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	495375	A. BUILDING _____ B. WING _____	C 11/16/2022

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EMPORIA REHABILITATION AND HEALTHCARE CENTER	**200 WEAVER AVENUE EMPORIA, VA 23847**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/13/22 through 11/16/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/13/22 through 11/16/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five complaints were investigated during the survey. (VA00056722- substantiated with no deficient practice; VA00056592- substantiated with deficiency; VA00056319- substantiated with deficiency; VA00055737- substantiated with deficiency; VA00054256- unsubstantiated). The census in this 120 certified bed facility was 93 at the time of the survey. The survey sample consisted of 37 resident reviews, and 35 employee record reviews.	F 000		
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt	F 569		

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

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resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

§483.10(f)(10)(v) Conveyance upon discharge, eviction, or death.
Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to convey a resident's personal funds within 30 days of discharge to one resident, (Resident #303), in a survey sample of 37 Residents.

The findings included:

For Resident #303, the facility staff did not issue a refund of trust funds within 30 days of the Resident's discharge.

On 11/16/22, a review of the Resident trust account "Trial Balance" report revealed that Resident #303 had a negative account balance in the amount of -$917.41.

Review of the electronic health record revealed that Resident #303 was initially admitted to the facility on 05/13/2021 and discharged to the hospital on 11/08/2021. Resident #303 expired at the hospital.

On 11/16/22 at 8:56 AM, Surveyor B conducted

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an interview with the Business Office Manager/Employee M. Employee M was asked about Resident #303's negative account balance. Employee M said, "It is money that is due back to his account, they deducted his care cost twice. I've sent them [referring to Corporate] emails to correct it, but it hasn't happened." Surveyor B asked Employee M to provide the business office file for Resident #303. Employee M said, "I will have to locate it." The file was not received prior to the conclusion of the survey.

Review of the Resident Statement for Resident #303's trust account revealed that at the time of his discharge on 11/8/2021, the trust account balance was $40.00. On 12/1/2021, a personal check was deposited in the amount of $898.58, which brought the account balance to $938.58.

On 11/16/22 at approximately 10 AM, Employee N, the Corporate Business Office Consultant, reviewed the account and indicated that Resident #303 was due a refund in the amount of $938.59, which was the $40 balance at the time of discharge, plus the personal check in the amount of $898.58, plus $0.01 interest.

On 11/16/22 at approximately 1 PM, Employee N was asked about the expected timeframe for closing a Resident's trust account and issuing any refunds due after discharge. Employee N said, "Within 30 days."

During a survey debriefing on 11/16/2022 at approximately 1:30 PM, the facility Administrator, Director of Nursing, and Corporate Director were informed of these findings for Resident #303.

On 11/16/22 at 4:13 PM, Surveyor B was

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F 569	Continued From page 3 provided a form that read, "Resident Refund Information," which indicated a check in the amount of $1,856.00 had been requested with the "Reason for Refund: Resident d/c [discharged], refund needs to be sent to clear the negative balance in RFMS [Resident Fund Management System]." Surveyor B asked if Resident #303 was due a refund in the amount of $1,856.00. The facility Administrator said she would have Employee N, the Corporate Business Office Consultant come discuss it. On 11/16/22 at approximately 4:25 PM, Employee N stated, "This refund request is to be deposited into the trust account, which will clear the negative balance, and a check for the refund will be issued to the estate division for the Resident." Employee N stated, "It won't take long to get all this done." When asked why it has been a year and not taken care of previously, Employee N said, "It fell through the crack." A review was conducted of the facility policy titled, "Accounting and Records of Resident Funds." This policy didn't address the process or requirements with regards to issuing refunds or closing the trust account. No further information was provided.	F 569		
F 570 SS=E	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced	F 570		

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by:
Based on staff interview and facility record review, the facility staff failed to have a sufficient surety bond to assure the security of all personal funds of residents deposited with the facility, affecting 85 of 93 facility Residents who had a patient trust account.

The findings included:

For 85 Residents, the facility staff failed to maintain a surety bond in a sufficient amount to assure the security of all personal funds deposited with the facility.

On 11/13/22, during an entrance conference conducted with the facility Administrator, the survey team requested a copy of the facility surety bond and current Resident trust fund balance.

On 11/16/22, the surety bond was reviewed and revealed that the coverage amount was for $125,000, but the bond expired/ended on 10/1/22. The current Resident trust account balance was reviewed and revealed 85 Residents had open and active accounts with the facility. Of the 85 open accounts, 74 had an active balance, which totaled $126,453.02.

On 11/16/22 at 8:56 AM, Surveyor B conducted an interview with the Business Office Manager/Employee M. Employee M provided Surveyor B with a copy of a surety bond, and upon review, it was identified that the surety bond was coverage for the previous facility owner and the facility under the previous business name. When questioned, Employee M said she wasn't sure if it was effective/transferring for the new

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owner or not. When Surveyor B informed the facility staff that the bond was not enough coverage to cover the current trust account balance, the Business Office Manager/Employee M said, "Oh wow, so if it is in effect it wouldn't cover it."

On 11/16/22 at approximately 9:30 AM, Employee N, the Corporate Business Office Consultant arrived and provided Surveyor B with a surety bond that was current and in effect. This bond had a coverage limit of $125,000. Employee N was informed that the coverage amount was not sufficient to cover the current trust account balance.

Review of the facility policy, "Surety Bond," revealed, in part, "Policy Statement: Our facility has a current surety bond or provides self-insurance to assure the security of all residents' person funds deposited with the facility. Policy Interpretation and Implementation: 1. This facility holds a surety bond to guarantee the protection of residents' funds managed by the facility on behalf of its residents. 2. A surety bond is an agreement between the facility, the insurance company, and the resident or the State acting on behalf of the resident, wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages, and accounts for..."

On 11/16/22 at approximately 2 PM, the facility Administrator was made aware that the facility's surety bond at the time of survey was not sufficient to cover the amount of funds deposited with the facility on behalf of Residents.

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F 570	Continued From page 6 No further information was provided.	F 570		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580		

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update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to notify the responsible party for a change in condition for one Resident (Resident #80) in a sample size of 37 Residents.

The findings included:

For Resident #80, the facility staff failed to notify the responsible party when a new wound was discovered on 08/04/2022.

On 11/14/2022 and 11/15/2022, Resident #80's clinical record was reviewed.

An excerpt of a provider note dated 08/04/2022 at 8:41 A.M. under the header "Assessment/Plan" documented, "Open wound to right sacral area-acute; new rec' [sic] given."

The nursing progress notes from 08/04/2022 through 08/10/2022 were reviewed. There was no evidence the responsible party was notified.

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F 580	Continued From page 8 On 11/16/2022 at approximately 1:45 P.M., the Administrator and Director of Nursing (DON) were notified of findings. When asked about the expectation for responsible party notification of a new sacral wound, the DON stated the responsible party should have been notified. A review of the facility policy, "Change in a Resident's Condition or Status," revealed, in part, "Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status..." No further information was provided prior to exit.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		

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services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, Resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide a homelike environment for one Resident (Resident #11) in a sample size of 37 Residents.

The findings included:

For Resident #11, the facility staff failed to ensure comfortable water temperatures for personal hygiene and incontinence care.

On 11/13/2022 at 1:15 P.M., Resident #11 was interviewed. When asked about any care concerns, Resident #11 indicated that water in the bathroom sink does not get hot. Resident #11 stated that staff knows about it and they use cold cloths with incontinence care. During the course

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of the interview, this surveyor ran the hot water in the sink for approximately 3 minutes. The water did not heat up and felt cooler than 98.6 degrees Fahrenheit.

On Resident #11's quarterly Minimum Data Set with an Assessment Reference Date of 08/17/2022, the Brief Interview for Mental Status was coded as 15 out of 15, indicating the resident was cognitively intact.

A review Resident #11's care plan with a revision date of 05/25/2022 revealed, in part: "[Resident #11] has an ADL [activities of daily living] self-care performance deficit ...Has episodes of incontinence. Provide peri care as needed."

On 11/14/2022 at 2:50 P.M., this surveyor and the Maintenance Director entered Resident #11's bathroom. The Maintenance Director turned the hot water on. The Maintenance Director stated that it takes a while for the water to heat up. At approximately 2:54 P.M., the Maintenance Director placed a thermometer under the running water that had been running for approximately 4 minutes. The temperature was 87 degrees Fahrenheit. The Maintenance Director left the water running, left the room, and entered the room bathroom next door. He turned on the hot water in that sink and then returned to Resident #11's bathroom. When asked why this was done, the Maintenance Director stated that running both at the same time will help to increase the water temperature quicker. At 2:55 P.M., the water temperature was 91 degrees Fahrenheit. At 2:56 P.M., the water temperature was 95 degrees Fahrenheit. At 2:57 P.M., the water temperature was 100 degrees Fahrenheit. As the Maintenance Director continued to hold the thermometer under

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F 584	Continued From page 11 the running water, the temperature rose to 102 degrees Fahrenheit. When asked if this was acceptable to take over 7 minutes for the water temperature to reach only 102 degrees Fahrenheit, the Maintenance Director stated that it usually doesn't take that long. On 11/14/2022 at 4:00 P.M., the administrator and Director of Nursing were notified of findings. A policy for acceptable water temperatures was requested. On 11/15/2022 at 1:13 P.M., Surveyor B interviewed Certified Nursing Assistant (CNA) E. When asked about the water temperatures in Resident rooms, CNA E stated that staff needs to let the water run before it will heat up, and it's been that way for about a month. On 11/15/2022 at approximately 1:15 P.M., Surveyor B interviewed Registered Nurse (RN) B. When asked about the water temperatures in Resident rooms, RN B stated that there were a few days with no hot water, and the aides were having to heat up water in the microwave to provide care. On 11/15/2022, the facility staff provided a policy, "Water Temperatures." A review of this policy revealed, in part: "Let the hot water run from the faucet for 3-5 minutes ...Ensure patient room water temperatures are between 105-115 degrees Fahrenheit." No further information was provided prior to exit.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12	F 602		

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§483.12
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure that Residents are free from abuse and exploitation for 1 Resident (Resident #303) in a survey sample of 37 Residents.

The findings included:

For Resident #303, the facility staff misappropriated the Resident's money by deducting funds from the Resident's trust account after the Resident's discharge, leaving the account in a negative balance, and preventing the facility staff from issuing a refund due to the Resident for over a year following the Residents discharge.

Review of the electronic health record revealed that Resident #303 was initially admitted to the facility on 05/13/2021 and discharged to the hospital on 11/08/2021. Resident #303 expired at the hospital.

On 11/16/22, a review of the Resident trust account "Trial Balance" report revealed that Resident #303 had a negative account balance in the amount of -$917.41.

On 11/16/22 at 8:56 AM, Surveyor B conducted

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an interview with the Business Office Manager/Employee M. Employee M was asked about Resident #303's negative account balance. Employee M said, "It is money that is due back to his account. They deducted his care cost twice. I've sent them [referring to Corporate] emails to correct it, but it hasn't happened." Surveyor B asked Employee M to provide the business office file for Resident #303. Employee M said, "I will have to locate it," indicating that it was no longer in her office since the Resident was discharged. The file was not received prior to the conclusion of the survey.

Review of the Resident Statement for Resident #303's trust account revealed that at the time of his discharge on 11/8/2021, the trust account balance was $40.00. On 12/1/2021, a personal check was deposited in the amount of $898.58, which brought the account balance to $938.58.

On 11/16/22 at approximately 10 AM, Employee N, the Corporate Business Office Consultant, reviewed the account and stated to Surveyor B that Resident #303 was due a refund in the amount of $938.59. This included the $40 balance at the time of discharge, plus the personal check in the amount of $898.58, plus $0.01 interest. When asked to explain why the deductions were made and paid to the facility after the Resident's discharge, Employee N said, "The system is set up to automatically deduct it each month."

Employee N then explained that Resident #303's social security income was deposited into the account in December 2021 and January 2022, and that is what was deducted from the Resident's account. Employee N further

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confirmed that the Resident was discharged in November 2021, and no funds/money was due to the facility in December 2021 or January 2022, when the withdrawals in the amounts of $900 and $956 were made. Following the facility's withdrawal of funds, the Social Security Administration then recovered/withdrew the funds from the account for the checks that had been deposited, after the Resident's death, which left the account with a negative balance.

On 11/16/22 at 1:22 PM, an interview was conducted with Employee Q, the social worker. Employee Q defined misappropriation as, "When a person uses the money for purposes that were not intended." When asked if misappropriation occurs when money is withdrawn from a Residents' trust account to pay the facility when money is not owed to the facility, the social worker said, "Yes."

During a survey debriefing on 11/16/2022 at approximately 1:30 PM, the facility Administrator, Director of Nursing, and Corporate staff were informed of these findings for Resident #303.

On 11/16/22 at 4:13 PM, Surveyor B was provided a form that read, "Resident Refund Information," which indicated a check in the amount of $1,856.00, had been requested, with the "Reason for Refund: Resident d/c [discharged], refund needs to be sent to clear the negative balance in RFMS [Resident Fund Management System]." When Surveyor B asked why Resident #303 was due a refund in the amount of $1,856.00, the facility Administrator said she would have Employee N, the Corporate Business Office Consultant come discuss it.

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F 602	Continued From page 15 On 11/16/22 at approximately 4:25 PM, Employee N stated, "This refund request is to be deposited into the trust account, which will clear the negative balance, and a check for the refund will be issued to the estate division for the Resident." Employee N stated, "It won't take long to get all this done." When asked why it has been a year and not taken care of previously, Employee N said, "It fell through the crack." A review of the facility policy, Accounting and Records of Resident Funds," revealed, in part: 2. Individual accounting ledgers are maintained in accordance with generally accepted accounting principles." A review of the Office of Justice Programs document, "Generally Accepted Accounting Principles (GAAP) Guide Sheet," revealed, in part: Principle of prudence: the accounting entries are timely and realistic ...Conducting monthly reconciliations will ensure that errors are identified and rectified for the purpose of accurate reporting. These measures are some of the ways recipients can verify that they are providing transparent and consistent financial records, despite the structure of their organization..." This information was accessed online at: https://www.ojp.gov/sites/g/files/xyckuh241/files/media/document/GAAP_Guide_Sheet_508.pdf No further information was provided.	F 602		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		

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F 607	Continued From page 16 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement their abuse policy for 14 employees (Staff #3, 8, 11, 12, 16, 19, 21, 22, 24, 25, 32, 33, 34 and 35) in a sample of 25 employees reviewed. The findings included: The facility staff failed to implement their abuse policy with regards to the pre-hire screening of 14	F 607		

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employees, including license/certification verifications and/or criminal background checks.

On 11/13/22, during the entrance conference conducted with the facility Administrator, a listing of employees hired since the facility's previous licensure survey was conducted in 2019 was requested.

On 11/14/22, the list of new hires was reviewed and a sample was selected. The facility Administrator was asked to provide evidence of the 25 sampled staff's sworn statement, criminal background check and professional license verification conducted prior to or at the time of hire.

On 11/15/22 at 10:30 AM, the Administrator was asked to explain why criminal background checks (CBCs) are performed for potential employees. The Administrator said, "[the CBC] is used to verify and check for any barrier crimes such as any type of abuse and neglect ...we get it at the time of hire ...we run the checks to keep our residents safe."

When asked to explain the purpose of the professional license look-up, the Administrator said, "to make sure they have an active license and that there is no disciplinary action by the licensing board that would keep them from working in the nursing home, and that they are licensed to provide proper care to residents."

On 11/15/22, a review of the new hire documents revealed the following:

1. For Staff #3, who was an RN (registered nurse) hired 9/26/22, the facility did not verify the license

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until 11/16/22. Therefore, the facility was neither aware if her RN license was active at the time of hire, nor were they aware if she had any adverse actions/sanctions against her license that may indicate a history of abuse.

2. For Staff #16, an RN who was hired 4/15/21, the facility staff failed to verify her professional RN license until 6/15/21.

3. For Staff #11, an LPN (licensed practical nurse) hired 6/12/19, the facility staff failed to verify that she had a nursing license in good standing until 4/1/20, which was over 6 months after her hire/employment began.

4. For Staff #19 an LPN hired 05/3/21, the facility staff failed to verify that she held a current and unencumbered nursing license until 9/7/21, after she had already been working in the capacity of a nurse and providing direct resident care.

5. For Staff #21, an LPN was hired 8/31/21, the facility staff permitted Staff #21 to work in the capacity of a nurse without having verified that she held a current and active nursing license, and without knowing if she had any adverse actions/reports against her professional license. The facility staff did not perform a license verification until 9/20/21.

6. For Staff #12 an LPN hired 2/12/20, the facility staff failed to conduct a criminal background check until 10/1/2020, and did not verify her professional nursing license until 7/7/2020. Staff #12 was permitted to provide direct Resident care without the facility having knowledge if she was convicted of a barrier crime and if she held a current/unencumbered nursing license to

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practice.

7. On 8/31/22, Staff #22 was hired as a certified nursing assistant (CNA). The facility staff failed to obtain a criminal background check.

8. For Staff #8, hired 9/28/22 as a CNA (certified nursing assistant), the facility staff failed to verify her CNA certification until 11/14/22, following the survey team requesting her records.

9. For Staff #24, a CNA hired 9/24/22, the facility failed to obtain a criminal background check to ensure Staff #24 had not been charged and convicted of a barrier crime. Additionally, the facility conducted a license verification with the board of nursing on 9/26/22, which revealed there was additional information related to prior adverse actions on her license. The facility staff failed to conduct the steps necessary to see what the adverse actions were and verify if she was eligible for employment. Staff #24 remained an active employee, providing direct Resident care at the time of survey. On 11/16/22, Surveyor B asked Employee M, the business office manager if she had taken the steps necessary to determine what the additional information on her CNA license was, and Employee M said, "I did not."

10. For Staff #25, hired 8/31/22 as a CNA, her criminal background check had been pulled on 11/14/2016, and indicated that it was "in process." The facility staff failed to obtain the full report to determine what the criminal charges included. At the time of survey, the facility staff requested a criminal background check, which indicated, "Transaction is being processed." Employee M confirmed, "It indicates they have a criminal

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history." Employee M confirmed that during the course of Staff #25's employment from 8/31/22-11/11/22, she had worked as a CNA, providing direct Resident care, and the facility was not aware of her criminal background. Additionally, her CNA certification had not been verified until her file was pulled for the survey team on 11/14/22. Staff #25's employment with the facility had terminated on 11/11/22.

11. For Staff #32, hired at the facility on 1/13/22, the facility staff ran his criminal background check on 11/8/21, when he was employed previously at the facility. The facility staff then ran another criminal background check on 11/15/22.

12. For Staff #33, hired at the facility on 1/18/22, the facility was unable to provide any evidence of a criminal background check being conducted until 11/14/22. The request read, "Transaction is being processed." The facility Administrator stated that the employee had been removed from the schedule until they received the full report and could review what his criminal charges were, to determine if the employee had a barrier crime that would prevent continued employment.

13. For Staff #34, hired 4/27/22, the facility staff failed to evidence a criminal background check.

14. For Staff #35, hired 8/3/22, the facility failed to submit any personnel records to indicate that any pre-hire screening, to include a criminal background check, was conducted for this employee.

Review of the facility policy, "Abuse Prevention Program," revealed, in part: "As part of the resident abuse prevention, the administration will

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implement the following protocols: ...2. Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has: a. been found guilty of abuse, neglect, exploitation, or mistreatment by a court of law; b. had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or c. a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property...."

The facility staff also provided the survey team with a policy titled, "Licensure, Certification, and Registration of Personnel." This policy read,"4. Our facility conducts employment background screening checks, reference checks, license verifications and criminal conviction investigation checks in accordance with current federal and state laws. 5. Personnel undergoing a background investigation, if employed, will not be permitted to perform any duties that require a license/certification/registration until such investigation reveals a current unencumbered license/certification/registration...6. Should the background investigation reveal that the employee/applicant does not hold a current unencumbered or valid license/certification/registration, the employee will not be employed (or discharged if employed) and appropriate state and federal officials will be notified of such information..."

On 11/15/22, Surveyor D shared the above findings with the facility Administrator.

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F 607	Continued From page 22 On 11/16/22, Surveyor B met with Employee M, the business office manager. Each of the above employee's files were reviewed again. The hire dates for each of the employees was confirmed by Employee M, and the above findings were confirmed, with no additional information provided. On 11/16/22 at approximately 1:30 PM, during a debriefing with the facility Administrator, Director of Nursing and Corporate staff, Surveyor B explained that many of the concerns shared by Surveyor D with regards to the personnel records and screening of new employees remained. No further information was provided.	F 607		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident	F 626		

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who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to permit a resident to return to the facility for one Resident (Resident #300) in a survey sample of 37 Residents.

The findings included:

For Resident #300, the facility staff failed to permit the Resident to be readmitted to the facility after being discharged to the hospital on 8/16/22.

Resident #300's diagnoses included, but were not limited to: Paranoid schizophrenia, major depressive disorder, bipolar disorder, and current episode manic severe with psychotic features.

On 11/14/22, a clinical record review was conducted. This review revealed that Resident #300 was admitted to the facility on 11/17/21, and discharged on 2/18/22. The Resident was then

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readmitted on 3/16/22, and discharged on 8/16/22. According to the nursing notes, Resident #300 was sent to the hospital on 8/16/22 for increased lethargy, slurred speech, and decreased oxygen saturation.

Review of Resident #300's progress notes revealed entries that indicated Resident #300 was gaining access to staff areas such as laundry, soiled utility room, and the nursing area behind the nursing station. Several entries indicated the Resident entered the room of other Residents and took their belongings. Resident #300 was non-complaint with her diabetic diet, had episodes of yelling out, and on a few occasions, expressed suicidal ideation.

A review of multiple psychiatric notes revealed no indication Resident #300 was a danger to herself or others. In late July 2022, Resident #300 was sent to the emergency room without any indication for hospitalization, and returned to the facility without being admitted.

On 7/21/22 at 11:17 AM, an entry was made into the progress notes by the nurse practitioner that read, "Pt [patient] placement remains appropriate."

A review of the care plan for Resident #300, initiated 3/18/22, revealed, in part: "[Resident #300's name redacted] plans to be Long Term Care...[Resident #300's name redacted] to accept placement in the facility through next review."

On 11/14/22, during the end of day meeting, the facility Administrator was asked to provide any documentation she had with regards to Resident #300 not being readmitted to the facility following

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the resident's 8/16/22 discharge to the hospital.

On 11/15/22, the facility Administrator provided the survey team with a discharge notice that had been issued to Resident #300 dated 3/18/22. The notice that indicated the Resident would be discharged 4/18/22. The reasons for discharge were: "The health of other individuals in this facility is endangered, the safety of other individuals in this facility is endangered."

Resident #300 March 2022 clinical record was again reviewed. There were no progress notes by facility staff or the physician that specifically indicated the Resident had been determined to be a danger to the health and safety of other Residents.

On 11/15/22, the facility Administrator was asked if this was the only discharge notice issued to Resident #300, and, if so, and why the resident did not discharge on 4/18/22. The facility Administrator stated that the Resident was not discharged because a safe discharge could not be made at that time, and the discharge notice was not ever reissued/renewed.

On 11/16/22, the facility Administrator provided evidence that the facility had received a request from a hospital on 8/22/22, asking the facility consider Resident #300 for readmission. The facility responded, "Decline. We are unable to accept this prior resident at [facility name redacted]. She has been denied by our senior leadership team at [company name redacted] for all of our facilities due to dangerous and disruptive behaviors to our staff and residents. Please search for placement at other facilities for LTC [long term care]. Thank you, [name of

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F 626	Continued From page 26 Regional Director of Business Development redacted] [phone number redacted] Does not meet admission criteria." Review of the facility policy titled, "Transfer or Discharge Notice" was reviewed. This policy read, "1. A resident, and/or his or her representative (sponsor), will be given a thirty (30)-day advance notice of an impending transfer or discharge from our facility...5. The reasons for the transfer or discharge will be documented in the resident's medical record..." On 11/16/22, during the end of day meeting held with the facility Administrator, Director of Nursing and Corporate staff they were made aware that the discharge notice issued to Resident #300 had expired at the time the hospital was seeking readmission, when the facility declined the Resident. They were also made aware that there was not documentation within the clinical record that indicated she was a danger to herself and others. No further information was provided.	F 626		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, and facility documentation review, the facility staff failed to provide care and services in accordance	F 658		

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with professional standards of practice for 2 Residents (Resident #80, Resident #299) in a sample size of 37 Residents.

The findings include:

1. For Resident #80, the facility staff failed to document assessment findings for a pressure ulcer.

On 11/14/2022 and 11/15/2022, Resident #80's clinical record was reviewed.

An excerpt of a provider note dated 08/04/2022 at 8:41 A.M documented, "Open wound to right sacral area-acute; new rec' [sic] given."

A weekly nursing skin assessment, "Weekly Skin Review," dated 08/04/2022 at 1:10 P.M. documented that Resident #80's skin was intact.

The nursing progress notes from 08/04/2022 through 08/10/2022 were reviewed. There was no evidence the newly discovered sacral wound was assessed, described, or measured.

On 11/16/2022 at approximately 8:15 A.M., the Wound Nurse Practitioner (Employee P) and the Assistant Director of Nursing (ADON) were interviewed. When asked about the origin of Resident #80's wound, the ADON stated that it was first discovered by an aide on 08/04/2022. The ADON stated that the aide notified the nurse, the nurse notified the facility nurse practitioner, and a wound treatment was initiated on that day. The ADON verified there were no nursing progress notes about it.

On 11/16/2022 at approximately 1:45 P.M., the

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Administrator and Director of Nursing (DON) were notified of findings. When asked about the expectation, the DON stated staff should document the size (measurements), shape, wound bed, surrounding skin, and pain level of the new wound on the skin assessment.

According to "Taylor's Clinical Nursing Skills," 5th Edition, 2019, published by Lippincott, "Wounds are assessed for appearance, size, drainage, pain ...and the evidence of complications."

2. For Resident #299, the facility staff failed to provide feeding tube site care from 06/08/2022 through 07/01/2022.

On 11/14/2022, Resident #299's closed clinical record was reviewed. Resident #299 was admitted to the facility on 04/12/2022 and discharged on 07/01/2022. According to a physician's note dated 06/09/2022 at 4:01 P.M., Resident #299 went to the hospital for a surgical procedure and returned to the facility the same day on 06/08/2022.

A review of Resident #299's care plan dated 04/20/2022 revealed, in part: "[Resident #299] requires tube feeding related to a diagnosis of dysphagia following a CVA (cerebrovascular accident).,.Provide [feeding tube] site care as ordered."

A physician's order dated 04/04/2022 with an end date of 06/07/2022 documented, "Monitor PEG [percutaneous endoscopic gastrostomy (feeding) tube] for S/S [signs and symptoms] of infection." There were no orders to monitor the PEG tube site or provide PEG site care from the resident's

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F 658	Continued From page 29 return to the facility on 06/08/2022 through the resident's discharge on 7/1/22. On 11/15/2022 at 1:50 P.M., the administrator and Director of Nursing were notified of findings. On 11/16/2022 at 8:00 A.M., the Director of Nursing verified there were no orders for PEG tube site care or monitoring when Resident #299 returned to the facility from the hospital on 06/08/2022. The Director of Nursing stated that it was a clerical error that the orders were not re-entered. A review of the facility policy, "Gastrostomy/Jejunostomy Site Care," revealed, in part: "The purposes of this procedure are to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection...Verify that there is a physician's order for this procedure." According to a Lippincott publication, "Clinical Nursing Skills," 2019, Fifth Edition, Chapter 11: "Caring for a Gastrostomy Tube...Providing care at the insertion site is a nursing responsibility and is important in the prevention of complications." No further information was provided prior to exit.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab,	F 661		

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radiology, and consultation results.
(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to complete a discharge summary to include recapitulation of stay for 1 resident (Resident #99) in the survey sample of 37 residents.

The findings included:

For Resident #99, the facility staff failed to complete a recapitulation (discharge summary) of care, after discharge from the facility on 8/9/22.

Resident #99 was first admitted to the facility on 7-1-19, and discharged on 8-9-22.

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F 661	Continued From page 31 Resident #99's clinical record was reviewed and revealed a discharge minimum data set assessment (MDS), with an assessment reference date (ARD) of 8-9-22. Resident #99 was discharged to the hospital on 8-9-22. The Resident's closed record was reviewed on 11-15-22. Neither a discharge summary, nor a recapitulation of stay was included in the clinical record. The Administrator and Director of Nursing (DON) were notified of the missing discharge summary at the end of day meeting on 11-15-22. On 11-16-22 at 10:30 a.m. the Administrator and DON stated that they could not locate a discharge summary in the clinical record for Resident #99. No further information was provided by the facility.	F 661		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		

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§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on Staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to provide adequate nutrition and hydration for one Resident (Resident #99) in a survey sample of 37 residents.

The findings included:

For Resident #99 the facility staff knew for 2 days that the Resident was not eating nor drinking sufficient fluids. Staff did not intervene, and the Resident was subsequently hospitalized with dehydration, malnutrition, bowel impaction, and severe Hypernatremia (high sodium in the bloodstream).

Resident #99 was first admitted to the facility on 7-1-19, and discharged on 8-9-22.

Resident #99's clinical record was reviewed and revealed a discharge minimum data set assessment (MDS) with an assessment reference date (ARD) of 8-9-22. The document coded the Resident with severe cognitive impairment, unable to walk, unable to feed self, and extensive to total dependence on staff for all activities of daily living.

Resident #99 was discharged to the hospital on 8-9-22. The Resident's closed record was

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reviewed on 11-15-22. No discharge summary, nor recapitulation of stay was included in the clinical record.

Interdisciplinary nursing and physician Progress notes were reviewed on 11-15-22, and documented the following chronology of events;

On 8-6-22 at 2:27 PM, the Resident was confused, and had a change in level of consciousness.

On 8-7-22 at 9:18 AM, nurses documented that the Resident would not swallow food or medications, and only accepted a small amount of fluid. The note went on to describe the resident was not alert per his baseline, and took longer to respond to verbal stimuli. The note stated that the Resident's speech was unclear, and there was a "hard black crust covering tongue & hard palate." The nurse documented: "Communication placed in provider book for review." The doctor was neither called nor notified of the Resident's oral findings, refusal of food, medications, and fluids, or of his change in level of consciousness.

On 8-8-22 at 9:21 AM, providers' notes indicated that the nurse practitioner was aware of medication refusal. However, there was no documentation that they are aware of inability to eat or drink, and there was no mention of the black crust on the Resident's tongue and palate. The evaluation document under the Physical exam portion of the note documented: "Oropharynx, nasal mucosa, without inflammation."

On 8-8-22 at 10:40 AM, routine Complete Blood

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Count (CBC), and Basic Metabolic Profile (BMP) blood labs were obtained. These lab tests were ordered on 1-31-22 to be completed every 6 months in February, and August.

On 8-8-22 at 6:22 PM, a nurses documented "Resident did not eat dinner tonight, would not fully wake up to safely feed him."

On 8-9-22 at 12:23 AM, the labs were resulted and faxed to the facility with critically high levels of Sodium, Chloride, Blood Urea Nitrogen (BUN), Creatinine, and Osmolality, which are all indicators of dehydration.

On 8-9-22 at 9:45 AM, the nurse practitioner documented: "Decreased intake... black coating to tongue and hard palate...patient not responding as usual...lab noted with critical values." The note goes on to say that lab test results had critical values for Hypernatremia, high chloride, acute kidney injury with elevated BUN and Creatinine.

On 8-9-22 at 10:45 AM, nurses documented "order to send out to ER (emergency room)".

The nurse practitioner was not available for interview, as the facility had hired a new medical team for the facility, and those providers no longer worked there, according to the Administrator and Director of Nursing (DON).

Activity of daily living (ADL) records were reviewed and revealed that on 8-5-22, the Resident became completely dependent on staff for feeding, and on 8-6-22 ate nothing for the evening meal. On 8-7-22 the Resident stopped taking any nutrition and fluids, skipping the

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F 692	Continued From page 35 evening meal, with no further nutrition or hydration consumed after that. The Resident was sent out to the hospital on 8-9-22 at approximately 11:00 AM, having had no nutrition or hydration from 8-7-22 at 2:15 PM (2 days). On 11-16-22 at 10:00 AM, an interview was conducted with the DON. The DON stated the physician was not called when the resident initially refused to eat and drink on 8/7/22. Hospital records were reviewed, and revealed that Resident #99 was admitted to the Intensive care unit (ICU) in the hospital and treated acutely for malnutrition, dehydration, and fecal impaction requiring stool to be decompressed. The Resident was stabilized, and then placed on hospice care at the Veterans Administration hospital. The Resident's most recent care plan with a revision date of 5-23-22 was reviewed and revealed that the Resident had an updated care plan for; oral care, constipation, nutrition, and hydration. The plan was not followed. The Administrator and Director of Nursing (DON) were notified of the failure to intervene for 2 days in the dehydration and malnutrition incident for Resident #99 at the end of day meeting at 4:00 PM on 11-16-22. On 11-17-22 at the end of day meeting at 4:00 PM, the Administrator and DON stated they had no further information to provide. COMPLAINT DEFICIENCY .	F 692		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 36 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility documentation review, the facility staff failed to remove expired medications and supplies from the supply that was available for administration to residents in 1 of 3 medication carts, and in 2 of 3 medication storage rooms inspected. The findings included: 1. The facility staff failed to remove multiple	F 761		

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expired medications from the supply available to residents on 1 medication cart on the East Wing.

On 11/14/22 at 09:51 AM, an inspection of the East A medication cart was conducted by Surveyor B, in the presence of LPN F. The cart contained the following medications:
a. Sodium Bicarbonate 10 gr (grams) (650 mg [milligrams]) antacid, bottle of 1000 white tablets, which was opened and 1/2 full, which expired October 2022.
b. A 1000 count bottle of Acetaminophen Regular strength pain reliever 325 mg, which was open and 1/2 full, expired October 2022.

LPN F confirmed the medications were expired and, despite this, were available for administration. When asked why it is important to ensure medications are not expired, LPN F said, "We want them to be effective for the patient." LPN F was asked whose responsibility it is to ensure that medications are not expired, she said, "It is everybody's responsibility to check for dates."

2. The facility staff failed to appropriately store medical/laboratory supplies in the supply room on the central wing, where expired supplies were available for use.

On 11/15/22 at 08:47 AM, the central wing medication room was inspected in the presence of the Director of Nursing (DON). When asked why it is important to ensure items are within date and not expired, the DON said, "You don't want to give meds that are expired because they can be contaminated with bacteria." The following items were observed:
a. A box of Safety Lancets, (device used to prick

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the skin) which appeared unopened and was a quantity of 100, expired: 02/2022.
b. Three "E-swab Collection and transport system for aerobic, anaerobic and fastidious bacteria" (swab and collection tube used to collect samples for laboratory testing), which expired 12/31/2021.

3. The facility staff failed to store over the counter (OTC) medications in a manner to ensure that expired medications were not available for administration in the supply room.

On 11/15/22 at approximately 9:00 AM, an inspection of the medical supply room was conducted with Employee R, the supply clerk present. In the supply room, Employee R opened a locked file cabinet containing the "house stock" of OTC medications. The following was observed:
a. Triple Antibiotic Ointment, 1 oz. tube. 13 tubes were noted to have expired: 08/22
b. Cranberry Supplement 450 mg, 100 tab bottles. Three bottles were noted which expired 05/22.
c. Regular strength Aspirin 325 mg tablets, 100 tab (tablet)bottles. 4 bottles were noted which expired 06/22.
d. Original strength heartburn relief: famotidine tablets, 10 mg, 30 tablets in the package, expired: 8/22.
e. Nighttime sleep-aide: Diphenhydramine HCL 25 mg, 24 caplets, 1 box expired: 5/2021.
f. Major-prep Hemorrhoidal ointment: 2 oz. tube. Two tubes were noted with an expiration date of 3/22.
g. Daily Vitamin (Multivitamin/multimineral supplement: 100 tabs per bottle. Two bottles had an expiration date of 2/22, and an additional bottle expired 3/22.

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F 761	Continued From page 39 h. Acidophilus with Pectin: 100 caps, two bottles expired: 9/22. i. Daily fiber powder: 23.3 oz. (1.4 lbs.) container, expired 10/22. j. Saline Nasal Spray: sodium chloride 0.65% 1.5 oz. container: Eleven bottles expired 08/22. Employee R said she, "Checks it [the cabinet] once a month and moves the ones [items/bottles] getting ready to expire to the front [so they will be used first]." When asked when she last checked the cabinet, Employee R said, "Friday [11/11/22]. When asked why she wants to make sure items are not expired, Employee R said, "because residents can get sick if they take an expired medicine." The Director of Nursing entered the supply room while the inspection was taking place, and was made aware of the items noted that were expired. Review of the facility policy titled, "Storage of Medications" revealed, in part: "4... Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed." On 11/15/22, the facility Administrator, Director of Nursing and Corporate staff were made aware of the expired medications being available for administration. No further information was provided.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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F 812	Continued From page 40 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to follow proper sanitation protocol to prevent a potential outbreak of foodborne illness for 5 out of 12 days in November 2022. The findings included: The facility staff failed to verify acceptable chemical sanitation level in the sanitation sink for all three meals on 11/04/2022, 11/07/2022, and 11/12/2022; and following the dinner meal on 11/05/2022, 11/06/2022, 11/08/2022, 11/10/2022, and 11/11/2022. On 11/13/2022 at 12:25 P.M. this surveyor observed the 3-compartment sink log. All three meals on 11/04/2022, 11/07/2022, and 11/12/2022, and the dinner meals on 11/05/2022, 11/06/2022, 11/08/2022, 11/10/2022, and	F 812		

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F 812	Continued From page 41 11/11/2022 were blank. There was no evidence the chemical sanitation level was checked to ensure adequate sanitation of pans. On 11/13/2022 at 4:00 P.M., the administrator and Director of Nursing were notified of findings. On 11/14/2022 at 9:50 A.M., the dietary manager was interviewed. When asked about the expectation for the sanitation log, the dietary manager stated the pans are washed in the three compartment sink, so the chemical sanitation should be checked after each meal. The dietary manager stated she has already started to in-service her staff about it. This surveyor and the dietary manager observed the 3-compartment sink log and all the blank areas observed on 11/13/2022 were now filled in. When asked about this, the dietary manager pointed to 11/12/2022 to show it documented "late entry." When asked about 11/04/2022 and 11/07/2022, the dietary manager stated she didn't know anything about it. The facility staff provided a copy of their policy entitled, "Preventing Foodborne Illness." In Section 9, it documented, "All food service equipment and utensils will be sanitized according to current guidelines and manufacturers' recommendations." No further information was provided prior to exit.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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F 880	Continued From page 43 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to implement effective infection control practices for one out of one building, and in one of three care units. The findings include: 1. The facility staff failed to maintain an effective water management program to prevent the growth of legionella. Legionella was confirmed in 5 of the 20 sources tested in July 2022. Also, the facility staff failed to treat the sources as recommended by the state certified biological water testing center, and check the effectiveness of the treatment they implemented on 08/05/2022.	F 880		

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1. On 11/15/2022 at approximately 3:45 P.M., the water management program was reviewed with the administrator. When asked how their building water systems were assessed for potential legionella pathogens, the administrator stated that testing samples were sent out. When asked about the testing results, the Administrator provided a copy of the testing results dated 08/02/2022. According to the legend of the document, the Most Probable Number (MPN) "less than 35 does not need treatment." There were 5 out of 20 sources that reported an MPN greater than 35:
#4. East B showerhead = 41.6
#5. East B shower =156.6
#9. (blank) = 448.9
#16. Beauty shop = 188.2
#17. (blank) = greater than 2,273
When asked if the sources were treated, the administrator stated she would have to ask the Maintenance Director about it.

On 11/16/2022 at 8:45 A.M., the Maintenance Director was interviewed. When asked about the treatment for the presence of Legionella, the Maintenance Director confirmed he treated the 5 sources on 08/05/2022 (three days after the notification). When asked about the treatment process, the Maintenance Director stated he was directed by the state certified biological water testing center to take the showerheads off and soak them in a 10% bleach solution and "Simple Green" solution for one hour. The Maintenance Director confirmed he did not retest to evaluate the effectiveness of the treatment. The Maintenance Director provided a copy of his handwritten notes pertaining to the sources tested which included but was not limited to: "#9.

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Central Sink Bathroom." "#17. Rm [room] 102 sink."

On 11/16/2022 at 9:45 A.M., the Maintenance Director participated in an observation of the East B shower room. The showerheads were connected to a hose approximately 3 feet in length. The showerhead and hose entry into the wall were at approximately the same height, creating a loop in the hose and an opportunity for water to settle in the dependent loop of the hose. When asked how the hose was cleaned, the Maintenance Director stated he used a brush approximately 7 inches long to insert into the hose once the showerhead was removed. The Maintenance Director confirmed he did not clean the entire inner hose. The Maintenance Director then stated after cleaning the hose with the brush, he immediately ran water through the hose for about 15 minutes before putting the showerhead back on.

On 11/16/2022 at 10:15 A.M., the Maintenance Director provided a copy of the treatment recommendations. An excerpt of the recommendations included: "Then brush inside pipes to remove any biofilm around opening. Let stand 15 minutes then brush again before rinsing." The treatment provided by the Maintenance Director did not include letting the solution stand for 15 minutes.

On 11/16/2022 at approximately 11:45 A.M., the administrator and Director of Nursing were notified of findings.

2. On 1 of 3 Resident care units, the East Wing, two facility staff failed to wear a mask, covering the nose and mouth, while in direct contact with

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Residents, while the facility was in an active COVID outbreak.

On 11/13/22 at 11:30 AM, upon the survey team's entry to the facility, a sign on the front door stated the facility was in a COVID outbreak and an N-95 mask (medical respirator) and eye protection were required in patient care areas. The survey team then observed LPN (licensed practical nurse) B standing in the east wing hallway, without any type of mask on. LPN B retrieved medications out of the medication cart and entered Resident room 110 or 112, without wearing a mask.

On 11/13/22 at approximately 11:33 AM, RN (registered nurse) B walked past LPN B and identified herself as the supervisor on duty. RN B stated the facility was in an active COVID outbreak, and that N95 masks were being worn for source control, and that eye protection was also being worn in resident care areas. When asked why LPN B was not wearing a mask, RN B observed LPN B in the hall and said she should have been wearing a mask. When asked who is responsible for enforcing and ensuring staff are wearing the proper source control, RN B stated that, as supervisor on duty, it was her responsibility.

On 11/13/22 at approximately 12:30 PM, the facility Administrator confirmed that the facility was still in a COVID outbreak status, and N95 masks and eye protection were to be worn in all Resident care areas. The administrator was made aware of the above observation.

On 11/15/22 at 1:13 PM, Employee G, an activity assistant, in the East Wing day room with 13

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Residents. Employee G's mask was pulled down under her chin, not covering her mouth or nose while she was helping arrange Resident seating. In this process, she assisted residents to move to a different spot in the room so that others could get into the room. Two of the 13 Residents were observed to not be wearing a mask. Employee G was asked why she wasn't wearing her mask and she said, "It's just a habit, so I can breathe, it gets tight."

On 11/15/22 at 1:16 PM, Employee F, the activities director, stated the reason staff are wearing masks is "because of our COVID outbreak." When asked if they were currently in a COVID outbreak, Employee F said, "Yes, as of now we are in outbreak." When asked who the mask protects, she said "All of us." Employee F confirmed that the mask is to be worn so that the nose and mouth are covered. Employee G walked into the room during the conversation. Employee F, who is the immediate supervisor of Employee G, was informed that Employee G was observed in the day room with her mask below her chin. Employee F said, "It must have slipped down." Employee G, who had entered the interview area, then said, "It won't stay up." Employee F then helped Employee G properly place the mask straps, which Employee G was currently wearing with both the upper and lower straps around her neck.

On 11/15/22 at approximately 5 PM, the infection preventionist was asked if staff have to wear source control, and to explain what is to be used and why. The Infection Preventionist (IP)/Employee D said, "They are to wear an N-95 because we are in outbreak." When asked who the mask protects, the IP said, "Us and the

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F 880	Continued From page 48 Resident." The IP further explained that a mask is to be worn over the mouth and nose, and the only time it can be removed is while eating or drinking, and if in their office behind closed doors with no resident present. When asked if a staff member is conducting an activity within a group of 13 Residents in the day room, what PPE [personal protective equipment] would need to be worn, he IP said, "Goggles and an N95." A review was of the facility policy, "Guidance and Protocol COVID-19," dated September 27, 2022, revealed, in part: "Source Control: When community transmission levels are high, source control is recommended for everyone in areas where they could encounter patients. Health care personnel (HCP) may choose not to wear source control when in areas restricted from patient access or encounter, and community level of transmission not high. [sic] When community transmission levels are not high, source control is recommended for individuals under the following conditions... As a resident or worker in an area of the facility where there is COVID-19 outbreak..." On 11/15/22, during an end of day meeting, the facility Administrator, Director of Nursing, and Corporate staff were made aware of the above findings. No further information was provided.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-	F 883		

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F 883	Continued From page 49 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		

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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 staff interview, clinical record review, and facility documentation review, the facility staff failed to provide influenza vaccines for 3 residents, Residents #5, #8, and #34, out of 5 residents reviewed for influenza immunization; and facility staff failed to provide a pneumococcal vaccine for 1residents, Resident #8, out of 5 residents reviewed for pneumococcal immunization.

The findings include:

1. The facility staff failed to provide influenza immunization for Residents #5, #8, #34, and #77.

1a. Resident #5, who was admitted to the facility on 9/9/22, had no clinical assessment with regard to current influenza immunization status, no evidence of being offered immunization against influenza, and no documentation of resident refusal or medical contraindication.

On 11/14/22, an interview was conducted with the Director of Nursing (DON), who accessed the clinical record for Resident #5 and verified the findings.

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A review of the facility policy, "Vaccination of Residents," dated October 2019 revealed, in part: "All residents will be offered vaccines that aid in preventing infectious diseases...All new residents shall be assessed for current vaccination status upon admission."

On 11/14/22 during the end of day meeting, the Facility Administrator and DON were made aware of the findings. On 11/15/22, the Facility Administrator provided a Vaccine Consent Form for Resident #5, dated 11/1/22, which contained a check mark next to "Influenza Vaccine...phone consent given."

On 11/16/22, the facility Medical Director stated it was his expectation that every resident would be assessed, at the time of their admission to the facility, in order to determine their overall vaccination status, particularly for influenza, pneumonia, and COVID-19 immunization.

No further information was provided.

1b. Resident #8, who was admitted to the facility on 8/9/22, had no clinical assessment with regard to current influenza immunization status, no evidence of being offered immunization against influenza, and no documentation of resident refusal or medical contraindication.

On 11/14/22, an interview was conducted with the Director of Nursing (DON) who accessed the clinical record for Resident #8 and verified the findings.

On 11/14/22 during the end of day meeting, the Facility Administrator and DON were made aware

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of the findings.

No further information was provided.

1c. For Resident #34, who was admitted to the facility on 10/1/18, there was no documentation of the flu vaccine being offered, refused, contraindicated, or administered for 2021.

On 11/14/22, an interview was conducted with the Director of Nursing who accessed the clinical records for Resident #34 and verified the findings.

On 11/14/22 during the end of day meeting, the Facility Administrator and DON were made aware of the findings.

No further information was provided.

2. The facility staff failed to provide pneumococcal immunizations for Residents #8 and #77.

Resident #8, who was admitted to the facility on 8/9/22, had no clinical assessment with regard to current pneumonia immunization status, no evidence of being offered immunization against pneumonia, and no documentation of resident refusal or medical contraindication.

On 11/14/22, an interview was conducted with the Director of Nursing (DON) who accessed the clinical record for Resident #8 and verified the findings. A facility policy was requested and received.

A review of the facility policy, "Vaccination of Residents," dated October 2019 revealed, in part: "All residents will be offered vaccines that aid in

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F 883	Continued From page 53 preventing infectious diseases...All new residents shall be assessed for current vaccination status upon admission." On 11/14/22 during the end of day meeting, the Facility Administrator and DON were made aware of the findings. On 11/16/22, the facility Medical Director stated it was his expectation that every resident would be assessed, at the time of their admission to the facility, in order to determine their overall vaccination status, particularly for influenza, pneumonia, and COVID-19 immunization. No further information was provided.	F 883		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or	F 886		

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suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing

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efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with CDC (Centers for Disease Control) and CMS (Centers for Medicare & Medicaid Services) guidance/requirements during a facility wide COVID-19 Outbreak for facility staff and residents; and the facility staff failed to conduct COVID-19 testing for 2 residents, Residents #85 and #93, out of 2 newly admitted residents reviewed for COVID testing.

The findings included:

1. The facility staff failed to conduct COVID-19 testing on October 29, 2022 following the identification of a COVID-19 Outbreak on October 27, 2022.

On 11/15/22, a group interview was conducted with the Director of Nursing (DON) and the Infection Preventionist (IP). The DON stated the IP reported a resident had tested positive for COVID-19 on 10/26/22, and COVID-19 Outbreak broad-based testing began on 10/27/22 for all staff members and residents. The IP stated that the facility's infection control program includes following all recommended CDC guidelines.

Review of the facility's COVID-19 Outbreak testing records revealed a COVID-positive resident identified on 10/26/22, and facility-wide COVID-19 testing of all staff and residents occurring on 10/27/22, 10/31/22, 11/3/22, 11/7/22, 11/10/22, and 11/14/22. There was no COVID-19

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testing performed on 10/29/22, 48 hours following the outbreak, which was confirmed by the IP on 11/15/22.

Review of the facility policy, "Guidance and Protocol-COVID-19," dated September 27, 2022 revealed, in part: "Testing Requirements shall be based on parameters and in a manner consistent with current standards of practice for COVID-19."

Review of the CDC document, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," dated September 23, 2022 revealed, in part: "Nursing Homes ...Responding to a newly identified SARS-CoV-2 infection in any HCP [Healthcare Personnel] or resident ...Perform testing for all residents and HCP....Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test, this will typically be at day 1 (where day of exposure is day 0), day 3, and day 5."

On 11/15/22, the Facility Administrator, DON, and IP were updated on the findings. No further information was provided.

2. For Residents #85 and #93, the facility staff failed to conduct COVID-19 testing upon their admission to the facility.

2a. For Resident #85, the facility staff failed to conduct COVID-19 testing upon his admission to the facility on 10/20/22, and failed to document the results of a COVID-19 test performed on

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10/27/22.

Resident #85 was admitted to the facility on 10/20/22. However there was no evidence of COVID-19 testing performed by facility staff until 10/27/22. There was no documented result for the COVID-19 test performed on 10/27/22 in his medical record.

2b. For Resident #93, the facility staff failed to conduct COVID-19 testing upon her admission to the facility on 10/20/22 and failed to document the results of a COVID-19 test performed on 10/27/22.

Resident #93 was admitted to the facility on 10/20/22. However there was no evidence of COVID-19 testing performed by facility staff until 10/27/22. There was no documented result for the COVID-19 test performed on 10/27/22 in her medical record.

On 11/15/22, a group interview was conducted with the Director of Nursing (DON) and the Infection Preventionist (IP), both of whom confirmed that COVID-19 community transmissibility levels have been high, including September and October 2022. The IP stated that the facility's infection control program includes following all recommended CDC guidelines. The IP also stated the facility requires residents to be tested for COVID before admission to the facility. The DON and IP stated only Positive COVID test results are documented in the resident's clinical record, adding, "we do not document negative results."

Review of the facility policy "Guidance and Protocol-COVID-19" dated September 27, 2022

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F 886	Continued From page 58 revealed, in part: "Screening Testing recommended for new admissions when community transmission levels are high." A review of the CDC document, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," dated 9/23/22 revealed, in part: "Nursing Homes ...Managing admissions and residents who leave the facility ...In general, admissions in counties where Community Transmission levels are high should be tested upon admission...Testing is recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test." Review of the CMS (Centers for Medicare & Medicaid Services) Memo Ref: QSO-20-38-NH, revision date 9/23/2022, page 9, revealed, "For residents, the facility must document [COVID-19] testing results in the medical record." On 11/15/22, the Facility Administrator, DON, and IP were updated on the findings. No further information was provided.	F 886		
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	F 887		

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F 887	Continued From page 59 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 (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	F 887		

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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 staff record review, staff interview, and facility documentation review, the facility staff failed to provide COVID-19 immunization for 1 resident, Resident #77, in a survey sample of 5 residents reviewed for COVID-19 vaccination.

The findings include:

The facility staff failed to offer and/or provide a second primary COVID-19 vaccine to Resident #77.

Resident #77, was admitted to the facility on 8/4/21. A review of the clinical record revealed a "COVID-19 Vaccination Screening & Encounter Form," which documented the consent and administration of "COVID-19 Vaccine Moderna (0.5ml), 1st dose" on 9/13/21.

Resident #77 had no documentation with regard to an offer to provide a second primary dose of the Moderna COVID-19 vaccine, education, or documentation of resident refusal or medical contraindication.

On 11/14/22, an interview was conducted with the Director of Nursing (DON), who verified the findings for Resident #77. The DON stated a second COVID-19 vaccine should have been

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offered to Resident #77 in order to provide full immunization for COVID-19, and stated, "This may have been an oversight."

Review of the facility's policy, "COVID-19 Vaccinations," revealed, in part: "It is the policy of this facility to ensure that all eligible employees and residents are vaccinated against COVID-19 as per applicable Federal, State, and local guidelines."

Review of the CDC (Centers for Disease Control and Prevention) document, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," dated September 23, 2022, revealed, in part: "1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic...Encourage everyone to remain up to date with all recommended COVID-19 vaccine doses...HCP [Healthcare Personnel], patients, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine."

Review of the CDC document, "Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States," dated October 19, 2022 revealed, in part: "Recommendations for COVID-19 vaccine use ...Groups recommended for vaccination ...COVID-19 vaccination is recommended for everyone ages 6 months and older in the United States for the prevention of COVID-19...CDC recommends that people stay up to date with COVID-19 vaccination by completing a primary series and receiving the most recent booster dose recommended for them by the

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F 887	Continued From page 62 CDC...Schedule: ages 12 years and older ...Moderna COVID-19 Vaccine...People ages 12 years and older: A 2-dose primary series and 1 bivalent mRNA booster dose (Moderna or Pfizer-BioNTech) is recommended, the primary series doses are separated by 4-8 weeks." On 11/15/22, the Facility Administrator and Director of Nursing were updated. No further information was provided.	F 887		