physician's order for her left resting hand splint had been discontinued by the Director of Nursing (DON) on 3/31/23. She stated the DON told her that Resident #40's therapist instructed her to discontinue this order because there needed to be more training done with staff. The DON was not present in the facility and was not available for telephone interview. On 4/27/23 at 1:34 PM an interview with the Regional Vice President of Therapy indicated it would not be the process for the therapy department to go back and do more training with nursing staff after the resident had been discharged from therapy. She stated the physician's order for nursing staff to continue applying a left resting hand splint would only have been entered by the therapist after nursing staff training was completed. She went on to say if had been determined afterwards that the nursing staff required more training, it would require a new physician's order for the resident to be seen by therapy and the resident would need to be placed back on the therapy case load. She stated the process was for the nursing staff training to be completed before the resident was discharged from therapy. She went on to say therapy would not discharge a resident before nursing staff training was completed.	F 688		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		5/25/23

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F 698	Continued From page 40 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident receiving dialysis had a physician's order for 1 of 1 sampled resident (Resident #24) reviewed for dialysis. Findings included: Resident #24 was admitted to the facility on 12/8/11 with diagnoses that included end stage renal disease and dependence on renal dialysis. Resident #24's care plan dated 3/5/23 noted he was on hemodialysis related to end stage renal disease. Interventions included to assess resident upon return from dialysis treatment, monitor access site for bleeding and/or signs of infection, and communicate with dialysis treatment center as indicated for adjustments in resident's care. Review of the comprehensive Minimum Data Set (MDS) dated 3/7/23 revealed the resident was cognitively intact. The MDS was coded Resident #24 as receiving dialysis. Resident #24's medical record was reviewed and revealed there was no physician order for dialysis. An interview was conducted on 4/26/23 at 3:03 P.M. with Nurse #1. During the interview, Nurse #1 reviewed Resident #24's electronic medical record (EMR) and indicated there was no order for dialysis. She indicated the dialysis order for	F 698	F698 Dialysis On 5/12/23, the Unit Manager updated the order for dialysis for resident #24. On 5/10/23, the consultant completed an audit of all residents receiving dialysis to ensure orders are in place in the electronic record to include days of the week and location of dialysis, dialysis site is assessed immediately upon return from dialysis and each shift for bruit and thrill and that communication sheet is completed with each dialysis appointment. The Unit Manager will address all concerns identified during the audit to include clarifying dialysis order with the physician and updating electronic record and/or education of staff. The audit will be completed by 5/24/23. On 5/12/23, the Director of Nursing initiated an in-service with all nurses regarding Dialysis Residents with emphasis on (1) ensuring appropriate order is in place to include days of week and location (2) assessment of dialysis site with documentation in the electronic record and (3) completion of dialysis communication sheet prior to and upon return from dialysis. In-service will be completed by 5/24/23. After 5/24/23, any nurse who has not worked of completed the in-service will complete prior to next	

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F 698	Continued From page 41 Resident #24 should be in the computer. An interview was conducted on 4/26/23 at 4:13 P.M. with the Unit Manager. During the interview, the Unit Manager indicated Resident #24 should have an order in his EMR for his dialysis treatment that listed the dialysis center and the days he attended dialysis. The Unit Manager indicated Resident #24 had been a resident at the facility for many years and him not having an order for dialysis was an oversite. An interview was conducted on 4/27/23 at 11:44 A.M. with the Cooperate Clinical Director. During the interview, the Cooperate Clinical Director indicated every resident in the facility who received dialysis should have an order for dialysis treatment. She further indicated she was unsure why there was no order for Resident #24.	F 698	scheduled work shift. All newly hired nurses will be in-service during orientation regarding Dialysis Residents. The Unit Manager will audit all residents receiving dialysis weekly x 4 weeks then monthly x 1 month utilizing the Dialysis Audit Tool. This audit is to ensure orders are in place in the electronic record to include days of the week and location of dialysis, dialysis site is assessed immediately upon return from dialysis and each shift for bruit and thrill and that communication sheet is completed with each dialysis appointment. The Unit Manager will address all concerns identified during the audit to include clarifying dialysis order with the physician and updating electronic record and/or education of staff. The DON will review the Dialysis audit weekly x 4 weeks to ensure all concerns are addressed. The DON will present the findings of the Dialysis Audit Tools to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Dialysis Audit Tools 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=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring.	F 867		5/25/23

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A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

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

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F 867	Continued From page 43 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance	F 867		

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F 867	Continued From page 44 improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, resident, physician, and staff interviews and record review, the facility's Quality Assurance (QA) process failed to maintain implemented procedures, monitor, and revise as needed the action plans developed for the recertification and complaint investigation survey of 12/16/21 in order to sustain compliance. This was for 1 recited deficiency on the current	F 867	F867 QAPI/QAA Improvement Activities On 5/12/23, The Facility Consultant initiated an audit of previous citations and action plans within the past two years related to F677 ADL Care Provided for Dependent Residents	

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F 867	Continued From page 45 recertification and complaint investigation survey of 4/27/23. The deficiency was in the area of activities of daily living care (F677). The continued failure during these federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross-referenced to: F677 - Based on record review, observation, staff, and resident interviews the facility failed to provide (1) incontinence care hygiene (Resident #13), (2) nail care (Resident #264) and failed to (3) rinse soap from a resident (Resident #88) during a bath for 3 of 3 residents who were dependent on staff for activities of daily living care. During the recertification and complaint investigation survey of 12/16/21 the facility was cited for failing to provide incontinent care. During an interview on 4/27/23 at 4:09 PM the Administrator stated she believed the repeat deficiency was a result of staff turnover, utilization of agencies, and inconsistent core nursing leadership as a result of staff turnover.	F 867	to ensure the Quality Assurance (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 QA Nurse for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to the education of staff. Audit will be completed by 5/24/23. On 5/12/23, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing 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 5/24/23. All newly hired Administrator, DON and QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns, to include ADL Care Provided for Dependent Residents will be taken to the Quality Assurance committee for review monthly x 3 months by the Quality Improvement Nurse. The Quality	

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F 867	Continued From page 46	F 867	Assurance committee will review the data and determine if a 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 ADL Care Provided for Dependent Residents 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, development of action plans as indicated to determine the need and/or frequency of continued 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	F 883		5/25/23

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F 883	Continued From page 47 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 48 (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 and Responsible Party (RP) interviews the facility failed to provide documentation of the risks versus the benefits of the influenza vaccine and attempted to administer an influenza vaccine to a resident whose RP had not provided informed consent. This was for 1 of 5 residents (Resident #84) reviewed for immunizations. Findings included: A review of the facility policy titled "Immunizations" last revised on 10/2/2020 revealed in part, "Documentation of the immunizations will be noted in the resident's medical record. Physician orders may be obtained for the resident immunization, as indicated. Consent forms should be obtained, as appropriate. Flu Immunization: Residents and employees will be offered the flu vaccine annually from early October to March. Residents or employees cannot be required to receive the vaccine if; it is medically contraindicated, the individual has an allergy to eggs, if the individual has already been immunized during the time period, if after being fully informed of the health	F 883	F883 Influenza and Pneumococcal Immunizations Resident #84 no longer resides in the facility. . On 5/10/23, the Assistant Director of Nursing 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, to ensure residents/resident representative was educated on the risk/benefits of receiving/refusing vaccine with documentation in the electronic record and that appropriate consent obtained prior to administering vaccines. The Assistant Director of Nursing 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,	

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F 883	Continued From page 49 benefits and risks, the individual refuses the vaccine." Resident #84 was admitted to the facility on 9/3/21. A review of Resident #84's admission Consent/Release form signed by his RP on 9/3/21 revealed in part he had no allergy to eggs. It further revealed his RP did not authorize the administration of the influenza vaccine to Resident #84 based upon educational materials which included the risks and benefits. A review of his quarterly Minimum Data Set (MDS) assessment dated 3/2/23 revealed he was severely cognitively impaired. He rejected care on 1 to 3 days of the assessment look back period. He received the influenza vaccine at the facility on 11/8/22. A physician's order for influenza vaccine intramuscularly dated 11/8/22 was noted in Resident #84's medical record. A review of the immunization section of Resident #84's medical record revealed documentation by the Infection Preventionist (IP) that consent for the influenza vaccine administration was obtained on 11/17/22. It further revealed documentation by the IP that the influenza vaccine was administered to Resident #84 intramuscularly (in a muscle) in his right deltoid (an arm muscle) on 11/8/22 at 12:00 PM. There was no documentation that Resident #84's RP had been provided education on the risks versus the benefits of this vaccine. A review of the November 2022 Medication	F 883	obtaining appropriate consent and providing vaccine per resident preference and/or education of staff. Audit will be completed by 5/24/23. On 5/12/23, the Director of Nursing initiated an in-service with all nurses regarding Immunizations. Emphasis is on educating resident/resident representative on the risks/benefits or receiving/refusing vaccines, obtaining appropriate 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 5/24/23, After 5/24/23, any nurse who has not worked or received the in-service will complete in-service prior to the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Immunizations. The Assistant Director of Nursing will audit 10 resident immunizations 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, appropriate consent and physician order for vaccine obtained prior to administering vaccine, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined following education. The Assistant Director of Nursing will address all	

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F 883	Continued From page 50 Administration Record (MAR) for Resident #84 revealed documentation by Nurse #6 on 11/8/22 an attempt was made to administer the influenza vaccine to Resident #84, but he refused. On 4/26/23 at 12:42 PM a telephone interview with Resident #84's RP indicated he was not able to make decisions for himself. She stated she refused the influenza vaccine for Resident #84 on his admission to the facility when she was asked about it. She went on to say she was aware of the risks versus the benefits of the vaccine. The RP stated Resident #84 had the influenza vaccine one time before his admission to the facility and got very sick after so she would never consent to him having it again. She went on to say she could not recall who called her or exactly when, but the last time someone from the facility called her about Resident #84 receiving the influenza vaccine, she told them again she did not want him to have it. On 4/26/23 at 12:58 PM an interview with the IP indicated she recalled obtaining consent from Resident #84's RP for him to receive the influenza vaccine because he was not able to make that decision for himself. She stated she did not recall the exact date she obtained the consent, but it would have been before the administration of the vaccine. She went on to say she should have documented education on the risks versus the benefits of the vaccine, who she spoke to, and the date and time she obtained the consent in Resident #84's medical record but hadn't. She further indicated this must have been an oversight. On 4/26/23 at 1:41 PM a telephone interview with Nurse #6 indicated she recalled Resident #84.	F 883	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 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.	

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F 883	Continued From page 51 She stated he frequently refused his medication. She stated when she attempted to administer the influenza vaccine to Resident #84 on 11/8/22, he refused. She stated she documented this refusal in his MAR. On 4/27/23 at 12:45 PM an interview with the facility Corporate Clinical Director indicated based on the Chart Codes for Resident #84's MAR the documentation on 11/8/22 by Nurse #6 for the influenza vaccine Resident #84 refused the administration of the vaccine on that date. She went on to say there was not clear documentation in Resident #84's medical record that informed consent was obtained for the vaccine administration. She further indicated staff were instructed when consent was obtained there should be documentation in the medical record of who provided the consent and when the consent was obtained.	F 883		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures	F 888		5/25/23

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must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or

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its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner

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F 888	Continued From page 54 recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to meet the requirement of 100 percent (%) staff COVID-19 vaccination rate and implement an effective tracking process for COVID-19 vaccinations when Maintenance Assistant #1 worked without being fully vaccinated and without an exemption. The facility was not in outbreak status and had no positive cases of COVID-19 among residents. The facility's community transmission rate was	F 888	F888 COVID-19 Immunization On 5/10/23, the maintenance assistant #1 received required second step for completion of COVID vaccine series per facility protocol. . On 5/10/23, the Medical Records initiated an audit of COVID vaccination status for all current staff. This audit was to identify	

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F 888	Continued From page 55 low. Findings included: A review of the facility's Infection Control Manual last revised 12/12/22 Appendix A: COVID-19 Infection Prevention and Control Program Guidelines revealed in part, "9. Immunization Overview: [The facility] strives to provide and maintain a safe workplace for all employees, residents and visitors. Vaccinations have significantly reduced the mortality rate and provided for a reduction in serious illness of COVID-19 making nursing homes, both as a place to live and work, safer. In light of this, and in accordance with CMS (Centers for Medicare and Medicaid Services) mandates, [the facility] will require that all employees be fully vaccinated with some limited exceptions. Vaccination under this policy is a mandatory condition of employment unless a request for reasonable accommodation is approved. Vaccination Recommendations: a. Mandatory HCP (Health Care Personnel) Vaccination under this policy is a mandatory condition of employment unless a request for reasonable accommodation is approved. Applicants are required to be fully vaccinated, and proof of full vaccination should be required at the time of hire. 3. Partial Vaccination: If the facility hires staff that are in the process of completing their vaccination series, these staff must follow the same guidelines as staff hired with approved exemptions which include wearing source control at all times." It further revealed in part, " Applicants for employment are required to be fully vaccinated and provide proof of full vaccination, or have an approved exemption, at the time of hire. If a new hire is allowed to start that is not fully vaccinated,	F 888	any staff who are not up to date on COVID vaccine or have a documented refusal of vaccine per facility protocol. The Assistant Director of Nursing will address all concerns identified during the audit to include removal of employee from work schedule until wavier obtained or vaccine series completed per facility protocol. Audit will be completed by 5/24/23. On 5/12/23, the Director of Nursing initiated an in-service with all staff regarding Covid Immunizations with emphasis on facility requirement that employees complete the require series of Covid vaccines or obtain a wavier exempting employee from vaccine requirement and any employee who fails to meet the criteria of employment will be removed from the schedule until series completed or wavier obtained. In-service will be completed by 5/24/23. After 5/24/23 any staff who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired staff will be in-service during orientation regarding Covid Immunizations. On 5/12/23, the Director of Nursing initiated an in-service with the Director of Nursing (DON) and Infection Preventionist (IP) regarding Covid Immunizations with emphasis on facility requirement that employees complete the require series of Covid vaccines or obtain a wavier exempting employee from vaccine requirement and the responsibility of the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 888	Continued From page 56 he or she should complete their series of vaccinations outside the facility. The facility should maintain a log of [health care personnel] which includes employees, contracted staff, volunteers, and/or students' vaccination status." A review of the COVID-19 Staff Vaccination Status Matrix provided by the facility on 4/25/23 revealed 1 staff member of 96 total facility staff were partially vaccinated without an exemption resulting in the percent of current staff vaccinated being 99%. A review of the vaccination documentation provided by the facility revealed Maintenance Assistant #1 received his first dose of vaccine on 12/16/22. His date of hire was 1/10/23. He had not received a second dose of vaccine. He did not have an approved exemption. On 4/26/23 at 2:20 PM Maintenance Assistant #1 was observed in the Maintenance Director's office. He was wearing a source control mask. An interview with Maintenance Assistant #1 at that time indicated when he was hired the facility got him in the door and told him he needed to get his second dose as soon as possible. He stated he had been regularly working in the facility since then. He went on to say he sometimes worked in resident rooms when residents were present. He further indicated he always wore a source control mask because he had been told he needed to do that until he got his second dose. Maintenance Assistant #1 stated no one at the facility followed up with him to see whether he had gotten his second dose. He went on to say he hadn't really tried to get a second dose until last week. He further indicated he had gone to a pharmacy to	F 888	DON and IP to ensure vaccines are received timely and employee chart updated. In-service will be completed by 5/24/23, After 5/24/23 any staff who has not worked or received the in-service will complete in-service prior to the next scheduled work shift. All newly hired staff will be in-service during orientation regarding Covid Immunizations. Medical Records and Human Resources will audit 10% of staff covid immunization record weekly x4 weeks then monthly x 1 month utilizing the Immunization Audit Tool. This audit is to ensure staff receive and complete COVID vaccine or have a documented refusal of vaccine per facility protocol. The Assistant Director of Nursing will address all concerns identified during the audit to include removal of employee from work schedule until wavier obtained or vaccine series completed per facility protocol. The IP 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 04/27/2023

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F 888	Continued From page 57	F 888		

get it and had been told they were not taking any walk-in appointments. Maintenance Assistant #1 stated he then called the local Health Department and was told they were not giving any second doses of the vaccine and were only giving bivalent booster doses. He further indicated he let the Maintenance Director know this and had been told the facility would give him his second dose when they had their next vaccine clinic. He stated he had not been told when this would be.

An interview with the Maintenance Director on 4/26/23 at 2:25 PM indicated when Maintenance Assistant #1 was hired he had been told that Maintenance Assistant #1 needed to get his second dose as soon as possible. He went on to say no one had followed up with him regarding this and he had not followed up with Maintenance Assistant #1. He stated last week Maintenance Assistant #1 let him know that he was having trouble getting his second dose. The Maintenance Director went on to say he passed this information on to Human Resources (HR). He further indicated HR #1 told him this week that Maintenance Assistant #1 could get his second dose at the next facility vaccine clinic. He stated he had not been given a date for this.

On 4/26/23 at 2:47 PM an interview with the Infection Preventionist (IP) indicated she could not say what happened with Maintenance Assistant #1. She stated she did not keep track of whether employees got their second dose of vaccine. She went on to say Nurse #5 had been keeping up with employee vaccines until she left the facility. She further indicated she did not know who was doing it now.

On 4/27/23 at 8:10 AM a telephone interview with

frequency of monitoring.

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Nurse #5 indicated she no longer worked at the facility. She stated she had been the Assistant Director of Nursing at the facility from September 2022 through the end of December 2022 when she became the DON. She went on to say she had been the DON at the facility from the end of December 2022 until she left the facility in February 2023. She stated she had no role in keeping track of employee vaccines. She stated she asked about this and was told someone else was taking care of it.

On 4/26/23 at 2:59 PM an interview with the Administrator indicated the DON kept track of employee initial vaccine information and the Assistant Director of Nursing (ADON) followed up with employees if they needed additional doses. She further indicated she was told yesterday Maintenance Assistant #1 was having trouble getting his second dose and he was waiting until the next facility vaccine clinic. She went on to say there had recently been 2 or 3 vaccine clinics scheduled at the facility, but they had to be cancelled because the facility was not able to get doses of the vaccine.

The DON was not present in the facility and was not available for interview.

The ADON was not present in the facility and was not available for interview.

On 4/27/23 at 8:02 AM an interview with HR #1 indicated when she received employee applications for employment, she asked applicants if they had both doses of vaccine and let them know that this was mandatory unless they applied for and were granted an exemption. She stated she did not do any follow-up with

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employees to determine whether they got any additional doses. She went on to say she did not know who did that. She further indicated she had been made aware last week that Maintenance Assistant #1 was having trouble getting his second dose. HR #1 stated Maintenance Assistant #1 was signed up to get his second dose at the next facility vaccine clinic. She went on to say she did not know when that would be.

On 4/27/23 at 12:45 PM an interview with the Corporate Clinical Director indicated the facility policy was that employees could be hired if they received their first dose of the vaccine and were not yet eligible to receive the second dose. She went on to say employees needed to receive their second dose as soon as they were eligible unless they had a waiver. She further indicated the IP should be monitoring and following up with employees to make sure they received their second dose in a timely manner.