STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING ______ B. WING ______	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHAVEN HEALTH AND REHABILITATION CENTER	**801 GREENHAVEN DRIVE** **GREENSBORO, NC 27406**

(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 A unannounced complaint investigation and recertification survey were conducted on 3/11/24 through 3/14/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # USK011.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey were conducted from 3/11/24 through 3/14/24. Event ID # USK011. The following Intakes were investigated NC00208208; NC00212602; NC00207211; NC00205990; NC00211000; NC00212020; NC00208924; NC00213553; NC00209444; NC00211443; NC00206022; NC00211083; NC00210350; NC00212245; NC00206722; NC00206425. 2 of 52 complaint allegations resulted in a deficiency.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §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.	F 561		4/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE — 04/05/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561	Continued From page 1 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility failed to allow residents assessed to be safe to smoke the ability to smoke independently at any time of his/her choice. This occurred for 3 of 3 residents (Resident #47, #8, and #69) who expressed a desire to smoke at times other than the supervised smoking times designated by the facility. This practice had the potential to affect other safe smokers in the facility. The findings included: A review of the facility's Smoking Policy (Revised on 10/15/22) was conducted. A section of the policy entitled "Determination of Smoking Residents' Supervision Needs" included the following Procedures, in part: #3 (of 6). "After completion of each assessment, the interdisciplinary care plan (ICP) team will review and determine the smoking status (supervised/unsupervised) of the resident. a) When the Smoking Evaluation identifies a	F 561	F561 SELF DETERMINATION Resident #69, #8, #47 were identified to be supervised smokers. On 3/28/2024 all residents listed above had smoking assessments completed by the Assistant Director of Nursing to determine if they were safe smokers or unsafe smokers. Residents #69, #8, and #47 were assessed to be dependent smokers. On 03/29/2024, resident #69, #8, and #47 were provided education on smoking policy in accordance with the results of the smoking assessment by the Assistant Director of Nursing. On 03/29/2024 Assistant Director of Nursing/Minimum Data Set (MDS) Coordinator reviewed care plans for the residents listed above were reviewed and revised in accordance with the results of the smoking assessments. On 3/20/24 the Assistant Director of Nursing initiated smoking evaluations for all residents that choose to smoke that	

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Continued From page 2

resident with any potential hazard risk, including but not limited to a cognitive deficit, the resident will be allowed to smoke only during this facility's designated smoking times with direct staff supervision.
b) When the Smoking Evaluation identifies a resident without any potential hazard risk and who is safe to smoke independently, the resident will be allowed to smoke unsupervised, at any time of his/her choice."

An observation was conducted on 3/12/24 at 3:13 PM of a sign placed on the door leading to the facility's designated smoking area. The sign read:
"Smoking Schedule
1st 11:00 AM - 11:30 AM
2nd 2:00 PM - 2:30 PM
3rd 5:00 PM - 5:30 PM"

a. Resident #47 was admitted to the facility on 3/12/20 with cumulative diagnoses which included diabetes and history of a stroke.

The resident's most recent Minimum Data Set (MDS) was an annual assessment dated 12/4/24. The MDS revealed Resident #45 had intact cognition.

A review of Resident #47's electronic medical record (EMR) included a Smoking Evaluation dated 3/2/24. The "Outcome" section of the Smoking Evaluation reported the following:
1. Outcome: Resident is a safe smoker and may smoke independently at this time.
2. Resident Education: Education on Smoking Policy provided. In agreement to follow.
3. Care Plan reviewed and revised as necessary (Dated 3/2/24).

F 561

was completed on 3/27/24 to assess for the resident ability to smoke independently or with supervision. On 3/27/24 all residents were found to be dependent smokers upon completion of the smoking assessment. After 3/27/24, any resident identified as independent smokers, by completion of the smoking assessment, will be provided education by the Social Worker on the facility smoking policy, storage of smoking materials and the ability to smoke as desired. After 3/29/24, independent smokers will be granted access to their smoking materials by alerting the smoking attendant or nurse, who will then go and get the smoking materials that will be stored in the medication room. Smoking materials will be returned to the nurse or smoking attendant when returning inside the facility for safe keeping until requested for by the owner. After 3/29/24, all independent smokers will be educated on this process.
On 3/29/2024 all residents identified as smokers care plans were reviewed and revised as needed by Assistant Director of Nursing/Minimum Data Set (MDS) Coordinator.
Beginning 3/29/24 Smoking times will not be limited or scheduled for residents who smoke independently. The residents that are assessed to be independent smokers will have access to their smoking materials, upon request, with the assistance of the facility assigned nursing staff in adherence to the facility smoking policy.
On 4/1/24, All staff including agency and contract staff were educated by the Staff

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F 561	Continued From page 3 An interview was conducted on 3/12/24 at 3:40 PM with Resident #47. During the interview, the resident confirmed she was a smoker. When asked, Resident #47 reported that although she was a safe smoker, she was only allowed to smoke during the scheduled smoking times of 11:00 AM, 2:00 PM and 5:00 PM. She stated that they (the smokers) didn't understand why they were only allowed to go out at these times if they were safe smokers. b. Resident #8 was admitted to the facility on 2/2/21 with cumulative diagnoses which included diabetes and cerebrovascular disease (a disorder where the blood flow to the brain is affected). The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 2/9/24. The MDS revealed Resident #8 had intact cognition. A review of Resident #8's electronic medical record (EMR) included a Smoking Evaluation dated 3/2/24. The "Outcome" section of the Smoking Evaluation reported the following: 1. Outcome: Resident is a safe smoker and may smoke independently at this time. 2. Resident Education a. Education on Smoking Policy provided. In agreement to follow. 3. Care Plan reviewed and revised as necessary (Dated 3/2/24). An interview was conducted with Resident #8 on 3/12/24 at 4:20 PM. During the interview, Resident #8 confirmed she was a smoker. The resident reported she was only allowed to smoke during the supervised smoking times designated by the facility (11:00 AM, 2:00 PM, and 5:00 PM).	F 561	Development Coordinator on ensuring facility adherence to the smoking policy on independent smokers, including choice of time. After 4 /11/24 any nurse, nursing assistants, agency and contract staff who have not worked or received the in-service will be in-serviced prior to the next scheduled work shift. All newly hired nurses, nursing assistants, agency and contract staff will be in-serviced during orientation regarding adherence to the smoking policy. On 4/2/24 The Assistant Director of Nursing /Minimum Data Set (MDS) Coordinator have complete Smoking Audits to ensure sustained compliance with the smoking policy. Beginning 4/8/24, the Unit Manager will randomly audit compliance by interviewing all residents who are independent smokers one time per week for 4 weeks, then monthly for 2 months ensure smoking policy compliance. The independent smokers will be asked if they are being allowed to smoke at times of their choice. This audit will be documented on the Independent Smokers audit tool. Director of Nursing or Administrator will review Smoking Audits weekly for 4 weeks, and then monthly for 2 months. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 3 months or until a time determined by the Quality Assurance Performance Improvement (QAPI) members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for	

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F 561	Continued From page 4 When asked, the resident reported she was "not happy" she was limited to smoking during the facility's designated smoking times. c. Resident #69 was admitted to the facility on 6/15/23 with cumulative diagnoses which included non-traumatic spinal cord dysfunction. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 2/21/24. The MDS revealed Resident #69 had moderately impaired cognition. A review of Resident #69's electronic medical record (EMR) included a Smoking Evaluation dated 3/2/24. The "Outcome" section of the Smoking Evaluation reported the following: 1. Outcome: Resident is a safe smoker and may smoke independently at this time. 2. Resident Education: Education on Smoking Policy provided. In agreement to follow. 3. Care Plan reviewed and revised as necessary (Dated 3/2/24). An interview was conducted on 3/12/24 at 4:25 PM with Resident #69. During the interview, the resident confirmed she was a smoker and was only allowed to smoke at 11:00 AM, 2:00 PM and 5:00 PM. When asked what her thoughts were about the designated smoking times, the resident emphatically stated she wanted "More!" An observation was conducted on 3/13/24 at 11:10 AM as an Activities Department Aide unlocked the coded door leading to the facility's designated smoking area. Residents wishing to smoke were observed to follow the Aide outdoors to the enclosed patio.	F 561	sustained compliance. Date of Alleged Compliance: 4/11/24	

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F 561	Continued From page 5 An interview was conducted on 3/13/24 at 11:15 AM with the Activities Director as she approached the smoking area. When asked, the Activities Director reported the Activities Department assumed the primary responsibility to supervise all the smokers during the scheduled smoking times. An interview was conducted on 3/13/24 at 3:30 PM with the facility's Interim Administrator in the presence of the corporate Regional Vice President. During the interview, the concern related to the facility's mandated supervision and restriction of smoking times for residents assessed as safe smokers was discussed. The Interim Administrator reported the supervised smoking schedule was already in place when he came to the facility in mid-January. He confirmed the designated, supervised smoking times currently applied to all smokers. The Interim Administrator stated, "It's an issue that needs to be addressed."	F 561		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services;	F 576		4/11/24

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F 576	Continued From page 6 (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to provide mail delivery to the residents on Saturdays for 9 of 9 (Resident #1, #11, #16, #283, #42, #14, #45, #47 and #50) residents in resident council. Findings included: An interview with members of the resident council on 3/12/24 at 1:30 pm revealed that the facility did not deliver any mail on Saturdays. The members present for the meeting were Resident #1, Resident #11, Resident #16, Resident #283,	F 576	F 576 Right to Forms of Communication with Privacy Residents #1, #11, #283, #42, #14, #45, #47 and #50 were identified as residents and the facility failed to provide mail delivery on Saturdays. On 4/1/2024 all residents listed above were notified that mail delivery will be taking place every Saturday by the Business Office Manager. All residents with mail will receive their mail on the weekends, in addition to weekdays."	

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F 576	Continued From page 7 Resident #42, Resident #14, Resident #45, Resident #47 and Resident #50. All residents that were present indicated they did not receive mail on Saturdays. The residents reported that mail was only delivered during the week by the Activities Director (AD) and/or her Aide and they had to wait until Monday to receive mail. An interview was conducted on 3/12/24 at 2:57 pm with the Activities Department Aide. She revealed the activities department delivered mail Monday through Friday and on Monday they have mail in their mailbox from the weekends. She was aware that mail should be delivered on Saturdays, but indicated it probably was not delivered on Saturdays. An interview was conducted on 3/12/24 at 3:00 pm with the Activities Director (AD) who revealed she or her Aide delivered mail Monday through Friday. The weekend Receptionist was supposed to deliver mail on the weekends, but they had a new Receptionist, and she may not been aware that she should have delivered mail. The Receptionist started less than a couple of weeks ago. Interview further revealed that the AD didn't know there was a problem and she would talk to the new Receptionist to put a plan in place right now. An interview was conducted on 3/13/24 at 5:38 pm with the evening and weekend Receptionist and revealed that mail was delivered to the front desk on the weekends and she either placed mail in the AD's box or the Accounts Receivable Director's (ADR) box. Interview further revealed she started working at the facility less than a couple of weeks ago and her role was to make sure the mail was placed in the AD's box or the	F 576	The Business Office Manager held a resident council on 4/2/2024 to inform all alert and oriented residents that mail delivery will be taking place every Saturday. Weekly audits will be conducted by the Administrator to ensure compliance with mail delivery. In-service education was completed by the Administrator on 3/13/24 with the Business Office Manager regarding these practices to ensure that residents receive mail on the weekends. Beginning 4/8/24 an audit will be completed each Saturday to ensure mail is delivered to all residents. Monitoring will be completed as follows: 1 time per week x 4 weeks, then 1 time per month for 2 months. The administrator will monitor audit findings to ensure mail is delivered daily to include weekends. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 3 months or until a time determined by the Quality Assurance Performance Improvement (QAPI) members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. Date of Alleged Compliance: 4/11/24	

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F 576	Continued From page 8 ARD's box, not to deliver to the residents. During an interview on 3/14/24 at 1:56 pm, the Administrator indicated they would have staff deliver the mail to residents on Saturdays.	F 576		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585		4/11/24

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F 585	Continued From page 9 facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions	F 585		

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F 585	Continued From page 10 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to investigate and resolve grievances for Residents #46 and #42 and maintain evidence demonstrating the result of the grievances for Residents #282, #29, #68. This was for 5 of 5 residents reviewed for grievances. The findings included: 1a. Resident #46 was admitted on 5/7/20. A review of Resident #46's grievance dated 1/8/24 was conducted and revealed no documented investigation or follow up noted on the grievance form.	F 585	F 585 GRIEVANCES On 4/2/2024 all residents #46 and #42 currently reside in the facility were given a copy of the facility grievance policy and informed of the facility grievance process by the Activities Director. Residents identified as #46 and #42 were provided follow-up to their alleged concerns and/or grievances. The follow-up was documented by the Administrator on resident #46 and #42 concern form and added to the Grievance Tracking Log. Residents #282, #281 and #68 a Grievance form was completed on 4/8/24, the residents were provided follow-up by the Administrator.	

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GREENHAVEN HEALTH AND REHABILITATION CENTER	**801 GREENHAVEN DRIVE GREENSBORO, NC 27406**

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F 585	Continued From page 11 An interview was conducted with Resident #46 on 12/1/2023 at 1:45 PM and she revealed she had shared a grievance regarding poor call light response times and never received a response. 1b. Resident #42 was admitted on 3/20/20. A review of Resident #42's grievances dated 1/8/24 and 1/24/24 was conducted and revealed no documented investigation or follow up noted on the grievance form. The 1/8/24 grievance expressed by Resident #42 was related to the failure of the nursing staff to provide Activities of Daily Living (ADL) care in a timely manner. The grievance shared on 1/24/24 was regarding the resident's medications, incontinence care, and staff failing to be polite in their interactions with her. An interview was conducted with Resident #42 on 3/14/24 at 3:55 PM. During the interview, the resident was asked if she recalled whether the facility responded to the concerns/grievances she had shared on 1/8/24 and 1/24/24. Resident #42 was unable to recall what the concerns were at that time and therefore, she could not address whether she received a response from the facility or follow-up information on the resolution of these concerns. 2. A review of the facility grievance log was conducted from August 2023 to March 2024. The review revealed logged grievances for Resident 281 dated 10/9/23, a grievance for Resident # 282 dated 11/5/23 and a grievance for Resident #68 dated 9/29/23. No copies of these three grievances were provided by the facility.	F 585	A public posting entitled "Grievance Posting" is located near the entrance of the center identifying the designated Grievance Officer. Grievance Concern Forms are also available at this location. A Resident council meeting was held on 4/2/24, by the Activities Director, residents were educated on the Grievance Policy; specifically, residents were educated on their rights as it pertains to filing a grievance as well as the facilities responsibility to ensure prompt resolution. Education initiated on 4/5/24 by the Staff Development Coordinator for all staff on the grievance policy, the facility responsibility on how to file a grievance/complaint, its available to the resident as well as the facilities obligation to provide prompt resolution. Staff were informed of the location of grievance forms and the internal process for filing and responding to Concerns/Grievances. After 4 /11/24 any nurse, nursing assistants, agency and contract staff who have not worked or received the in-service will be in-serviced prior to the next scheduled work shift. All newly hired nurses, nursing assistants, agency and contract staff will be in-serviced during orientation regarding the grievance policy. Initiated on 4/8/24 by Administrator will complete an audit of the grievance log for the previous 60 days to ensure all grievances were resolved with documentation of the grievance results. The Administrator/Director of Nursing will monitor and track concerns/grievances on the designated Grievance Log to ensure appropriate and timely resolution including	

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F 585	Continued From page 12 An interview was conducted on 3/14/24 at 9:57 AM with the Administrator. He revealed that he was not able to provide completed grievances forms for residents #46 and #42 but felt that the grievances had been investigated. He also revealed Residents #282, #68, and #281 had logged grievances but the facility did not maintain a copy of these grievances and was not sure why this occurred. A follow up interview was conducted on 3/14/24 at 8:02 AM and he revealed that he was not able to locate any of the missing information and that the facility should have a documented record of grievance resolution, complainant follow up and the records should have been maintained for three years.	F 585	obtaining signatures to ensure satisfaction of the outcome to the grievance filed. Audits will be completed 1 time a week for 4 weeks and then monthly for two months. The Administrator/Director of Nursing will report all grievances to the Quality Assurance Performance Improvement (QAPI) committee for further review and consideration. The Administrator/Director of Nursing will request attendance at the Resident Council meetings each month to educate on Grievance Policy/Procedure. The Director of Nursing is responsible for the correction plan and the Administrator for sustained compliance. Date of Alleged Compliance: 4/11/24	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		4/11/24

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F 609	Continued From page 13 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and submit an initial report within 2 hours to the state regulatory agency for an allegation of family provided sitter to resident abuse for 1 of 3 residents reviewed in facility reported incidents (Resident #68). Findings included: A review of the initial report on 1/13/24 at 11:30 pm revealed the facility was made aware Resident #68 alleged his family provided sitter hit him in the stomach. No injuries were reported. The initial report was faxed to the state regulatory agency on 1/14/24 at 4:52 pm. An interview was conducted with the Administrator on 3/14/24 at 1:48 pm which revealed he was made aware of the allegation of abuse on 1/13/24 around 11:30 pm and immediately started their investigation. Interview further revealed Administrator did not have access to a fax machine. The Administrator indicated all steps were taken within 2 hours except faxing in the initial report to the state regulatory agency.	F 609	F609 Reporting of Alleged Violations The allegation of abuse by resident #68 was reported on 1/13/24 at 11:30 pm. Investigative Report for resident #68 was faxed to the state regulatory agency on 1/14/24 at 4:52 pm. On 4/5/24 the Director of Nursing initiated an audit of all reportable events to the Health Care Personnel Investigations (HCPI) for the past 30 days. This audit is to ensure all reportable events were reported within the two-hour time frame when indicated and that the facility submitted an accurate investigation report within 5 days per the HCPI requirements. The Administrator will address all concerns identified during the audit to include completion of initial and investigative reports when indicated and staff education. The audit will be completed by 4/9/24. On 4/3/24, the Facility Nurse Consultant initiated an in-service with the Administrator and Director of Nursing regarding Health Care Personnel Investigation Reportable Requirements with emphasis on reporting allegations	

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F 609	Continued From page 14	F 609	within 2 hours when indicated and completion of an accurate investigation report within 5 days per Health Care Personnel Investigation (HCPI) requirements. All newly hired Administrators and/or Director of Nursing will be in-serviced by the Facility Nurse Consultant during orientation regarding Health Care Personnel Investigation Reportable Requirements. Beginning on 4/9/24 The Administrator will review all Abuse investigative folders 5 times a week x 4 weeks then monthly x 1 month utilizing the Health Care Personnel Investigation (HCPI) Audit Tool. This audit is to ensure all Health Care Personnel Investigation (HCPI) reportable events are reported timely and an accurate investigative report completed within 5 days per HCPI requirements. The Administrator/Director of Nursing will address all areas of concern identified during the audit to include reporting initial and investigative reports when indicated and re-training of staff. The Administrator will review and initiate the HCPI Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will present the findings of the Health Care Personnel Investigation (HCPI) Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Quality Assurance Performance Improvement (QAPI) Committee will meet monthly for 2 months and review the Health Care Personnel Investigation (HCPI) Audit Tool to determine trends and/or issues that may	

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F 609	Continued From page 15	F 609	need further interventions put into place and to determine the need for further frequency of monitoring. The Director of Nursing is responsible for the correction plan and the Administrator for sustained compliance. Date of Alleged Compliance: 4/11/24	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		4/11/24

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F 657	Continued From page 16 by: Based on staff interviews and record reviews, the facility failed to review and revise a resident's care plan when indicated for 4 of 29 sampled residents (Resident #47, Resident #8, Resident #69, and Resident #46). The care plan for Residents #47, #8 and #69 were not revised to accurately reflect the results of their Smoking Evaluation. Resident #46's plan of care was not updated when there was a change in her Advance Directive. The findings included: 1-a. Resident #47 was admitted to the facility on 3/12/20 with cumulative diagnoses which included diabetes and history of a stroke. The resident's most recent Minimum Data Set (MDS) was an annual assessment dated 12/4/24. The MDS revealed Resident #47 had intact cognition. A Smoking Evaluation was completed on 3/2/24. The "Outcome" section of the Smoking Evaluation reported the following: 1. Outcome: Resident is a safe smoker and may smoke independently at this time. 2. Resident Education: Education on Smoking Policy provided. In agreement to follow. 3. Care Plan reviewed and revised as necessary The resident's current Care Plan included the following area of focus, "Resident is a supervised smoker / Problematic manner in which resident acts characterized by inappropriate smoking of tobacco related to: Cognitive impairment, Physical limitations" (Revised on 4/21/23). Goal:	F 657	F657 Care Plan Timing and Revision On 3/28/2024 #69, #8 and #47 had smoking assessments completed by the Assistant Director of Nursing to determine if they were safe smokers or unsafe smokers. Resident #69, #8, #47 were identified to be supervised smokers. On 03/29/2024, resident #69, #8, and #47 were provided education on smoking policy in accordance with the results of the smoking assessment by the Assistant Director of Nursing. On 03/29/2024 Assistant Director of Nursing/Minimum Data Set (MDS) Coordinator reviewed care plans for the residents listed above were reviewed and revised in accordance with the results of the smoking assessments. On 3/14/24, the Director of Nursing completed a review of Advance Directive orders for resident #46 with needed revisions completed by the Director of Nursing to reflect the status change. On 3/27/24, Corrective action for all residents potentially affected was completion of a current Smoking Evaluations by Assistant Director of Nursing. Care plans were reviewed and updated by Director of Nursing 3/27/24. On 3/14/24, The Director of Nursing completed a review of all residents with Advance Directive orders, care plan review and updates were completed by the Director of Nursing for any status changes. On 4/11/24, Changes in smoking status will be reviewed daily in Cardinal Interdisciplinary Team Meeting by use of	

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F 657	Continued From page 17 "Resident will smoke safely in designated areas with supervision thru next review." Interventions included, in part: "Evaluate resident's ability to smoke safely on a consistent and regular basis." 1-b. Resident #8 was admitted to the facility on 2/2/21 with cumulative diagnoses which included diabetes and cerebrovascular disease (a disorder where the blood flow to the brain is affected). Review of the resident's EMR indicated her most recent Minimum Data Set (MDS) was a quarterly assessment dated 2/9/24. The MDS revealed Resident #8 had intact cognition. A review of Resident #8's EMR included her most recent Smoking Evaluation dated 3/2/24. The "Outcome" section of the Smoking Evaluation reported the following: 1. Outcome: Resident is a safe smoker and may smoke independently at this time. 2. Resident Education a. Education on Smoking Policy provided. In agreement to follow. 3. Care Plan reviewed and revised as necessary (Dated 3/2/24). The resident's current Care Plan was reviewed and included the following area of focus, "Resident has been evaluated to be an unsafe smoker due to smoking in unauthorized areas." The care plan was last revised on 9/8/23. Goal: "Resident will smoke safely in designated areas with supervision thru next review." Interventions included, in part: "Assist resident to designated smoking areas during established facility smoking times" and "Do not leave resident unattended while smoking." 1-c. Resident #69 was admitted to the facility on	F 657	the Smoking Audit Tool for tracking changes of smoking status and the smoking status of new admissions/readmissions to the facility to include care plan revision and updates. On 4/11/24, Changes in the status of resident's advanced directives will be reviewed daily in the Cardinal Interdisciplinary Team meeting by use of the Advance Directives Audit Tool for tracking changes of advance directives and review of advance directives for new admissions/readmissions to the facility to include care plan revision and updates. The Director of Nursing will review all findings and address areas of concern. On 4/11/24 Re-education to the MDS Coordinator provided by the Director of Nursing related to care plan revision related to current smoking status or changes in smoking status and status of advanced directives or changes to advance directives. On 4/11/24, The Director of Nursing will review 5 random resident care plans weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool to ensure Smoking preferences and whether they are supervised or independent and for Advance Directives correctly identified. The Director of Nursing/ Assistant Director of Nursing will review the Care Plan 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 Care Plan Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Quality	

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6/15/23 with cumulative diagnoses which included non-traumatic spinal cord dysfunction.

Further review of the resident's EMR indicated her most recent Minimum Data Set (MDS) was a quarterly assessment dated 2/21/24. The MDS revealed Resident #69 had moderately impaired cognition.

A review of Resident #69's electronic medical record (EMR) included her most recent Smoking Evaluation dated 3/2/24. The "Outcome" section of the Smoking Evaluation reported the following:
1. Outcome: Resident is a safe smoker and may smoke independently at this time.
2. Resident Education: Education on Smoking Policy provided. In agreement to follow.
3. Care Plan reviewed and revised as necessary (Dated 3/2/24).

The resident's current Care Plan was reviewed and included the following area of focus, "Resident is a supervised smoker." Goal: "Resident's preference to use tobacco/tobacco substitute products of her choices will be honored thru next review."

An interview was conducted with the facility's Director of Nursing (DON) in the presence of the Regional Nurse Consultant. Upon inquiry as to who was responsible to ensure a resident's care plan accurately reflected the results of a resident's Smoking Evaluation, the DON stated the MDS nurse assumed that responsibility. She stated both a resident's Smoking Evaluation and care plan should include the same information.

An interview was conducted on 3/14/24 at 11:45 AM with the MDS nurse. During the interview, the

F 657

Assurance Performance Improvement (QAPI) Committee will meet monthly x 2 months and 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. All concerns identified during the audit. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Director of Nursing is responsible for the correction plan and the Administrator for sustained compliance.

Date of Alleged Compliance: 4/11/24

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MDS nurse reviewed the most recent Smoking Evaluations and care plans for Resident #47, Resident #8, and Resident #69. The nurse confirmed the care plans were not in agreement with each resident's most recent Smoking Evaluation and determination of being a safe, independent smoker. The MDS nurse reported she would need to modify each residents' plan of care to accurately reflect the conclusion of the residents' Smoking Evaluations.

An interview was conducted on 3/14/24 at 3:30 PM with the facility's Interim Administrator. Concern regarding the residents' care plans not containing the same information as indicated by their Smoking Evaluations was discussed. The Interim Administrator stated he had been made aware of the issue and that it would need to be addressed.

2. Resident #46 was admitted on 5/7/20.

The most recent Minimum Data Set (MDS) was a significant change in status assessment dated 1/4/24, which revealed Resident #46 had intact cognition.

A review of Resident #46 electronic medical record (EMR) revealed a physician's order dated 1/4/24 to change the full code status to Do Not Resuscitate (DNR).

A review of Resident #46's paper chart revealed a physician signed DNR form effective 1/4/24 with no expiration date.

A review of Resident #46's care plan noted as revised on 1/25/24 revealed a care plan for full code status.

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F 657	Continued From page 20 An interview was conducted with MDS Nurse #2 on 03/13/24 at 10:20 AM. She confirmed that she revised the care plan on 1/25/24 to continue the full code directive and did not realize that there was a new order for DNR on 1/4/24. She further revealed the care plan should have been updated to reflect the change in code status to a Do Not Resuscitate but it was missed. An interview was conducted with the Administrator on 03/14/24 at 08:01 AM. He revealed that when a change in code status occurs the residents care plan should be updated to reflect the correct code status.	F 657		
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:	F 688		4/11/24

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F 688	Continued From page 21 Based on observations, staff interviews and record review, the facility failed to apply splints for 1 of 1 resident (Resident #33) reviewed for contractures. The findings included: Resident #33 was admitted on 12/27/23 with diagnoses of hypertension, diabetes, cerebral vascular accident, and left-hand contracture/hemiparesis. Review of admission Minimum Data Set(MDS), dated 1/3/24 , indicated Resident #33 was severely cognitively impaired and required total assistance with activities of daily living. The MDS coded Resident #33 with left hand contracture. Review of the occupational discharge summary dated 2/1/24, documented Resident #33 met the goal on 2/12/24. Resident #33 exhibited left upper extremity pain with passive range of motion and application of resting hand splint. Resident #33 tolerated up to 4 hours wearing once splint was applied. Review of the functional maintenance record restorative phase three for Resident #33 completed by occupational therapy on 2/9/24, range of motion task was to provide passive range of motion to left upper extremities daily with activities of daily living. The approach was to apply the resting hand splint for two hours daily. Review of the physician order dated 2/26/24, revealed an occupational therapy evaluation and treatment for contracture management, documented place left hand orthotic once daily. There was no documentation of when to remove splint.	F 688	F 688 Increase/Prevent Decrease ROM/Mobility Resident #33 was provided a left-hand splint on 4/5/24 by Occupational Therapist. The care plan and resident care guide was reviewed and updated on 4/5/24 to accurately reflect the resident's current plan of care. Occupational Therapist will provide in-service to nursing on 4/8/24 on the splint's use to include donning, doffing, and monitoring skin under splint. On 4/9/24, the Unit Manager initiated an audit of all residents requiring splints to ensure they are available and applied as ordered. The Director of Nursing and/or Unit Manager will address all concerns identified through the audit. On 4/1/24 the Assistant Director of Nursing met with the Rehabilitation Director to in-service on nursing procedure and notification when a splint is recommended by therapy. On 4/9/24, the Staff development coordinator started an in-service with all nurses and nursing assistants, including agency and contract staff on using splints usage and application. In-service will be completed by 4/11/24. After 4/11/24 any nurse, nursing assistants, agency and contract staff who have not worked or received the in-service will be in-serviced prior to the next scheduled work shift. All newly hired nurses, nursing assistants, agency and contract staff will be in-serviced during orientation regarding splint usage and application. Beginning on 4/11/24 An audit of all residents that require splints will be	

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F 688	Continued From page 22 Review of the Medication Administration Records (MAR) for February 2024 and March 2024 for Resident #33 revealed documentation of the left-hand splint application was being done at 7:30 AM. An observation was conducted on 3/11/23 at 10:10 AM, Resident #33 was in bed and her left hand was contracted with no splint. There was no splint available in the room. An observation was conducted 03/11/24 11:34 AM, the left hand continued to be without a splint. There was no splint available in the room. An observation was conducted on 3/12/24 at 7:45 AM, the left hand had no splint in place. There was no splint available in the room. An observation was conducted on 3/12/24 at 8:20 AM, resident in bed with a splint in place. An observation was conducted on 3/12/24 at 10:00 AM, resident remain in bed without splint in place. There was no splint available in the room. An observation was conducted 3/12/24 at 12:26 PM, with the Director of Nursing, Resident #33 was in bed with no splint in place on her left hand. The Director of Nursing confirmed Resident #33's left hand was contracted and there was no splint in place. She further stated Resident #33's splint was not on the list of residents who had assistive devices provided by the rehabilitation therapy department. She stated she would follow-up with therapy regarding the use of a splint for Resident #33. The Director of Nursing stated she was unaware of the location of the splint. An interview was conducted on 3/12/24 at 12:36	F 688	completed by the Unit Manager 1-time weekly x 4 weeks, then monthly x 2 month utilizing the splint audit tool. The Director of Nursing will address all concerns identified during the audit to include re-training of nursing staff. The Director of Nursing will present the findings of the Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The Director of Nursing is responsible for the correction plan and the Administrator for sustained compliance. Date of Alleged Compliance: 4/11/24	

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F 688	Continued From page 23 PM, Nurse Aide #4 stated she was not sure Resident #33 wore a hand splint and could not recall when the resident had a left-hand splint . She did not apply the splint application because she did not know she wore one. An interview was conducted on 3/12/24 at 3:00 PM, in conjunction with a record review with Nurse#3, stating she was unaware the resident had an order for a splint. Nurse#3 reviewed the physician orders and confirmed there was order for a left hand orthotic to be worn every day. She stated orders for splint application would have been on the MAR. Review of the MAR revealed documentation the splint was applied but she could not recall when she had observed left-hand splint on the resident. The Nurse #3 searched for the splint in the room and the splint could not be located. An interview was conducted on 3/12/24 at 3:44 PM, in conjunction with an observation with Nurse Aide #5 stated she reviewed the resident care card and there was no information about the resident wearing any type of splint. The care card only stated the resident always wore a protective boot on left foot. Nurse Aide #5 confirmed there was no splint in place on the left hand. Nurse Aide #5 stated was she unaware the resident should be wearing a splint. An interview was conducted on 3/12/24 at 4:00 PM, the Nurse#4 stated she was unaware the resident had an order for a splint. She indicated she did not know where the splint was located. She further stated when residents wore splints, the information would be on the physician order and flagged on the medication administration record as a reminder to ensure the splints were applied.	F 688		

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F 688	Continued From page 24	F 688		

A follow-up interview was conducted 3/13/24 at 1:49 PM, in conjunction with a record review with the Director of Nursing reviewed the occupation therapy discharge summary dated 2/12/24, revealed the resident was to wear the splint for 4 hours a day and staff were trained on the application process. She confirmed the physician order dated 2/26/24 for the left-hand orthotic was to be worn every day. The Director of Nursing further stated the physician order would include frequency of donning/doffing and the care plan would be updated to reflect the addition of the splint. She further stated nursing would also document on the MAR when the splint was applied and removed. The Director of Nursing stated she was unaware of the location of the splint at this time and would place the splint order on hold until the resident could be re-evaluated, and all staff trained on the application of the splint. She stated she would follow-up with therapy regarding the use of a splint for Resident #33. The Director of Nursing stated she was unaware of the location of the splint

An interview was conducted on 3/12/24 at 2:00PM, in conjunction with a record review with the Certified Occupational Therapist Assistant stated therapy was doing trial palm splints/hand rolls on the resident from 1/24/24-2/12/24, she stated the discharge summary documented the resident tolerated the splint application up to 4 hours once splint was applied. She reviewed the order dated 2/26/24 and confirmed the transcription of the order did not include what was in the discharge summary and staff knowledge or application of splint was not available. She also confirmed the location of the splint was also not available.

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F 688	Continued From page 25 An observation was conducted on 3/13/24 at 7:30 AM, Resident #33 was lying in bed without splint. A follow-up observation was conducted on 3/13/24 at 8:43 AM, in conjunction with record review, with the Director of Nursing, revealed Resident #33 did not have a splint on and there was no splint available for the resident. The Director of Nursing acknowledged that staff had been documenting on the medication administration record(MAR) for February 2024 and March 2024, the splint was being applied at 7:30 AM, 3/11/24-3/13/24 during the week of survey, however there was no splint in place or available.	F 688		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		4/11/24

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F 761	Continued From page 26 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove the expired medications from the refrigerator and expired supply kits from the medication storage room. Findings included: On 3/11/24 at 12:45 PM, observation of the medication storage room with Nurse #6 revealed: a. in the refrigerator, there were two opened and not dated multi-dose vials of Influenza Vaccine, 5 milliliters (ml); one multi-dose vials of Influenza Vaccine, 5 ml, opened on 11/8/23. The manufacturer's instruction was to discard after 30 days, which would be on 12/1/23. There was one expired multidose vial of Levemir insulin, 100 units in 1 milliliter, 10 milliliters, opened on 1/6/24 and marked to discard on 2/13/24. b. inside the cabinets, there were 18 expired sealed plastic bags of Secondary Administration Sets (3 of them expired on 7/20/23, 5 - on 8/1/23, 6 - on 8/8/23 and 4 - on 8/20/23); 1 sealed plastic bag of Dressing Change Tray, expired on 11/23/23; 1 plastic bag of Foley Catheter Insertion Tray, expired on 10/31/22 and 4 Pivodon-Iodine Swab sticks, expired in November 2023. On 3/11/24 at 1:15 PM, during an interview, Nurse #6 indicated that the nurses who worked on the medication carts, were responsible for	F 761	F761 Label/Store Drugs and Biologicals On 3/12/24 the Director of Nursing removed and destroyed all medications and supplies that were not labeled with an open date and/or expired from the refrigerators in medication rooms and medication storage cabinets. On 4/2/24 by the Unit Manager an audit of medication rooms to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed and/or returned to the pharmacy timely for destruction. The Director of Nursing will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility protocol, returning expired or discontinued medications to the pharmacy for destruction when indicated and locking medication cart. On 3/12/24 the Director of Nursing initiated an in-service with all nurses and medication aides regarding Medication Storage with emphasis on labeling medications with an open date/expiration date responsibility to check medication cart/medication storage room daily for expired medications and discarding	

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F 761	Continued From page 27 discarding expired medications from the medication storage room. She mentioned that per training, every nurse should check the date of opening on multi-dose medications. The nurse stated that she had not checked the expiration date of medications in the medication storage room at the beginning of her shift. On 3/11/24 at 1:25 PM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible to check all the medications in medication storage rooms for expiration date and remove expired medications and supplies every shift. She expected that no expired items be left in the medication storage room. On 3/11/24 at 1:30 PM, during an interview, the Administrator expected no expired items to be left in the medication storage rooms.	F 761	expired medications per pharmacy policy. In-services will continue and be completed on 4/11/24 by the Staff Development Coordinator. After 4/11/24 any nurse or medication aide who has not worked or received the in-service will complete in-service prior to the next scheduled work shift. All newly hired nurses or medication aides will be in-serviced during orientation regarding Medication Storage. The Unit Manager will initiate on 4/8/24 an audit of all medication rooms weekly x 4 weeks then monthly x 1 month utilizing the Medication Storage Audit Tool. This audit is to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed. The Assistant Director of Nursing will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility protocol. The Assistant Director of Nursing will review Medication Cart Storage Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. for completion and to ensure all areas of concerns were. The Director of Nursing will present the findings of the Medication Cart Audit Tool and Medication Storage Room Audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Quality Assurance Performance Improvement (QAPI) Committee will meet monthly for 2 months	

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F 761	Continued From page 28	F 761	and review the Medication Cart Audit Tool 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 of monitoring. The Director of Nursing is responsible for the plan of correction and the Administrator responsible for sustained compliance. Date of Alleged Compliance: 4/11/24	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input 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.	F 867		4/11/24

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F 867	Continued From page 29 §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (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	F 867		

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performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or 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:

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F 867	Continued From page 31 (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 record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey dated 4/12/21 and the recertification and complaint survey dated 1/13/23. This was for one deficiency in the area of Grievances (585) which was originally cited during the recertification and complaint investigation survey conducted on 4/12/21 and recited during the current recertification and complaint investigation conducted on 3/14/24. In addition, Care Plan timing/revision (657) and Medication Storage (761) here were originally cited during the recertification and complaint investigation survey conducted on 1/13/23 and recited during the current recertification and complaint investigation conducted on 3/14/24. The repeated citations during the three surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross referenced to: F 585: Based on record review, resident, and staff interviews the facility failed to investigate and resolve grievances for Residents #46 and #42 and maintain evidence demonstrating the result	F 867	F867 QAPI/QAA Improvement Activities On 4/5/24, the Facility Nurse Consultant completed an in-service with the Administrator, and Director of Nursing regarding the Quality Assurance process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the Quality Assurance process, modification, and correction if needed, to prevent the reoccurrence of deficient practice to include grievances, care plan timing, revision, and medication storage. 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 Quality Assurance process. All newly hired Administrator, and Director of Nursing will be educated during orientation regarding the Quality Assurance Process. All data collected for identified areas of concerns to include Grievances, care plan timing and revision and medication storage will be taken to the Quality Assurance committee for review monthly x 2 months. The Quality Assurance committee will review the data and determine if plans of corrections are being followed, if changes in plans of action are	

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F 867	Continued From page 32 of the grievances for Residents #282, #29, #68. This was for 5 of 5 residents reviewed for grievances. During the recertification and complaint survey dated 4/12/21 the facility failed to initiate a written grievance summary for grievances verbally reported for one of one resident reviewed for grievances. F 657: Based on staff interviews and record reviews, the facility failed to review and revise a resident's care plan when indicated for 4 of 29 sampled residents (Resident #47, Resident #8, Resident #69, and Resident #46). The care plan for Residents #47, #8 and #69 were not revised to accurately reflect the results of their Smoking Evaluation. Resident #46's plan of care was not updated when there was a change in her Advance Directive. During the recertification and complaint survey dated 1/13/23 the facility failed to review and update a care plan and ensure the care plan was signed for 1 of 5 residents reviewed for weight loss. F 761: Based on observations and staff interviews, the facility failed to remove the expired medications from the refrigerator and expired supply kits from the medication storage room. During the recertification and complaint survey dated 1/13/23 the facility failed to label inhalers and multidose vials with the date open and date to expire, dispose of expired	F 867	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 Administrator. The Facility Nurse Consultant will ensure the facility is maintaining an effective Quality Assurance program by attending Monthly Quality Assurance meetings monthly x 2 months and ensure implemented procedures and monitoring practices to address interventions, to include Grievances, care plan timing and revision and medication storage. The Facility Nurse Consultant will immediately retrain the Administrator and Director of Nursing for any identified areas of concern. The results of the Monthly Quality Assurance meeting will be presented by Administrator to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring. The Director of Nursing is responsible for the correction plan and the Administrator for sustained compliance. Date of Compliance: 4/11/24	

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F 867	Continued From page 33 medications, keep a medication refrigerated per pharmacy instructions, and label inhalers with the minimum required labeling (including a resident's name and instructions for administration) in 1 of 2 medication carts (Hall 300) and 1 of 1 medication rooms observed. An interview with the Administrator was conducted on 03/14/24 at 5:10 pm. He indicated his expectation was for the team to work together to maintain an effective Quality Assurance Performance Improvement Committee to ensure the facility does not repeat a previous deficient practice.	F 867		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review and staff interview the facility failed to monitor antibiotic usage in the facility for 6 of 13 months reviewed (August 2023, September 2023, October 2023, November 2023, December 2023, January 2024). Findings included: Review of the facility's policy titled Antibiotic	F 881	F 881 Antibiotic Stewardship On 3/14/24, the Assistant Director of Nursing implemented a system for antibiotic tracking as evidenced by the implementation of the Monthly infection Log for adherence to the facility Antibiotic Stewardship Policy. On 3/14/24, the Director of Nursing educated the Assistant Director of Nursing on implementing an Antibiotic	4/11/24

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GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DRIVE GREENSBORO, NC 27406

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F 881	Continued From page 34 Stewardship, revised on 03/04/24 revealed the following: "As a component of this facility's IPCP (infection prevention control program), the antibiotic stewardship program supports the appropriate and safe use of antibiotics in the treatment of residents' infections with a focus on the development and reduction of antibiotic-resistant organisms." On 03/14/24 at 3:00 pm an interview was conducted with the Assistant Director of Nursing (ADON), and she indicated she was unable to locate 2023 antibiotic stewardship information initially then presented with January 2023 through July 2023 antibiotic stewardship information. A review of February 2023 through January 2024 antibiotic stewardship revealed no information for antibiotic monitoring for the months of August 2023 through December 2023 and January 2024. During an interview on 3/14/24 at 4:15 pm with the Regional Nurse Consultant she indicated the previous ADON was responsible for the antibiotic stewardship, and she was here until December 2023. She indicated they were trying to find the rest of the antibiotic information. Attempted to contact the previous ADON and was unsuccessful. On 03/14/24 at 4:21 pm an interview was conducted with the Director of Nursing (DON), and she indicated her expectation was to monitor the antibiotics and infections on day one of the start of antibiotic. She indicated when an antibiotic started, they would ensure it was needed, track and trend the infections and review specifics of particular issues of infection	F 881	Stewardship/Tracking system for monitoring resident antibiotic use aligned with the facility policy by using the Monthly Infection Log. The Monthly Infection Log will be audited by the Director of Nursing starting 4/11/2024 weekly X 4 weeks and then monthly X 2 months to ensure that antibiotics are being properly tracked and initiated, results of these audits will be reviewed by Interdisciplinary Team for compliance. Any concerns will be addressed. The facility Quality Assurance Performance Improvement (QAPI) committee will discuss interventions and further monitoring/audits when recommended. The Infection Preventionist will audit all residents for appropriate antibiotic use for the past 30 days by completing the monthly infection log. Any concerns with the log will be discussed with the Director of Nursing followed by notification to the Medical Director for additional guidance if appliable. The Infection Preventionist will ensure that antibiotics are being tracked on the Monthly Infection Log. The Infection Preventionist will audit antibiotic orders starting 4/11/2024 weekly X 4 weeks and then monthly X 2 months to ensure that antibiotics are being properly tracked and initiated. Audits will be monitored at the QAPI committee Director of Nursing or Administrator will review Monthly Infection log weekly for 4 weeks, and then monthly for 2 months. Results of audit will be shared with the Quality Assurance Performance	

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F 881	Continued From page 35 monitoring monthly.	F 881	Improvement (QAPI) members for 3 months or until a time determined by the Quality Assurance Performance Improvement (QAPI) members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. Date of Alleged Compliance: 4/11/24	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (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.	F 883		4/11/24

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F 883	Continued From page 36 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to administer the influenza and pneumonia vaccine for residents who signed a consent form to receive influenza and pneumonia vaccines for 2 of 5 residents reviewed for infection control (Resident #33 and Resident # 54). The findings included: a. Resident #33 was admitted to the facility on	F 883	F883 Influenza and Pneumococcal Immunizations On 3/15/24 the Assistant Director of Nursing notified Medical Director of residents #33 and #54 desire to receive the Influenza or Pneumococcal Vaccine for this year 2024. Medical Director agreed to the vaccines. Residents #33 and #54 were notified of the Medical Director order. Education was provided to resident #33 and #54 on the Influenza and	

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F 883	Continued From page 37 12/27/23. Review of Resident #33's medical record revealed Resident's responsible party signed a "Consent/Release" form for the Flu Vaccine and the Pneumonia Vaccine on 12/29/23. There was a check mark on the line that read yes for the flu and pneumonia Vaccines are given annually unless medically contraindicated. I authorize the administration of the flu and pneumonia vaccine based upon educational materials which includes the risks and benefits given by the facility. Resident #33's admission Minimum Data Set (MDS) assessment dated 01/03/24 revealed Resident #33 had moderate cognitive impairment. Review of medical record for Resident # 33 revealed no information of Resident receiving the influenza and/or the pneumonia vaccines. b. Resident #54 was admitted to the facility on 01/17/24 and discharged to the hospital on 01/29/24 and readmitted to the facility on 02/06/24. Resident #54's quarterly Minimum Data Set (MDS) assessment dated 02/14/24 revealed Resident #54 was cognitively intact. Review of Resident #54's medical record revealed Resident's responsible party signed a "Consent/Release" form for the Flu Vaccine and the Pneumonia Vaccine on 01/17/24. There was a check mark on the line that read yes for the flu and pneumonia Vaccines are given annually unless medically contraindicated. I authorize the administration of the flu and pneumonia vaccine	F 883	Pneumococcal Vaccine. On 4/8/24 Resident #54 received education on Influenza and Pneumococcal Vaccine and received the vaccines on 4/9/24. On 4/2/24 for Resident #33 the Responsible Party was called and has declined the vaccines and will revisit in the Fall. On 3/15/24 the Assistant Director of Nursing conducted an audit of all residents who have consented to the Influenza and Pneumococcal Immunizations to ensure all residents requesting the immunizations have received their vaccine. All vaccines were given per the resident request beginning 3/15/24 and completed on 4/11/24. The Assistant Director of Nursing/Unit Managers will address all concerns identified during the audit. On 4/5/24, the Regional Nurse Consultant initiated an in-service with the Director of Nursing on the policy and procedure for offering residents the Influenza and Pneumococcal Immunizations on admission and on the resident and resident representative receiving education regarding the benefits and potential side effects of each immunization annually. The Director of Nursing will in-service the Assistant Director of Nursing-Infection Preventionist and the Unit Manager’s on the policy and procedure for offering residents the Influenza and Pneumococcal Immunizations on admission and on the resident and resident representative receiving education regarding the benefits and potential side effects of each immunization annually.	

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F 883	Continued From page 38 based upon educational materials which includes the risks and benefits given by the facility. Review of medical record for Resident #54 revealed no information of Resident receiving the influenza and/or the pneumonia vaccines. An interview was conducted on 03/14/24 at 03/14/24 at 1:38 pm with the Infection Preventionist and she indicated she had just started working in the facility a couple of weeks ago, but she had audited the vaccinations and was getting ready to obtain consents and administer the vaccines. She indicated she did not know why Resident #33 and Resident #54 did not receive their vaccines. On 03/14/24 03:12 PM an interview was conducted with the Director of Nursing (DON), and she indicated she started in January of this year and once the consent was signed the residents should have receive the requested vaccine. She indicated she did not know why Resident #33 and Resident #54 did not receive their vaccines.	F 883	On 4/11/24 The Director of Nursing/Assistant Director of Nursing/Unit Manager will audit all new admissions to ensure the resident and resident representative have been education on immunizations and offered to receive immunizations on admission. At admission, the Director of Nursing/Assistant Director of Nursing/Unit Manager will provide education to the resident and resident representative on Influenza and Pneumococcal immunizations and offer to provide the immunization. Immunizations for Influenza and Pneumonia immunizations will be audited weekly x 4 weeks and then 1-time monthly x 2 months. The Director of Nursing/Assistant Director of Nursing and Unit Managers will address all concerns identified during the audit to include additional education of nurses to include agency and contract staff. The Assistant Director of Nursing/Unit Managers will forward the results of Audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Quality Assurance Performance Improvement (QAPI) Committee will meet monthly x 2 months and review Immunization Audit 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. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. Date of Compliance: 4/11/24	

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F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and	F 887		4/11/24

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F 887	Continued From page 40 (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the COVID-19 immunization for 5 of 5 residents (Resident #46, Resident #14, Resident #26, Resident #33, and Resident #54) and offer the COVID-19 vaccine for 3 of 5 residents (Resident #26, Resident # 33, and Resident #54) and maintain a resident's record of COVID-19 vaccine history for 3 of 5 residents (Resident #26, Resident #33, and Resident #54), the failures regarding education, offering the vaccine, and maintain records were found for 5 of 5 residents reviewed for infection control. The findings included: a. Resident #46 was admitted to the facility on 05/07/20.	F 887	F877 COVID-19 Immunization On 4/5/24 Resident #46, #14, #26, #33, (#54 is currently not in the facility), were provided education on the benefits and potential side effects of the COVID-19 immunization. Resident #46, #14, #26, #33 were offered the COVID-19 immunization at that time. If any of the residents identified refuse the COVID-19 Immunization, it will be documented on the immunizations record on the resident chart in Point Click Care (PCC). If the identified residents request the COVID-19 Immunization, the administration of the immunization will be documented on the resident chart in Point Click Care (PCC). A COVID-19 immunization clinic sponsored by McNeil Pharmacy will be held on 4/22/24 to complete #46, #14, #26	

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F 887	Continued From page 41 Review of a significant change Minimum Data Set (MDS) assessment dated 01/04/24 revealed that Resident #46 was cognitively intact. Review of Resident #46's medical record revealed no information the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization. b. Resident #14 was readmitted to the facility on 03/12/21. Review of admission Minimum Data Set (MDS) assessment dated 01/08/24 revealed that Resident #14 was cognitively intact. Review of Resident #14's medical record revealed no information the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization. c. Resident #26 was admitted to the facility on 10/05/23. Review of the quarterly Minimum Data Set (MDS) assessment dated 01/08/24 revealed that Resident #26 had cognitive impairment. Review of Resident #26's medical record revealed no information the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization and no information about Resident #26 being offered and/or received the COVID-19 vaccine.	F 887	and #33 (#54 is no longer in the facility) vaccines. On 4/2/24 Assistant Director of Nursing/Unit Manager will audit all residents COVID-19 immunizations status, if given or not and vaccine history. On 4/9/24 the Assistant Director of Nursing will provide education to the resident and/or Responsible Party on the COVID-19 vaccine. If the immunization is accepted, the consent will be documented in Point Click Care (PCC), if refused it will be documented as refusal in (PCC) Immunizations tab. The audit will be completed on 4/11/24 by the Assistant Director of Nursing. A COVID-19 immunizations clinic sponsored by McNeil Pharmacy will be held on 4/22/24 for all residents wanting the COVID-19 vaccine. The Assistant Director of Nursing/Unit Managers will address all concerns identified during the audit. Signed Consent Forms will be placed in the resident chart and the immunizations will be recorded in the resident chart in Point Click Care after the vaccine clinic. On 4/2/24, Assistant Director of Nursing will audit all residents to ensure they have vaccination history documented as in Point Click Care (PCC) Immunizations section. The audit will be completed by 4/11/24. The Assistant Director of Nursing/Unit Managers will address all concerns identified during the audit. On 4/4/24, the Regional Nurse Consultant provided an in-service with the Director of Nursing/Assistant Director of Nursing-Infection Preventionist/Unit Managers on the policy and procedure for	

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F 887	Continued From page 42 d. Resident #33 was admitted to the facility on 12/27/23. Review of the quarterly Minimum Data Set (MDS) assessment dated 01/03/24 revealed that Resident #33 had cognitive impairment. Review of Resident #33's medical record revealed no information the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization and no information about Resident #33 being offered and/or received the COVID-19 vaccine. e. Resident #54 was admitted to the facility on 01/17/24, discharged to the hospital on 01/29/24 and readmitted to the facility on 02/06/24. Review of the quarterly Minimum Data Set (MDS) assessment dated 02/14/24 revealed that Resident #54 was cognitively intact. Review of Resident #54's medical record revealed no information the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization and no information about Resident #54 being offered and/or received the COVID-19 vaccine. An interview was conducted with the Infection Preventionist on 03/14/24 at 1:38 pm and she indicated she had been employed in the facility for 1 ½ weeks and had researched in the North Caroline (NC) Vaccine Registry the vaccines for the current residents and had checked the consents to see which Residents had consents had. She indicated some consents were in the	F 887	offering residents the COVID-19 immunization, documenting consent or refusal of the immunizations under the immunizations tab in the resident chart and the resident and resident representative have received education regarding the benefits and potential side effects of the immunization. On 4/9/24 The Director of Nursing will in-service the Assistant Director of Nursing-Infection Preventionist and the Unit Manager's on the policy and procedure for offering residents the COVID-19 Immunizations on admission and on the resident and resident representative receiving education regarding the benefits and potential side effects of each immunization annually, this will be completed on 4/11/24. On 4/11/24 The Staff Development Coordinator will audit all residents' charts to ensure the COVID-19 immunization has been offered and documenting consent or refusal of the immunizations under the immunizations tab in the resident chart. Immunizations will be audited 1-time weekly x 4 weeks and then 1-time monthly x 2 months. The Assistant Director of Nursing/Unit Manager will address all concerns identified during the audit to include additional education of nurses to include agency and contract staff. The Assistant Director of Nursing/Unit Managers will forward the results of Audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Quality Assurance Performance Improvement (QAPI)	

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F 887	Continued From page 43 computer and some were on paper, but now she was not able to locate the consents and or education regarding the COVID-19 vaccine for any residents and the Director of Nursing (DON) was trying to locate them. On 03/14/24 at 3:12 pm an interview was conducted with the DON, and she indicated she believed the consents were being done, however they were unable to locate them. The DON indicated the vaccine process was started on admission. She indicated they would check the record, and if a resident had been given the vaccine it was documented the computer, and if they have not received the vaccine, it was offered to them, and they received education about the vaccination. She stated the consents were obtained and the vaccine would be administered.	F 887	Committee will meet monthly x 2 months and review Immunization Audit 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. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. Date of Alleged Compliance: 4/11/24	