STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495430	A. BUILDING _____ B. WING _____	12/20/2022

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RIVERSIDE CONVAL CENTER-SALUDA	672 GLOUCESTER ROAD SALUDA, VA 23149

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/13/22 through 12/20/22. 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 12/13/22 through 12/20/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of 26 resident reviews and 23 employee record reviews.	F 000		
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);	F 580		1/31/23

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

Electronically Signed | 01/16/2023

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F 580	Continued From page 1 (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 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 Resident and staff interviews, facility documentation review and clinical record review, the facility staff failed to notify the doctor and	F 580	F580. Notify of Changes (Injury/ Decline/ Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	

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F 580	Continued From page 2 Resident representative timely of a Resident change in condition for 1 Resident (Resident #51) in a survey sample of 26 Residents. The findings included: For Resident #51, who reported visual hallucinations, the facility staff failed to notify the doctor and resident representative until the following day. On 12/13/22 at 12:23 PM, Resident #51 reported to Surveyor C that she is having visual hallucinations. Resident #51 presented to be alert, oriented and an accurate historian. Resident #51 said that the hallucinations started over the weekend and "they are really bad". Resident #51 described that she is "seeing building and people but can't touch them". The Resident denied any auditory hallucinations and reports she notified the nurse. On 12/13/22 at approximately 12:30 PM, Surveyor C went to LPN B, who was the assigned nurse for Resident #51, and made her aware that Resident #51 was reporting visual hallucinations. LPN B stated that she was aware and said, "She had COVID about 3 weeks ago and this is something we have been dealing with off and on since then, some days are worse than others. We are going to make the Dr. aware so they can keep an eye on her. Her vital signs are stable, her appetite is good, she still gets up and walks around in her room. We remind her to drink fluids, even though she has it there she doesn't always remember to drink them". On 12/14/22 at 10:42 AM, Resident #51 was observed sitting at nursing station. Surveyor C	F 580	1. Resident #51 was seen by the attending physician on 12/14/22 and the resident□s representative (RR) was made aware. No new orders were received. LPN B was provided 1:1 education by the Director of Nursing (DON) on 12/14/22 concerning notifying the medical provider and the RR of significant changes in condition. 2. All residents have the potential to be affected. The charts of all current residents will be audited by the DON/designee to ensure that the provider and RR were notified of any significant changes of condition. 3. The Clinical Educator or designee will provide education to all clinical staff concerning the need to report significant changes in condition to the medical provider and RR. 4. The DON or her designee will audit the 24-hour report to identify notices given concerning changes of condition for two (2) residents weekly for four (4) weeks and then one (1) resident weekly for eight (8) weeks to confirm that notifications were given to the provider and RR. The results of the audits will be reported to the facility□s QAPI Committee by the DON for evaluation of compliance and monitoring of continuous improvement. 5. January 31, 2023.	

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approached the Resident and asked how she was feeling. Resident #51 reported that she was still hallucinating and said, "it has never been this bad for this long, it is 24/7, I see the people but can't touch them and know they are a spirit, I am waiting for them to decide what they are going to do".

Review of the clinical record for Resident #51 revealed a "behavior note: written 12/13/22 at 13:10 by LPN B. The note read, "Resident reported to writer that she is having hallucinations, that are very strong like she has her sight back. Resident proceeded to tell writer while administering medication, that she seen 2 dogs sitting beside me, even though she knows there is nothing there. Resident stated these hallucinations having been happing since the weekend. Assured resident that writer would flag doctor, also advised resident to take in more water to increase hydration".

There was no indication that the doctor was made aware of the reported hallucinations until 12/14/22. The doctor saw Resident #51 on 12/14/22 and ordered lab work. The resident representative was notified on 12/14/22 and visited the Resident after being notified.

There was an entry into the clinical record of Resident #51 on 12/9/22, by Employee F, the social worker. The entry indicated that a brief interview for mental status (BIMS) was conducted, and Resident #51 scored 15 out of 15, which indicated she was cognitively intact.

On 12/15/22 at 6:15 PM, Resident #51 was visited in her room. She reported that the facility staff "took blood and urine, the urine test didn't

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take so they are going to get another one. I know they [hallucinations] aren't real but sometimes I don't know if I'm dreaming or hallucinating".

On 12/15/22 at 6:23 PM, an interview was conducted with LPN B. LPN B was asked to discuss when the medical providers (doctor and nurse practitioner) visit the facility and how the staff communicate with them. LPN B explained that the doctor comes on Tuesday and Fridays and the nurse practitioner comes on Mondays and Thursdays. LPN B stated if they are not in the facility where staff can tell them of anything, "we have their direct cell phone numbers and we can call them or message them via PCC [electronic health record system]. They are good about responding". LPN B went on to say that she always notifies the Resident's family member and then writes a progress note that everyone was notified.

During the above conversation/interview with LPN B, LPN B access the electronic health record system and displayed to Surveyor C how she can use the system to send a message to the provider. A record of the conversation is maintained in the system for a period of time. LPN B then accessed Resident #51's chart and was asked to show/display the communication with the provider. There were no communications noted for Resident #51. LPN B then said, "We got orders Tuesday and her labs were drawn yesterday, we are waiting on the cultures and urine results".

Further review of the clinical record revealed that the order for labs was not received until Wednesday, 12/14/22. There was no indication that the doctor or nurse practitioner had been

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notified of Resident #51's report of hallucinations until 12/14/22.

On 12/15/22, during an end of day meeting with the facility Director of Nursing (DON) and Corporate Staff, the DON was asked to explain how and when facility staff are to communicate Resident changes to the medical provider. The DON said, "If it is urgent, we call the provider and if it is after hours, we call the on-call provider. We can also communicate via PCC and send messages to them". The DON was asked if the messages in PCC are part of the clinical record and she indicated they are not, they are only visible for 7-14 days. The DON said that when the nurse practitioner comes, she gives a detailed report on the Residents and reports any changes. When asked what she had reported to the nurse practitioner on 12/13/22, the DON stated one Resident, which was not Resident #51. The DON accessed the messages to the provider in the electronic health record system for Resident #51 and noted there were not any notes to the provider present. When asked about the timing of notifying the doctor of a Resident's change in condition she reported that it should be reported immediately.

The DON also logged into the hospital-based record system, which is where their labs are processed and was able to access labs for Resident #51. Surveyor C was provided a copy. Review of the lab reports revealed the labs had been collected/drawn from the Resident on 12/15/22 at 6:44 AM.

On 12/19/22, a review of Resident #51's clinical record revealed that on 12/15/22 at 15:45, the doctor had called the facility and ordered to

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F 580	Continued From page 6 decrease the Resident's Synthroid medication dose in response to the TSH (Thyroid Stimulating Hormone) lab results. On 12/19/22, the facility Administrator was asked to provide the survey team with the facility policy with regards to notification of doctor of Resident's change in condition. The Administrator indicated the facility uses the "INTERACT Process" and provided documents describing this process. The document titled, "INTERACT Process" was reviewed and it read, "A. Change in Resident condition noted. B. Observer alerts LPN/RN using the Early Warning Stop and Watch Tool... C. LPN Observation/RN Evaluation. The nurse observes and evaluates reported change from the Stop and Watch...D. MD/NP/PA Notification-SBAR Form and Progress Notes. Fill out the SBAR Change in Condition form accurately and completely, as necessary. Call the provider. Document progress notes in the back of the SBAR form...". Review of the clinical record of Resident #51 again on 12/19/22, revealed there was no SBAR form to indicate the provider and resident representative were notified of the change in condition on 12/13/22. On 12/19/22 at 4:32 PM, the facility Administration and Corporate Staff were made aware of the above findings. No further information was provided prior to the conclusion of the survey.	F 580		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		1/31/23

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F 583	Continued From page 7 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility documentation review and clinical record review, the facility staff failed to provide privacy for 4 Residents (Resident #31, 20, 1, 29) in a survey	F 583	F583. Personal Privacy/ Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	

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F 583	Continued From page 8 sample of 26 Residents. The findings included: 1. For Resident #31, the facility staff failed to protect his personal privacy by leaving him unclothed and visible from the hallway wearing only an incontinence brief. On 12/13/22 at 12:03 PM, during tour, Surveyor C observed Resident #31 from the hallway. Resident #31 was observed lying in bed, no clothes on, wearing an incontinence brief and a urinary catheter was noted. Upon entry of the room, Resident #31 was interviewed but did not respond to Surveyor C. On 12/14/22, on numerous occasions throughout the day, Resident #31 was observed lying in bed with no clothes on and no covers. He was able to be observed from the hallway to have only an incontinence brief on. On 12/16/22 at 11:30 AM, Resident #31 was observed lying in bed with a blanket covering him. Upon further review, it was noted that there was no privacy curtain that could be pulled to protect his privacy, since it was a private room. On 12/16/22 at approximately 11:35 AM, an interview was conducted with CNA B, who was assigned to Resident #31. CNA B said it is important to protect a Resident's privacy for their dignity. When asked how she protects someone's privacy she said, "tell them what you are going to do, close the door and pull the curtain during care". On 12/16/22, a review of Resident #31's clinical	F 583	1. Resident #31 will have a privacy curtain installed. CNA B was provided 1:1 education by the DON on 12/16/22. regarding maintaining Resident #31□s privacy and dignity. Residents #1, #20 and #29 and/or their RRs will be notified of the potential risk to their PHI. RN D was provided 1:1 education by the DON on 12/16/22 on ensuring that individually identifiable protected health information (PHI) remains safeguarded and not accessible to others who do not have a need to know. 2. All residents have the potential to be affected. A 100% audit will be conducted by the DON or designee of all residents to ensure that their right to privacy and dignity is maintained. 3. The Clinical Educator or designee will provide all staff with education on privacy and dignity and protecting PHI. 4. The DON or designee will audit 2 resident rooms weekly for 4 weeks and 1 resident□s room weekly for 8 weeks to confirm that their privacy and dignity are being maintained. The DON or designee will spot-check the med cart laptops weekly for 8 weeks to ensure that PHI is being protected by minimization the screen or other tactics. The results of the audits will be reported to the facility□s QAPI Committee by the DON for evaluation of compliance and monitoring of continuous improvement. 5. January 31, 2023.	

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record was conducted. There was a care plan initiated 12/6/22, that read, "[Resident #31's name redacted] has preference of only wearing his brief while in bed". The goal for this focus area was, "Resident Preferences Will Be Considered When Providing Care". The intervention read, "Choosing clothes to wear: Somewhat Important to Resident". There was no indication within the care plan of how the facility would honor this preference while maintaining the Resident's privacy and dignity.

The facility policy regarding Resident Rights was requested and received. Review of the facility provided document read, "Resident's Rights and Responsibilities...Privacy and Confidentiality: The Resident has a right to personal privacy and confidentiality of his or her personal and medical records...".

On 12/19/22, during an end of day meeting, the facility Administrator, Director of Nursing (DON) and corporate staff were made aware of the multiple observations of Resident #31 noted above.

On 12/20/22 at 9:45 AM, the DON provided Surveyor C with a care plan for Resident #31 that was more elaborate than what Surveyor C had seen in the clinical record. The DON acknowledged that the care plan she provided was from the previous electronic health record (EHR) system. When asked if this was still the active care plan or the one in the electronic health record system/program currently being utilized by the facility, she said she didn't know.

Surveyor C then interviewed RN B, the MDS (minimum data set) coordinator. RN B said that

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the one in the current EHR system was the current care plan.

No further information was provided.

2. For Residents #1, #20, and #29, the facility staff failed to ensure their medical information was private and not accessible to others.

On 12/16/22 from 7:45 AM until 8:30 AM, RN D, the nursing supervisor, was observed during Resident #1, #20 and #29's medication administration. Throughout the medication administration RN D would prepare the medications at the medication cart, in the hallway. RN D would then enter the Resident's room to administer medication, discard water not consumed by the Resident and trash, then RN D washed her hands before returning to the medication cart. Each time RN D left the Resident's information which included medications, diagnosis, and other protected health information on the computer screen, unattended in the hallway, where other Residents, visitors and staff could observe the information. On 2 occasions during this process, Surveyor C returned to the medication cart and was able to review the Resident information on the screen. Following the medication administration observation when RN D was asked about this and notified, she had left the Resident information on the screen she responded, "I'm sorry".

The facility policy titled; "Medication Administration" was reviewed. This policy didn't address ensuring Resident protected health

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F 583	Continued From page 11 information is not left accessible/visible when the information is left unattended. Review of the facility policy regarding Resident Rights was reviewed. The policy stated, "...Privacy and Confidentiality: The Resident has a right to personal privacy and confidentiality of his or her personal and medical records. The resident has a right to secure and confidential personal and medical records. The resident has the right to refuse the release of personal and medical records except as provided under 483.70(i)(2) or other applicable federal or state laws..." On 12/16/22 at 9:23 AM, a meeting was held with the Director of Nursing (DON) and corporate staff. The above observations and findings from the medication administration observation were shared. No additional information was provided.	F 583		
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	F 584		1/31/23

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F 584	Continued From page 12 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 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, staff interview, and facility documentation review the facility staff failed to maintain a comfortable and homelike environment for 1 Resident (Resident #31) in a survey sample of 26 Residents. The findings included: For Resident #31, the facility staff failed to maintain a comfortable and homelike environment by not repairing the baseboard in the	F 584	F584. Safe/ Clean/ Comfortable/ Homelike Environment CFR(s): 483.10(i)(1)-(7) 1. The Facility Services Director replaced the baseboard cove molding in Resident #31□s room on Monday, December 19, 2022. CNA B was provided 1:1 education on the process for alerting Facility Services of maintenance needs via the Maintenance Log.	

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F 584	Continued From page 13 room that was pulled away from the wall. On 12/13/22 at 12:03 PM, during tour, Surveyor C observed Resident #31's room. It was noted that on the left side of the Resident, along the entire wall the cove base molding was peeling away from the wall exposing unfinished sheetrock that was not painted and in poor condition. Resident #31 was asked about it and how long it had been that way, but he didn't respond. On 12/15/22 at 11:30 AM, an interview was conducted with CNA B, who was assigned to Resident #31. CNA B was asked about the baseboard molding, and she said it had been that way a while. She couldn't define "a while" but said she had let maintenance know. On 12/15/22 at 12:35 PM, an interview was conducted with Employee H, the maintenance director. Employee H provided the survey team with his maintenance work order log, which was a paper form located at the nursing station where staff would indicate any repairs that were needed and in turn maintenance would log/indicate when the work was completed. This log was reviewed for the past 3 months with no notation of Resident #31's room. Employee H reported that he makes rounds within the facility daily to identify maintenance concerns or things that need repair in addition to the maintenance work order. Employee H also reported that the facility is in the process of doing some renovations/refurbishing of Resident rooms. He was able to recall the rooms that have been completed, none of which included Resident #31's room. When asked if there is a plan or system for which rooms would be scheduled next,	F 584	2. A 100% audit was conducted in all rooms on Jan. 12 and 13 by the Facility Services Director to ensure that the baseboard cove molding is intact and has not pulled away from the wall. Concerns noted are being corrected. 3. The Clinical Educator or designee will educate all staff on identification of maintenance needs to maintain a comfortable environment and the process for alerting Facility Services of needed repairs. 4. The Facility Services Director or designee will inspect 4 resident rooms weekly for 8 weeks to ensure that the environment is comfortable, is homelike, and that the baseboard cove molding has not pulled away from the wall. The results of the inspections will be reported to the facility□s QAPI Committee for evaluation of compliance and monitoring of continuous improvement. 5. January 31, 2023	

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Employee H indicated that he did not have a list and only knew that one specific room had been identified and the contractor made aware of, which was not Resident #31's room.

Each day from 12/15/22-12/16/22, the baseboard molding was noted to have not been repaired. On 12/16/22, some of the molding had completely unadhered from the wall and was laying in the floor.

On 12/19/22 at 11:38 AM, Resident #31's room was observed. The base board molding was observed to be taped to the wall using duct tape.

On 12/19/22 at 2:10 PM, Employee H, the maintenance director reported "the CNA told me she had knocked down the baseboard last week [referring to Resident #31's room]. I was putting it up with liquid nails but ran out. [Administrator's name redacted] has the credit card we use to make purchases so I will go this evening to get it".

On 12/19/22, during the end of day meeting, the facility Administrator, Director of Nursing and corporate staff were made aware of the above findings.

The facility policy regarding Resident Rights was requested and received. Review of the facility provided document read, "Resident's Rights and Responsibilities...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...".

On 12/20/22, the facility Administrator stated they

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F 584	Continued From page 15 did not have a specific written policy with regards to facility maintenance, preventative maintenance program or maintenance work orders, following the request for such policies. The Administrator did provide an excerpt from the facility employee orientation training program that read, "Promptly Report anything abnormal in the resident's room or unit such as: Burned out entrance or room lights (missing strings on lights, Inspection stickers missing from electrical equipment (all new admissions can't use electrical equipment until checked by maintenance., Loose or broken furniture (beds, over bed tables, chairs, side rails, bed locks), Wet or cracked ceiling tiles, Call bell system down (shower area, resident rooms), Call bells missing or pull string in bathroom, Loose grab bars, Leaks (faucets or commodes), Refrigerator temperatures > 41 degrees Fahrenheit, Holes in the walls..." No additional information was provided.	F 584		
F 658 SS=E	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 observation, staff interviews, facility documentation and clinical record review, the facility staff failed to follow standards of nursing practice affecting 4 Residents (Resident #1, 20, 41 and 262) in a survey sample of 26 Residents. The findings included:	F 658	F658. Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) 1. Residents #1 and #20 are receiving their medications as ordered. The provider and RRs were notified, and	1/31/23

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F 658	Continued From page 16 1. For Resident #1 the facility staff crushed an extended-release medication that is not to be crushed. On 12/16/22 at 7:54 AM, RN D, the nursing supervisor, was observed during medication administration of Resident #1's medication. RN D removed a Venlafaxine ER capsule 150 mg and a Venlafaxine ER capsule 75 mg from the pharmacy bag which was labeled and indicated "Do Not Crush". RN D opened both capsules emptying the contents into a plastic bag along with other medications for Resident #1 and crushed them all. RN D then mixed the crushed medications into apple sauce and entered the room of Resident #1 and administered the medications. Following the medication administration observation, Surveyor C asked RN D how she knew which medications to crush and which ones not to. RN D said they have a shift-to-shift report sheet that indicates how a Resident take their medications such as crushed, whole, with apple sauce, etc. When asked how they know if a medication can't be crushed, she said, "If they get their medications crushed then all of them can be crushed. Between us and the pharmacy they make sure of that. If there is something that can't be crushed the pharmacy would call us. If it is something that can't be crushed, they would change it to liquid". When asked if she double checks if things can or cannot be crushed, RN D said, "I wouldn't check each day, if it were something new, I probably would look". Surveyor C then asked about the medications that are ER (extended release), what this meant.	F 658	medical records were updated. RN D was re-educated by the DON concerning not crushing meds that are not supposed to be crushed by manufacturer□s specifications. Resident #41□s nicotine patch order was discontinued, and the patch was removed on 12/14/22. The head of Resident #262□s bed is being elevated, and new tubing has been hung and accurately dated and timed. LPN B was provided 1:1 education by the DON/designee concerning proper tube feeding administration. 2. All residents have the potential to be affected. A 100% audit was conducted by the DON/designee on 12/16/22 of all residents□ medications to ensure that residents requiring crushed medications will receive them in a form that can be crushed. Findings were submitted to the provider for order updates, as applicable. A 100% audit was conducted by the DON/designee of residents who have orders for a nicotine patch to ensure that they are not also continuing to smoke cigarettes while on the patch. A 100% audit was conducted by the DON/designee of residents receiving tube feeding to ensure that the head of their	

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F 658	Continued From page 17 RN D said, "ER means extended release, meaning the medication is slowly released into the system". When asked what the potential problem is if an extended-release medication is released all at one, RN D said, "It could result in overdose". RN D was shown the pharmacy package which contained Resident #1 and #20's medications that specifically read, "Do Not Crush" for medications that were crushed. RN D indicated she wasn't aware. A copy of the shift-to-shift report sheet was provided to the survey team. Review of this document revealed that Residents #1 was noted as taking medications crushed. The medication cart contained a "Nursing 2022 Drug Handbook" from Walters Kluwer. This book was reviewed and gave the following information for Venlafaxine ER: i. Page 1507-1508 read, "Venlafaxine... Administration PO [by mouth] ... For extended-release capsules and tablets, don't divide, crush, place in water, or allow patient to chew. May give pellet-filled capsules by carefully opening capsule and sprinkling the pellets on a spoonful of applesauce. Patient should swallow applesauce immediately without chewing, then follow with a glass of cool water to ensure that all pellets are swallowed..." Review of the facility policy titled; "Medication Administration" was conducted. This policy read, "...Crush only those meds that can be crushed. Refer to American Society of Consultant Pharmacists (ASCP) Crushed Medication list in each facility. Crushed meds can be thoroughly mixed individually with appropriate food to make swallowing easier...".	F 658	bed(s) was elevated, and tubing was labeled appropriately and that the feeding was being administered as ordered. 3. The Clinical Educator or designee will educate all nursing staff on following the professional standards of nursing practice related to medication administration, proper administration of tube feedings, use (or discontinuation of use) of nicotine patches while smoking, and following physicians orders. 4. The DON or designee will audit 1 med pass per week for 8 weeks to ensure that medication administration is being handled accurately, to include not crushing medications that are not to be crushed. For 8 weeks, a 100% audit of residents who have orders for a nicotine patch, if any, will be conducted weekly by the DON/designee to ensure that they are not also continuing to smoke cigarettes with nicotine patch. For 8 weeks, a 100% audit of residents receiving tube feeding will be conducted by the DON/designee to ensure tube feeding supplies are labeled and dated appropriately, HOB is elevated 35-45 degrees are being followed. The results of the audits will be reported to the facility s QAPI Committee for evaluation of compliance and monitoring of continuous improvement.	

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F 658	Continued From page 18 On 12/16/22 at 9:23 AM, a meeting was held with the Director of Nursing (DON) and corporate staff. The above observations and findings from the medication administration observation were shared. The DON was asked about extended-release medications and said, "you can't crush those because they get more medication at one time if it is crushed". No additional information was provided. 2. For Resident #20, the facility staff crushed a medication that is not supposed to be crushed. On 12/16/22 at 8:07 AM, RN D was observed during her medication administration of Resident #20's medications. RN D proceeded to remove Resident #20's medications from the pharmacy bag, which included but was not limited to: Duloxetine DR capsule 60 mg. RN D opened the Duloxetine capsule and poured the contents into a plastic bag with the other medications and proceeded to crush all the medications together. The pharmacy bag containing the medications was labeled as follows: " ...Duloxetine DR [delayed release] Cap 60 mg. sub for Cymbalta Dizzy/Drowsy, Do Not Crush ...". RN D then proceeded into Resident #20's room and administered the medications. Following the medication administration observation, Surveyor C asked RN D how she knew which medications to crush and which ones not to. RN D said they have a shift-to-shift report sheet that indicates how a Resident take their medications such as crushed, whole, with apple	F 658	5. January 31, 2023.	

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sauce, etc. When asked how they know if a medication can't be crushed, she said, "If they get their medications crushed then all of them can be crushed. Between us and the pharmacy they make sure of that. If there is something that can't be crushed the pharmacy would call us. If it is something that can't be crushed, they would change it to liquid". When asked if she double checks if things can or cannot be crushed, RN D said, "I wouldn't check each day, if it were something new, I probably would look".

RN D was shown the pharmacy package which contained Resident #1 and #20's medications that specifically read, "Do Not Crush" for medications that were crushed. RN D indicated she wasn't aware.

A copy of the shift-to-shift report sheet was provided to the survey team. Review of this document revealed that Resident #20 was noted as taking medications crushed.

The medication cart contained a "Nursing 2022 Drug Handbook" from Walters Kluwer. This book was reviewed and gave the following information for Duloxetine DR: Pages 479-480 read, "Duloxetine hydrochloride...Administration PO, give whole; don't crush or open capsules..."

Review of the facility policy titled; "Medication Administration" was conducted. This policy read, "...Crush only those meds that can be crushed. Refer to American Society of Consultant Pharmacists (ASCP) Crushed Medication list in each facility. Crushed meds can be thoroughly mixed individually with appropriate food to make swallowing easier...".

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On 12/16/22 at 9:23 AM, a meeting was held with the Director of Nursing (DON) and corporate staff. The above observations and findings from the medication administration observation were shared. The DON was asked about extended-release medications and said, "you can't crush those because they get more medication at one time if it is crushed".

No additional information was provided.

3. For Resident #41, the facility staff administered a nicotine patch per physician orders and provided the Resident cigarettes, which also contained nicotine, without a physician order or notification to the physician, to afford the practitioner the opportunity to make alterations to the Resident's treatment plan.

On 12/13/22, during an entrance conference with the Administrator, it was reported that Resident #41 smokes and leaves the property to do so.

On 12/13/22-12/15/22, Resident #41 was observed to exit the facility on several occasions to go smoke.

On 12/14/22 at 6:50 PM, an interview was conducted with LPN B and RN C. Both nurses confirmed that when Resident #41 got stronger and was able to walk she started smoking again. Both LPN B and RN C explained that Resident #41's cigarettes are kept by staff, and she will ask any staff member to get them for her when she wants to go out. Resident #41 will then sign a sign-out book kept at the nursing station and will leave the premises to smoke. Both nurses report

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that Resident #41 has been smoking for about 6 months now and is very complaint with giving staff her cigarettes upon her return but that they do not remove the residents nicotine patch prior to smoking.

On 12/14/22 at 7:10 PM, an interview was conducted with the Director of Nursing in the presence of the corporate nursing staff. The DON stated the risk of smoking while having a nicotine patch on is that "if she gets too much nicotine she could die". The Corporate nurse expressed that the concern for smoking while on a nicotine patch is nicotine toxicity.

On 12/14/22 at 8:02 PM, a telephone interview was conducted with the Nurse Practitioner (NP) and Surveyor B and C. The NP stated that she had spoken with Resident #41 about smoking while on the nicotine patch and was not aware that the Resident was smoking. The NP also stated that since nursing staff keep her cigarettes, she was expecting nursing staff to notify her if the Resident was smoking, however she had not given this instruction to nursing or written an order for such. The NP expressed that she had been made aware on the evening of 12/14/22, that Resident #41 was smoking. The NP said, "you can overdose on nicotine, and she is managing to smoke quite a bit, she is not supposed to be smoking on the patch. We need to have a team meeting and I plan to speak with [name of the attending physician redacted]".

A clinical record review was conducted of Resident #41's chart and revealed no indication that nursing staff had advised the nurse practitioner or doctor that Resident #41 was still continuing to smoke while on a nicotine patch.

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There was no indication that nursing staff were removing the patch prior to the Resident being given her cigarettes.

Review of the facility policy regarding smoking indicated that they were a smoke free facility.

No further information was provided.

4. For Resident #262, the facility staff failed to elevate the head of the bed in a 30-45-degree position while tube feeding was infusing, failed to date the feeding and on one occasion facility staff stopped the tube feeding for a period of time without a doctor's order.

On 12/13/22 at 01:05 PM, Resident #262 was observed lying in bed. She was noted to have tube feeding (Isosource) running at 50 ml., the bag was noted to have no date as to when it was hung. The bag of water for flushes was also noted to have no date.

On 12/13/22 at 03:02 PM, Resident #262 was observed to be lying flat in the bed, with the head of the bed not elevated. The tube feeding formula was still noted to not have a date. Surveyor C then went to get to the nurse, LPN B, who was assigned to Resident #262. LPN B reported that Resident #262 was new to the facility and was status post a stroke. LPN B stated, "She has continuous feeding with Isosource, is total care and can move left arm". LPN B was asked about the tube feeding, she stated, "we change it on our shift, usually it pops up to be done between 2-4 PM, we change all of the tubing, make sure the peg site is clean, put

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drain gauze is in place, and make sure tube is flowing".

On 12/13/22 at 3:10 PM, LPN B accompanied Surveyor C to the room of Resident #262. LPN B confirmed that the Resident was lying flat in bed and stated the CNA's must have left her that way after providing care. LPN B said that the Resident's head to be elevated 30-40 degrees to prevent aspiration. LPN B also confirmed that the tube feeding, and water flushes were not dated and therefore it was unknown when they were hung/put in place. LPN B stated she had come on shift at 7 AM, this morning and had not changed it. LPN B said she would assume it was hung yesterday but without the date she couldn't confirm that. LPN B then said, "I'm going to get one now so you can see the correct way it should be done".

On 12/13/22 at 3:15 PM, LPN B proceeded to change the tube feeding, water flush bag and tubing of both. LPN B dated each bag and indicated the time. LPN B proceeded to state that the tubing and everything is to be changed daily because if it gets any solidification in it and that goes back up, it will contaminate the feeding and risk the Resident getting a bacterial infection.

On 12/13/22 at 4:34 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked to describe how to care for a tube feeding resident. The DON said, "The head of the bed should be elevated 35-45 degrees". When asked what the purpose of this was, she said, "to prevent aspiration". When asked about dating of the feeding and tubing, the DON said, "We should label and date the bags and indicate the rate". When asked to explain the

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F 658	Continued From page 24 purpose of dating and the risks she indicated that tube feeding can spoil (go bad) after 24 hours. On 12/19/22 at 3:21 PM, Resident #262 was observed in bed, her tube feeding bag was empty and the pump was off. Surveyor C then asked LPN B about this. LPN B said, "I try to give her a little rest, she gets fidgety at times". Review of the clinical record for Resident #262 revealed the following orders: i. "Keep head of bed elevated at 30-45 degrees at all times during the administration of enteral feedings and 30 minutes after medication administration every shift for aspiration precaution", dated 12/9/22. ii. "Tube feeding: Isosource 1.5 @ 50cc/hr. continuous document intake every shift every shift for nutrition", dated 12/9/22. The facility policy regarding the care of and administration of tube feeding was requested. An untitled document was provided which read, "...23. Initiate enteral feedings as prescribed... 24. Elevate the head of the bed to a minimum of 30 degrees, but preferable to 45 degrees, when feedings are infusing. On 12/19/22 at 4:32 PM, during an end of day meeting, the facility Administrator, DON, and corporate staff were made aware of the above findings with regards to Resident #262. No further information was provided.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		1/31/23

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F 677	Continued From page 25 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to provide assistance to a Resident who was dependent upon staff assistance with activities of daily living for one Resident (Resident #29) in a survey sample of 26 Residents. The findings included: For Resident #29, the facility staff failed to assist the Resident when she requested a shower. On 12/13/22 at 3:25 PM, Surveyor C observed Resident #29 in the hallway at the nursing station and asked if she could be showered. Resident #29 stated, "I haven't had a shower since Monday before last and my body stinks". CNA C was at the nursing station and responded to Resident #29 by saying, "I'm here tomorrow on women's day and will try to get you in there then. Today is men's day and you don't want to be in there with stinky men". Resident #29 responded, "At this point I don't really care". CNA C said, "I promise I will try to get you in there first thing tomorrow, I promise". Review of Resident #29's clinical record revealed a care plan initiated 12/6/22, that indicated the Resident required staff assistance with ADL's (activities of daily living). One of the associated interventions read, "Staff to assist with ADLs as needed and document amount of assistance required per protocol.".	F 677	F677. ADL Care Provided for Dependent Residents CFR(s): 483.2a4(a)(2) 1. Resident #29 received a shower on Wednesday, December 14, 2022. CNA C was provided 1:1 education by the DON regarding strategies for assisting residents to receive a shower when requested, regardless of the facility□s normal schedule. 2. All residents have the potential to be affected. A 100% audit will be conducted by the DON/designee of all residents to ensure that their bathing needs are being met. 3. The Clinical Educator or designee will educate all clinical staff on strategies for determining residents□ bathing preferences upon admission, confirming them during care plan meetings, and providing assistance to honor resident requests for showers on days on which they are not normally scheduled to receive one. 4. The DON or designee will audit 2 residents weekly for 4 weeks and then 1 resident weekly for 8 weeks to confirm that their need and preference for showers is being met. The results of the audits will be reported to the QAPI	

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F 677	Continued From page 26 Resident #29 had a quarterly minimum data set assessment completed, which had an assessment reference date of 8/29/22. This assessment indicated Resident #29 had a brief interview for mental status score of 15, indicating she was cognitively intact. This same assessment noted Resident #29 as requiring physical help of staff for bathing. Review of the ADL record for December revealed Resident #29 had most recently received a bath on 12/7/22, prior to her request on 12/13/22. This document noted a refusal on 12/9/22. On 12/20/22, Surveyor C shared concern with regards to baths/showers for Residents with the facility Administration. No further information was provided.	F 677	Committee by the DON for evaluation of compliance and ongoing monitoring of continuous improvement. 5. January 31, 2023.	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 685		1/31/23

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F 685	Continued From page 27 Based on observation, Resident and staff interviews, facility documentation review and clinical record review, the facility staff failed to provide vision services for 2 Residents (Resident #25 and #44) in a survey sample of 26 Residents. The findings included: 1. For Resident #25 the facility staff failed to 1) arrange for repair of the Resident's glasses which were broken and 2) failed to make an appointment for evaluation of cataract removal as recommended for over a year. On 12/14/22 at 11:32 AM, Resident #25 was visited in his room. Resident #25 presented as being alert and oriented. Surveyor C observed that Resident #25's glasses were broken. The left side stem was taped, despite the tape the stem of the glasses was hanging downside of the Resident's face/cheek and his glasses were sliding down to the tip of his nose as a result. When asked, Resident #25 reported they had been broken for a while but they were working to get him Medicaid so they can get them fixed. Resident #25 reported this has been going on for 3 months. On 12/19/22 at 2:17 PM, Resident #25 was visited again. His glasses were still noted to be broken with the left stem taped. On 12/20/22 at 9 AM, Resident #25 was observed in the dining room eating breakfast. His glasses remained broken with the stem on the left side hanging down the side of his cheek. A clinical record review was conducted of Resident #25's chart. This review revealed the	F 685	F685. Treatment/ Devices to Maintain Hearing / Vision CFR(s): 483.25(a)(1)(2) 1. Resident #25 received new eyeglasses. Also, an appointment was made for Resident #25 with an ophthalmologist for evaluation of cataract removal, and he was seen on 1/12/23. The clinical record for Resident #44 was updated to note that a follow-up appointment for cataract evaluation has been set for 3/24/23. 2. All residents have the potential to be affected. A 100% inspection of the eyeglasses of all residents who wear eyeglasses will be conducted by the DON/designee to ensure that they are not broken. A 100% review of all recommendations from the facility□s contracted eyecare provider will be conducted by the DON/designee to ensure that follow-up orders or referrals were made and carried out as recommended. 3. The Clinical Educator or designee will educate all clinical personnel concerning the importance of inspecting and maintaining residents□ eyeglasses in good repair, as well as who to alert when repairs are or replacement is believed to be needed. 4. The DON or designee will audit 2 residents weekly for 4 weeks and then 1 resident weekly for 8 weeks to ensure that their eyeglasses are not broken and that	

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F 685	Continued From page 28 following: i. On 9/13/22, a quarterly minimum data set assessment was conducted. On this assessment Resident #25 was coded as having scored 15 out of 15 on a brief interview for mental status, which indicated he was cognitively intact. This assessment also coded Resident #25 as having impaired vision and requiring the use of glasses. ii. Resident #25 was seen by an on-site eye doctor on 11/23/21, which indicated the Resident's vision was 10/10 with his glasses. The progress notes from the eye doctor read, "Physician orders: Age-related nuclear cataract, bilateral- Cataracts- OU- moderate- recommend referral for cataract evaluation" iii. Resident #25 was seen again by the on-site eye doctor on 6/27/22. During this visit the doctor noted "Physician orders: ...2. Cataracts-OU-moderate- recommend referral for cataract evaluation to: [name and phone number of provider redacted] ... Plan and Treatment... Age-related nuclear cataract, bilateral- Cataracts-OU-moderate- patient was scheduled for cataract surgery but has not gone-- recommend referral for cataract evaluation". There was a nursing progress note written 6/27/22, in response to the eye doctor visit which made no mention of the recommendation for cataract evaluation..." iv. On 10/19/22, Resident #25 was again seen by the on-site eye doctor. This visit again recommended a referral for cataract evaluation. This visit note also indicated, "hyperopia/presbyopia- ordered new progressive addition glasses". There was no further information within the clinical chart as to the status of the glasses that had been ordered on 10/19/22, nor the status of	F 685	recommendations for follow-up have been undertaken. The results of the audits will be reported to the QAPI Committee for evaluation of compliance and ongoing monitoring of continuous improvement analysis. 5. January 31, 2023.	

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F 685	Continued From page 29	F 685		

or that an appointment for evaluation of his cataracts had been made.

On 12/19/22 at 2 PM, an interview was conducted with Employee F, the social worker. The social worker confirmed that an eye doctor comes on-site but stated she is fairly new to this facility and just knows he is scheduled to return in January.

The facility policy regarding consulting providers and physician orders was requested. The facility staff provided a document titled, "JOB AID - MANAGING PROVIDER ORDERS". This document read, "Procedure for Transcribing Physician Orders
1. Review the order for clarity and completeness. If the order is not clear or complete, contact the physician giving the order and obtain clarification. Discontinue the original order and write a new order that is clear and complete.... General Principles and Guidelines: Review the Pending and Queued Orders tabs of the EMR at least twice per shift to ensure that all orders have been transcribed/activated and the necessary actions for implementation have been done..."

On 12/19/22, during an end of day meeting held with the facility Administrator, Director of Nursing and Corporate staff, they were made aware of the above concerns.

On 12/20/22 at 9:44 AM, the Director of Nursing (DON) met with Surveyor C and provided a copy of a progress note written 12/20/22. The DON said, "we called this morning and made him an appointment and [Employee F's name redacted] is working on his glasses". The progress note indicated that Resident #25 had an appointment

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F 685	Continued From page 30	F 685		

scheduled for 5/17/23 for follow-up regarding cataracts.

On 12/20/22 at 10:50 AM, Surveyor C was provided a document and the DON stated they had been able to obtain Resident #25 an appointment for 1/12/22. The Corporate staff also stated they had ordered Resident #25 a pair of glasses from Amazon earlier that morning.

No further information was provided.

2. For Resident #44, the facility staff failed to arrange for evaluation of cataracts as per recommendations from the eye doctor.

On 12/14/22, an interview was conducted with Resident #44. Resident #44 mentioned that he has been waiting to get his eyes fixed for some time.

On 12/14/22, an interview was conducted with the spouse of Resident #44. The spouse said that they have been waiting and waiting for him to get his cataracts taken care of, but nothing seems to be happening.

A clinical record review was conducted of Resident #44's chart. This review revealed Resident #44 was seen by an on-site eye doctor on 11/23/21 and again on 6/27/22. Each of the progress notes from the eye doctor read, "Physician orders: 1. Cataracts-OU-moderate/progressive- recommend referral for cataract evaluation to: [office name and phone number redacted] ..."

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F 685	Continued From page 31	F 685		

A care plan note dated 8/4/22, read, "...Ophthalmology appointment for cataract surgery remains pending...".

The attending physician of Resident #44 saw him on 10/7/22, and made the following note, "...He also has had decline in his vision and optometry here has identified cataracts affecting both eyes. He would like to proceed with ophthalmology consult for cataract surgery...Have referred him to Ophthalmology to assess his candidacy for cataract surgery. In terms of preop evaluation will wait for ophthalmology opinion. Although he has multiple medical conditions and place him at high risk of major surgery a minor procedure like cataract surgery should be tolerated fairly well. Also, would like to get echocardiogram prior to doing assessment of risk of surgery. His EKG will be of little help for risk assessment of surgery given that he has a paced rhythm..."

There was no evidence within the clinical record of any upcoming appointment for cataract evaluation.

The facility policy regarding vision services, consulting providers and physician orders was requested. The facility staff provided a document titled, "JOB AID - MANAGING PROVIDER ORDERS". This document read, "Procedure for Transcribing Physician Orders: 1. Review the order for clarity and completeness. If the order is not clear or complete, contact the physician giving the order and obtain clarification. Discontinue the original order and write a new order that is clear and complete.... General Principles and Guidelines: Review the Pending and Queued Orders tabs of the EMR at least twice per shift to ensure that all orders have been

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F 685	Continued From page 32 transcribed/activated and the necessary actions for implementation have been done..." On 12/19/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above concerns with regards to the lack of follow-up for evaluation of cataract removal. On 12/20/22 at 9:43 AM, the DON provided a progress note that was written 12/19/22, and indicated it was a late entry for 10/14/22. It read that Resident #44 had an appointment on 3/24/23 for evaluation for cataract surgery. No further information was provided.	F 685		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to	F 686	F686. Treatment/ Svcs to Prevent/ Heal Pressure Ulcer CFR(s); 483.25(b)(1)(i)(ii)	1/31/23

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F 686	Continued From page 33 apply palm protectors to prevent the development of skin breakdown for one (1) Resident (Resident #31) in a survey sample of 26 Residents. The findings included: On 12/13/22 at 12:02 PM, Resident #31 was observed lying in bed. Resident #31 was noted with bilateral hand and wrist contractures and no splinting or device to prevent the development of wounds was noted. Resident #31 would not verbally respond to Surveyor C's questions. On 12/14/22 at approximately 10 AM, Resident #31 was observed lying in bed, no palm protector devices were noted. On 12/16/22 at 11:30 AM, Resident #31 was observed in bed, without a palm protector on. CNA B, who was assigned to Resident #31 was asked about splints or palm protectors and CNA B was able to find one palm protector in the chest of drawers. CNA B stated that Resident #31 will frequently refuse them. Resident #31 was asked about the palm protector and the Resident said, "Please put it on". CNA B assisted Resident #31 in extension of his fingers so that Surveyor C could observe the skin integrity of the palms, the skin was noted to be intact. A review of the clinical record for Resident #31 was performed. This review revealed a physician order dated 7/19/22, that read, "Hand Protectors Resident to have palm protectors to bilateral hands as tolerated two times a day". There were no nursing progress notes to indicate any Resident refusals. The ADL sheets for Resident #31 for the months of November and December were reviewed and there was no evidence of the	F 686	1. Resident #31 was evaluated by OT on 12/20/22. Based on the evaluation, the palm protectors were discontinued on 12/20/22. 2. All residents have the potential to be affected. A 100% audit of residents who wear adaptive equipment will be conducted by DON/designee to ensure that the devices are being applied in accordance with orders and documented within the clinical record. 3. The Clinical Educator or designee will educate all clinical staff on following physician□s orders for the application of adaptive equipment such as palm protectors. 4. The DON or designee will audit 2 residents weekly for 4 weeks and then 1 resident weekly for 8 weeks to ensure that palm protectors are in place, where ordered, and documentation supports their use or refusal by the resident. The results of the audits will be reported to the QAPI Committee for evaluation of compliance and ongoing monitoring of continuous improvement. 5. January 31, 2023.	

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F 686	Continued From page 34 palm protectors being refused. Review of the care plan for Resident #31 noted the following: A focus area initiated 11/10/22, with a revision on 11/12/22, that read, "[Resident #31's name redacted] has actual skin impairment: PI [pressure injury] to R [right] hand...". Interventions for this focus area made no mention of the palm protector. The facility Administrator was asked to provide facility policies related to assistive devices; no related policies were provided. On 12/19/22, the facility Administrator and Director of Nursing were made aware of the above findings. On 12/20/22 at 9:45 AM, the Director of Nursing provided Surveyor C with a copy of the physician order dated 7/19/22, that read, "Hand Protectors: Resident to have palm protectors to bilateral hands as tolerated". Surveyor C explained she had seen this order but there was no documentation within the clinical record to indicate Resident #31 had instances of refusals. No further information was provided.	F 686		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		1/31/23

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F 755	Continued From page 35 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility failed to provide medications as ordered by a physician for one Resident (Resident #262) in a sample of 26 residents. The findings included: For Resident #262, the facility staff failed to administer four medications as ordered because they were not available. Resident #262 was admitted to the facility on	F 755	F755. Pharmacy Srvcs/ Procedures/ Pharmacist/ Records CFR(s): 483.45(a)(b)(1)-(3) 1. The medications prescribed for Resident #262 are available as ordered. RN D was provided 1:1 education by the DON on 12/16/22. 2. All residents have the potential to be affected. The DON/designee audited 100% of medication administration records to ensure the availability of	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 36 12/9/22. A review of Resident #262'S clinical record was conducted. This review revealed the following excerpts from the progress notes: i. Note dated 12/09/2022 at 16:41, read, "hydralazine HCL Tablet 50 MG, Give 1 tablet via G-Tube every 8 hours for HTN. Pharmacy has not delivered, new admission". ii. Note dated 12/10/2022 at 09:53, read, "levetiracetam Solution 100 MG/ML. Give 5 ml via G-Tube every morning and at bedtime for Seizure disorder. None available". iii. Note dated 12/10/2022 at 09:53, read, "Famotidine Tablet 20 MG. Give 20 mg via G-Tube one time a day for Ulcer prevention. None available". iv. Note dated 12/10/2022 at 09:54, read, "Metoprolol Tartrate Tablet 75 MG, Give 75 mg via G-Tube in the morning for HTN. None available". According to the December 2022 MAR (Medication Administration Record), the above noted medications were not provided/administered. There was no documentation of the facility staff using medication from the Stat box or calling the physician to notify of the unavailable medications. On 12/16/22 at 8:30 AM, an interview was conducted with the RN D, who was administering drugs on the unit. RN D stated, if meds (medications) are not available, staff are to try to	F 755	medications as ordered. 3. The Clinical Educator or designee will educate all nursing staff on what to do if medications are not available as ordered, to begin with notifying the provider. 4. The DON or designee will audit 2 residents MARs weekly for 4 weeks and then 1 resident s MAR weekly for 8 weeks to ensure that their medications were administered as prescribed and not omitted due to the unavailability of a medication. The results of the audits will be reported at the QAPI meeting for evaluation for compliance and ongoing monitoring of continuous improvement analysis. 5. January 31, 2023.	

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F 755	Continued From page 37 get them out of the cubex (in-house stock of medications), if they aren't there, they call the pharmacy. On 12/16/22 at 9:23 AM, the DON (Director of Nursing) confirmed that if mediations are not available nurses are to go check the medication bank (in-house emergency box) and if it isn't available there, they are to notify the provider. The DON added that they can check the medications for that Resident in the next day's supply as well. The facility's medication administration policy was reviewed. This policy didn't address what the facility staff are to do if a medication is not available for administration. No further information was received prior to the conclusion of the survey.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to ensure the medication error rate was less than 5%. There were 2 medication errors (medications crushed that are not to be crushed) in 32 opportunities, resulting in an 6.25% error rate.	F 759	F759. Free of Medication Error Rates 5 Prcnt or More CFR(s): 483.45(f)(1) 1. Residents #1 and #20 are receiving their prescribed medications as ordered. RN D received 1:1 education from the DON.	1/31/23

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F 759	Continued From page 38 The findings included: On 12/16/22 at 7:54 AM, RN D, the nursing supervisor, was observed during medication administration of Resident #1's medication. RN D removed a Venlafaxine ER capsule 150 mg and a Venlafaxine ER capsule 75 mg from the pharmacy bag which was labeled and indicated "Do Not Crush". RN D opened both capsules emptying the contents into a plastic bag along with other medications for Resident #1 and crushed them all. RN D then mixed the crushed medications into apple sauce and entered the room of Resident #1 and administered the medications. On 12/16/22 at 8:07 AM, RN D was observed during her medication administration of Resident #20's medications. RN D proceeded to remove Resident #20's medications from the pharmacy bag, which included but was not limited to: Duloxetine DR capsule 60 mg. RN D opened the Duloxetine capsule and poured the contents into a plastic bag with the other medications and proceeded to crush all the medications together. The pharmacy bag containing the medications was labeled as follows: " ...Duloxetine DR Cap 60 mg. sub for Cymbalta Dizzy/Drowsy, Do Not Crush ...". RN D then proceeded into Resident #20's room and administered the medications. Following the medication administration observation, Surveyor C asked RN D how she knew which medications to crush and which ones not to. RN D said they have a shift-to-shift report sheet that indicates how a Resident take their medications such as crushed, whole, with apple sauce, etc. When asked how they know if a medication can't be crushed, she said, "If they get	F 759	2. All residents have the potential to be affected. A 100% audit was conducted by the DON/designee on 12/16/22 of all residents□ medications to ensure that residents requiring crushed medications will receive them in a form that can be crushed. Findings were submitted to the provider for order updates, as applicable. 3. The Clinical Educator or designee will educate all nursing staff on the medication administration process to include identifying medications that should not be crushed. 4. The DON or designee will audit 1 med pass per week for 8 weeks to ensure that medication administration is handled accurately, to include not crushing medications that are not to be crushed. The results of the audits will be reported to the QAPI Committee for evaluation of compliance and ongoing monitoring of continuous improvement analysis. 5. January 31, 2023.	

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F 759	Continued From page 39	F 759		

their medications crushed then all of them can be crushed. Between us and the pharmacy they make sure of that. If there is something that can't be crushed the pharmacy would call us. If it is something that can't be crushed, they would change it to liquid". When asked if she double checks if things can or cannot be crushed, RN D said, "I wouldn't check each day, if it were something new, I probably would look".

Surveyor C then asked about the medications that are ER (extended release), what this meant. RN D said, "ER means extended release, meaning the medication is slowly released into the system". When asked what the potential problem is if an extended-release medication is released all at one, RN D said, "It could result in overdose". RN D was shown the pharmacy package which contained Resident #1 and #20's medications that specifically read, "Do Not Crush" for medications that were crushed. RN D indicated she wasn't aware.

A copy of the shift-to-shift report sheet was provided to the survey team. Review of this document revealed that Residents #1 and #20 were both noted as taking medications crushed.

The medication cart contained a "Nursing 2022 Drug Handbook" from Walters Kluwer. This book was reviewed and gave the following information for Venlafaxine ER and Duloxetine DR:
i. Page 1507-1508 read, "Venlafaxine... Administration PO [by mouth] ... For extended-release capsules and tablets, don't divide, crush, place in water, or allow patient to chew. May give pellet-filled capsules by carefully opening capsule and sprinkling the pellets on a spoonful of applesauce. Patient should swallow

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F 759	Continued From page 40 applesauce immediately without chewing, then follow with a glass of cool water to ensure that all pellets are swallowed..." ii. Pages 479-480 read, "Duloxetine hydrochloride...Administration PO, give whole; don't crush or open capsules..." Review of the facility policy titled; "Medication Administration" was conducted. This policy read, "...Crush only those meds that can be crushed. Refer to American Society of Consultant Pharmacists (ASCP) Crushed Medication list in each facility. Crushed meds can be thoroughly mixed individually with appropriate food to make swallowing easier...". On 12/16/22 at 9:23 AM, a meeting was held with the Director of Nursing (DON) and corporate staff. The above observations and findings from the medication administration observation were shared. The DON was asked about extended-release medications and said, "you can't crush those because they get more medication at one time if it is crushed". The facility staff were made aware of the medication error rate of 9.38%. No additional information was provided.	F 759		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F 791		1/31/23

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F 791	Continued From page 41 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on Resident and family interviews, facility documentation review and clinical record review, the facility staff failed to provide dental services	F 791	F791. Routine/ Emergency Dental Services in NFs CFR(s): 483.55(b)(1)-(5)	

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F 791	Continued From page 42 for one Resident (Resident #44) in a survey sample of 26 Residents. The findings included: For Resident #44, the facility staff failed to arrange for dental services to obtain dentures following extraction of his teeth. On 12/14/22 at 10:03 AM, during an interview with Resident #44, a nurse entered the room to provide the Resident with medication. One of the pills was chewable and Resident #44 was having difficulty chewing the pill. Resident #44 mentioned that he had his teeth removed and keeps waiting for dentures. On 12/14/22, an interview was conducted with the spouse of Resident #44. The spouse said that they have been waiting and waiting for him to get his dentures taken care of, but nothing seems to be happening. A clinical record review was conducted of Resident #44's chart. This review revealed the following: i. A progress note written by the registered dietician on 8/4/22, read, "...Dental: Resident reports he has a DDS follow up appt next month to have dental extractions in prep for denture plates...". ii. A care plan note written 8/25/22, read, "...Resident reports inability to eat as much due to poor dentition. Dental appointment for extractions pending..." iii. On 9/6/22, the nurse practitioner saw Resident #44 and her note stated, "...patient attributes to poor dentition and dental pain. Dietary interventions. Dental issues. Looking for	F 791	1. Resident #44 had a dental appointment made for 12/27/2022 to evaluate and fit for dentures. Provider and RR were made aware. 2. All residents have the potential to be affected. A 100% audit of residents charts will be conducted by the DON/designee to ensure that any orders for dental consults have resulted in follow-up appointments being made. 3. Clinical Educator or designee will educate all clinical team members concerning the process for receiving, acknowledging, and acting upon recommendations for dental services, as well as documenting in the official clinical record the appointments made. 4. The DON or designee will audit 2 residents weekly for 4 weeks and the 1 resident weekly for 8 weeks to ensure that their dental needs are being addressed and recommendations are being followed up on. The results of the audits will be reported at the QAPI Committee for evaluation of compliance and ongoing monitoring of continuous improvement. 5. January 31, 2023.	

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F 791	Continued From page 43	F 791		

extraction and dentures. has appointment scheduled for dental follow-up some weight loss, has stabilized..."
iv. There was a handwritten note dated 9/13/22, from the provider who performed the extraction of 22 teeth. This noted indicated to follow up as needed.

There was no further mention in the clinical chart with regards to any scheduled follow-up or scheduled appointments regarding dentures for Resident #44.

On 12/19/22 at 2 PM, an interview was conducted with employee F, the social worker. Employee F stated that they do not have a dental provider that comes on-site, "we use the [name redacted] free clinic, a packet has to be sent for them to determine if the person is eligible for free services". Employee F provided surveyor C with a list of Residents she is working to obtain dental services for. Resident #44 was not noted/listed. Surveyor C asked Employee F if the free clinic was the only way for a person to obtain dental services and she said the DON had just found another dentist that accepts Medicaid. Employee F was asked about the MAP adjustment process, which is where a patient's income can be approved to use for non-covered services. Employee F had no knowledge of this process.

The facility policy regarding dental services and consulting providers was requested. No related policy was received.

On 12/19/22, during the end of day meeting, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings.

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F 791	Continued From page 44 On 12/19/22 at 2:31 PM, the DON stated they had made an appointment for Resident #44 for 12/27/22, to visit the free dental clinic to initiate the process for dentures. No further information was provided.	F 791		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		1/31/23

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F 883	Continued From page 45 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide a pneumococcal and/or influenza vaccine for 2 residents, Resident #53 and Resident #258, out of 5 residents reviewed for pneumococcal and influenza immunization. The findings include: 1. The facility staff failed to provide pneumococcal immunization for Resident #53. On 12/14/22, clinical record review was	F 883	F883. Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) 1. Resident #53, with approval from his RR/guardian, was offered the pneumococcal vaccination on 12/14/22. Resident #258□s RR was contacted on 12/15/22 and offered the influenza and pneumococcal vaccination for Resident #258.	

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F 883	Continued From page 46 performed for Resident #53 and revealed a document entitled, "Pneumococcal Vaccine Informed Consent", dated 11/8/22, signed by Resident #53, with a check mark placed next to the statement which read, "The undersigned does authorize the Center to administer the pneumococcal vaccine". There was no further documentation that indicated whether or not Resident #53 had received a pneumococcal vaccine. Resident #53 was admitted to the facility on 11/4/22. On 12/14/22, an interview was conducted with the facility Director of Nursing (DON), also serving as the facility's Infection Preventionist (IP), who accessed the clinical record for Resident #53 and verified the findings. The DON/IP stated, "I do not know why [name redacted, Resident #53] did not receive a pneumonia vaccination, he did consent to get one, it must have been an oversight". A facility policy on pneumococcal immunization was requested and received. Review of the facility policy entitled, "Influenza and Pneumococcal Immunization For Residents Policy", last date of review: 9/28/2022, read: "Policy Statement...This policy was created to prevent the occurrence of influenza and pneumonia that are vaccine-preventable...Each resident will be offered...lifetime immunization against pneumococcal disease...". On 12/14/22, during the end of day meeting, the Facility Administrator and the DON/IP were made aware of the findings. No additional information was provided prior to the survey Exit Conference held on 12/20/22.	F 883	2. All residents have the potential to be affected. 100% audit of Influenza Vaccine, Pneumococcal Vaccine Informed Consent forms will be conducted by the DON/designee to ensure that those electing to receive the vaccines or whose RR gave consent on their behalf, have, in fact, received them. 3. Clinical Educator or designee will provide education to the admissions team on the process for informing Nursing of residents consenting to receipt of influenza and pneumococcal vaccines expressed on the form during the admissions process and annually. 4. The facility will audit 1 new admission weekly for 8 weeks to ensure that form and selections made upon admission are conveyed to nursing and vaccines are administered as selected by the resident. The results of the audit will be reported at the QAPI Committee for evaluation of compliance and ongoing monitoring of continuous improvement. 5. January 31, 2023.	

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2. The facility staff failed to provide influenza and pneumococcal immunization for Resident #258.

On 12/14/22, clinical record review was performed for Resident #258 and revealed a document entitled, "Influenza Vaccine, Pneumococcal Vaccine Informed Consent", dated 11/28/22, signed by Resident #258's Responsible Party, with a check mark placed next to the statements which read, "The undersigned does authorize the Center to administer the influenza vaccine" and "The undersigned does authorize the Center to administer the pneumococcal vaccine". There was no further documentation that indicated whether or not Resident #258 had received either the influenza or pneumococcal vaccine. Resident #258 was admitted to the facility on 11/28/22.

On 12/14/22, an interview was conducted with the facility Director of Nursing (DON), also serving as the facility's Infection Preventionist (IP), who accessed the clinical record for Resident #258 and verified the findings. The DON/IP stated, "I do not know why [name redacted, Resident #258] did not receive the flu or pneumonia vaccination, I see the consent to get them, it was an oversight". A facility policy on influenza and pneumococcal immunization was requested and received.

Review of the facility policy entitled, "Influenza and Pneumococcal Immunization For Residents Policy", last date of review: 9/28/2022, read: "Policy Statement...This policy was created to prevent the occurrence of influenza and pneumonia that are vaccine-preventable...Each resident will be offered immunization against

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F 883	Continued From page 48 influenza...and lifetime immunization against pneumococcal disease...". On 12/14/22, during the end of day meeting, the Facility Administrator and the DON/IP were made aware of the findings. No additional information was provided prior to the survey Exit Conference held on 12/20/22.	F 883		
F 886 SS=D	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 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	F 886		1/31/23

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	495430	A. BUILDING _____ B. WING _____	12/20/2022

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F 886	Continued From page 49 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 efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with the Centers for Disease Control and	F 886	F886. COVID-19 Testing □ Residents & Staff CFR(s): 483.80(h)(1)-(6)	

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F 886	Continued From page 50 Prevention (CDC) guidance for 1 resident, Resident #258, in a sample of 5 Residents reviewed for COVID-19 testing. The findings included: For Resident #258, facility staff failed to conduct a COVID-19 test on 12/2/22 and 12/4/22, following her admission to the facility on 11/28/22. On 12/14/22, a clinical record review was conducted and revealed facility staff performed a COVID-19 test for Resident #258 on 11/29/22. There was no evidence of COVID-19 testing on Day 3 post-admission, 12/2/22, or Day 5 post-admission, 12/4/22. The COVID-19 Community Transmissibility Level for the facility was "HIGH" for the week 11/24/22 through 11/30/22. On 12/14/22, a group interview was conducted with the Director of Nursing (DON) who also serves as the facility's Infection Preventionist (IP) and the Corporate Director of Education, Employee C, both of whom confirmed that COVID-19 community transmissibility levels were high on 11/28/22. The DON/IP confirmed Resident #258 was tested for COVID-19 on 11/29/22 and not again until 12/6/22 due to COVID-19 outbreak testing being conducted on 12/6/22. The DON/IP stated that the facility's infection control program includes following all recommended CDC guidelines. A copy of the facility's COVID-19 Testing policy was requested and received Review of the facility policy titled, "LLH-IP-Coronavirus Policy", last updated 10/6/2022, page 9, section VIII "Admissions",	F 886	1. Resident #258 no longer meets new resident COVID-19 testing criteria. 2. All newly admitted residents have the potential to be affected. A 100% audit of residents admitted on or after 11/20/22 was conducted by the DON/designee to confirm that they were tested for COVID-19 upon admission according to then current CDC and CMS guidelines. 3. The Clinical Educator or designee will educate all nursing staff on the policy related to COVID-19 testing requirements for newly admitted residents according to the current CDC and CMS guidelines. 4. The DON or designee will audit new admissions and readmissions weekly for 8 weeks to ensure that the facility conducts COVID-19 testing according to current CDC and CMS guidelines. The results of the audit will be reported to the QAPI Committee for evaluation of compliance and ongoing monitoring of continuous improvement. 5. January 31, 2023.	

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F 886	Continued From page 51 item 1b, read, "When the community transmission is high: i. Newly admitted, readmissions, and residents who have left the facility for >24 hours will be tested immediately on the day of admission/readmission when Community Transmission Rate is high, if negative, testing will be repeated in 48 hours (Day 3), if negative, 3rd and final test will be done in 48 hours (Day 5) prior to discontinuation of precautions". The CDC document entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated September 23, 2022, page 11, subheading, "Nursing Homes", item 3 "Managing admissions and residents who leave the facility", read, "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". On 12/14/22, during the end of day meeting, the Facility Administrator and DON/IP were made aware of the findings. No additional information was provided prior to the survey Exit Conference held on 12/20/22.	F 886		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:	F 887		1/31/23

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F 887	Continued From page 52 (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (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	F 887		

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F 887	Continued From page 53 contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide COVID-19 immunization for 1 resident, Resident #53, in a survey sample of 5 residents reviewed for COVID-19 immunization. The findings included: The facility staff failed to provide evidence that Resident #53 was offered, educated, and provided/or declined COVID-19 vaccination. On 12/14/22, clinical record review was performed for Resident #53, admitted to the facility on 11/4/22. Resident #53 had no documentation with regard to COVID-19 immunization, to include the resident's current COVID-19 vaccination status, offer to provide immunization against COVID-19 infection, or documentation of resident refusal or medical contraindication. On 12/14/22, an interview was conducted with the Director of Nursing (DON), who was also the	F 887	F887. COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) 1. The RR/guardian for Resident #53 was offered COVID-19 vaccination for her father on 12/14/22. 2. All residents have the potential to be affected. A 100% audit of all residents will be conducted by the DON/designee to ensure a COVID-19 immunization is offered, educated, and provided or declined. 3. The Clinical Educator or designee will educate all nursing and admissions staff on facility policy for ensuring to COVID -19 immunization is offered and acceptance or declination is documented. Where a resident declines a COVID-19 vaccination for which they are eligible, staff will be educated to review this choice with the resident and/or their RR at least quarterly during their care plan meeting.	

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F 887	Continued From page 54 facility's Infection Preventionist (IP). The DON/IP verified the findings for Resident #53 and stated the COVID-19 immunization status should have been assessed at admission and The COVID-19 vaccine should have been offered. The DON/IP stated, "This was an oversight". A facility policy regarding COVID-19 immunization for residents was requested and received. Review of the facility policy titled, "LLH Resident COVID Vaccination", effective 9/16/2022, read, " Up to Date COVID vaccination is strongly recommended unless contraindications exist.." and item 1, "Upon admission, residents COVID vaccine status will be evaluated to determine if up to date". The CDC (Centers for Disease Control and Prevention) document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated September 23, 2022, page 2, item 1, read, "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". The CDC document titled, "Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States", updated October 19, 2022, page 3, heading "Recommendations for COVID-19 vaccine use", subheading "Groups recommended for vaccination", read, "COVID-19 vaccination is	F 887	4. The DON or designee will audit new admissions and readmissions weekly for 8 weeks to ensure that immunization against COVID-19 is offered and that acceptance or declination is documented. The results of the audits will be reported to the QAPI Committee for evaluation of compliance and ongoing monitoring of continuous improvement. 5. January 31, 2023.	

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F 887	Continued From page 55 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 CDC". On 12/14/22, during the end of day meeting, the Facility Administrator and DON/IP were made aware of the findings. No additional information was provided prior to the survey Exit Conference held on 12/20/22.	F 887		