STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 69 No further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to follow standards of practice affecting one resident (Resident #14) in a survey sample of 39 residents. The findings included: For Resident #14, the facility staff failed to monitor for changes in condition, and for medication interactions, following the implementation of an antipsychotic medication. On 10/17/2023, Resident #14 was visited in her room by Surveyor C. Resident #14 was awake, able to engage in conversation with no difficulty, and appeared to have some memory loss. There was no obvious significant hearing deficit noted. During the interaction and observations of the room, it was noted by the Surveyor that Resident #14 had multiple over-the-counter medications in the room. They included 2 foil blister packets on the bed, a bottle of Tylenol, and 2 cans of jock itch spray. On 10/18/2023, Surveyor C visited Resident	F 658	1. Resident #14 has been scheduled for psychotropic drug monitoring to assess for side effects. 2. All residents on psychotropic medications are potentially at risk for this deficient practice. Facility will conduct an audit of other residents on psychotropic medication to ensure there is appropriate monitoring of side effects. 3. Licensed Nursing Staff will be provided education by the DON on indications for use and side effects of antipsychotic medication as well as the facility process for monitoring and documenting side effects.	12/5/2023

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F 658	Continued From page 70 #14's room on 3 occasions, once mid-morning, once early afternoon, and again around 3:30 p.m. Each time, Surveyor C knocked on the resident's room door, entered the room, and called the resident's name. Resident #14 was observed laying on her bed asleep. Surveyor C got closer to the resident and called her name again, Resident #14 did not arouse. The over-the-counter medications remained at the bedside. The blister packs of medication were observed to be Mucinex and Nauzene. The Tylenol and jock itch spray remained in the room, and it was also noted that now there was Pepto Bismol present. On 10/18/2023 at approximately 3:30 p.m., Surveyor C interviewed CNA D. CNA D was in the hallway, outside of Resident #14's room and was filling a water pitcher with ice. CNA D was asked about Resident #14 and asked if she normally sleeps a lot. Surveyor C explained that she had attempted to visit the resident on several occasions, but the resident would not arouse. CNA D said he was in the hall filling the water pitcher to not awaken Resident #14. He said that normally she is awake. On 10/19/2023 at approximately 8:30 a.m., Surveyor C went to visit Resident #14 in her room again. Surveyor C knocked on the door, entered the room, and called the resident's name. Resident #14 did not respond. Surveyor C approached the bedside and observed Resident #14 asleep on top of the covers, with her dentures protruding from her mouth. Surveyor C called Resident #14's name again, with no response. The over-the-counter medications previously identified in the room remained present and in addition a container of Preparation	F 658	4. The Director of Nursing will conduct weekly audits of a random sample of 5 residents including any residents with new orders for psychotropic medications weekly for psychotropic medications, monitoring for side effects and appropriateness of their use. Results of the audits will be reported monthly by the DON to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC – 12/5/23	

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F 658	Continued From page 71	F 658		

H hemorrhoid cream was noted as well.

On 10/19/2023 at approximately 9:00 a.m., Surveyor C interviewed CNA B and CNA E. They were asked if Resident #14 usually sleeps a lot and is hard to arouse. They said she does sleep at times, but is easily aroused. They were informed that Surveyor C had made multiple attempts to visit the resident yesterday and again this morning, but Resident #14 was asleep and not responding to her name being called. They stated this was not the resident's normal behavior, but she had awakened for breakfast.

On 10/19/2023, an interview was conducted with CNA F. CNA F was asked about Resident #14. CNA F said he was not too familiar with the resident's pattern, but knew she stayed in her room a lot and would doze on and off at times.

On 10/18/2023 - 10/19/2023, a clinical record review was conducted. A progress note dated 10/16/2023, was noted that read, "Resident was seen by her outside PCP today. New order for Sulfamethoxazole 400 mg- Trimethoprim 80 mg, 1 tab every 8 hours x 7 days. Also an increase in Quetiapine/Seroquel to 50 mg once a day at bedtime." There was no indication that Resident #14's family member had been notified of the start of an antipsychotic medication.

Review of the Medication Administration Record (MAR) for October 2023 revealed that Resident #14 was not receiving Seroquel prior to 10/16/2023. Resident #14 did receive a dose on 10/17/2023 and 10/18/2023.

Physician's orders and the MAR revealed that that Resident #14 was started on Sertraline HCl

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F 658	Continued From page 72 oral tablet, (also known as Zoloft, which is an antidepressant) 50 mg, once daily for depression symptoms starting 08/12/2023. At the time of survey, this medication continued. It was also noted that the only order for over-the-counter medications that had been observed in the resident's room was for Preparation H, the other medications had no physician's order. Review of the progress notes revealed no evidence of any behaviors in the past 30 days that would have precipitated the medication change. On 10/18/2023 at 3:04 p.m., the Corporate Nurse Consultant identified the facility follows the Lippincott Nursing standards of practice for nursing care. On the afternoon of 10/19/2023, the facility Administrator, Director of Nursing, and Corporate staff were made aware that Resident #14 had multiple over-the-counter medications at the bedside and was displaying significant somnolence. The Corporate Nursing Consultant advised Surveyor C that the Administrator had removed 2 bottles of vodka from Resident #14's room earlier that day. Review of the facility policy titled, "Administration Procedures for all Medications," was reviewed. This policy read, "...IV. Administration:...8. Monitor for side effects or adverse drug reactions immediately after administration and throughout each shift. 13. Notify the attending physician and/or prescriber of:... c. Suspected adverse drug reactions." Review of the "Nursing Drug Handbook" revealed	F 658		

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F 658	Continued From page 73 on pages 478-479 the following information regarding Quetiapine/Seroquel: "Indications & Dosage: Management of signs and symptoms of psychotic disorders...Elderly: lower dosages, slower adjustment, and careful monitoring in initial dosing period... Adverse Reactions: CNS [central nervous system] dizziness, headache, somnolence, hypertonia, dysarthria, asthenia... Interactions: ... Drug-lifestyle: Alcohol use: increased CNS effects. Use cautiously... Nursing Considerations: Use with caution in patients with WV or cerebrovascular disease or conditions that predispose to hypotension, in those with a history of seizure threshold, and in patients who will be experiencing conditions in which the core body temperature may be elevated... Patient teaching: ...advise patient to avoid alcohol while taking drug." The "Lippincott Manual of Nursing Practice," eighth edition, was reviewed. On page 18, in box 2-3, "Common Legal Claims for Departure from Standards of Care," were noted to include, but not limited to: "Failure to monitor or observe a change in a patient's clinical status, failure to communicate or document a significant change in a patient's condition to appropriate professional...Failure to observe a medication's action or adverse side effect..." On the afternoon of 10/19/2023 during an end of day meeting, the facility Administrator, DON, and corporate staff were again made aware of the above concerns that Resident #14 was displaying significant somnolence and had a recent medication change that may be a contributing factor as well as the over-the-counter medications and alcohol that was noted in the room may be a contributing factor since they are	F 658		

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F 658	Continued From page 74 unaware of what and how much the resident may be self-administering. There was no evidence of nursing monitoring for side effects. 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 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, resident interview, facility staff interview, clinical record review, and facility documentation review, the facility staff failed to provide assistance to one resident (Resident #274), who was dependent upon staff for activities of daily living, in a survey sample of 39 residents. The findings included: For Resident #274, the facility staff failed to provide baths to include hair care, which resulted in the resident's hair becoming matted and having to be cut. On 10/17/2023 at 1:58 p.m., Resident #274 was visited in his room. Observations revealed that Resident #274's hair appeared uncombed, and it being matted in the back of his hair was noted. Resident #274 was asked about baths and showers, and he stated he had not been out of bed since his admission, which was 09/27/2023. On 10/18/2023 at 11:14 a.m., Resident #274 was	F 677	1. Resident #274 had care provided. 2. All dependent care residents of the facility have the potential to be affected by this alleged deficient practice. Facility wide audit of all dependent Residents conducted to ensure that ADL care is being regularly completed according to care plan and Resident preference. 3. Licensed staff and IDT members of the facility will be educated by the DON on the Hill Valley Healthcare Activities of Daily Living Policy and the importance of showers and all ADL care for dependent care residents. 4. DON will audit 3 residents weekly to ensure that all ADL care are being provided to all care residents. Results of weekly audits will be reported to the QAPI committee monthly x 3 months. The QAPI committee is responsible for the on-going monitoring of compliance. 5. DOC- 12/5/23	12/5/2023

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F 677	Continued From page 75	F 677		

visited in his room again. It was noted that his hair still appeared uncombed, and the resident said he had asked to be shaved and said, "They said if they can't get to it today, they will do it tomorrow." Later in the afternoon, Surveyor C visited Resident #274 and noted he had been shaven. When asked if he was bathed, he said, "Just a wash up," and his hair was still uncombed.

On 10/19/2023 at 11:56 a.m., Resident #274 was visited in the dining room. Resident #274 commented that it felt good to be up and out of the bed. When asked if he had a shower, he said, "No." Surveyor C commented that he looked nice sitting up, and the resident went on to say, "They cut my hair because it had knots in it."

On 10/19/2023 at 1:45 p.m., an interview was conducted with CNA B. CNA B was asked about showers and said they are given twice weekly and have a schedule at the nursing station. CNA B was asked about Resident #274's report that his hair had been cut. CNA B acknowledged she had cut the resident's hair and said, "He wanted me to, you couldn't get a comb through the knots." She then asked if this was a problem.

On 10/19/2023, a clinical record review was conducted. Review of the bathing records for Resident #274 revealed that from 10/06/2023 - 10/19/2023, the Resident was only provided partial baths or a bed bath. There was no evidence that Resident #274 had been offered a shower or tub bath. Review of the nursing notes revealed no documentation that the resident had refused.

Review of Resident 274's care plan revealed the

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F 677	Continued From page 76 resident "Has an ADL self-care performance deficit AEB [as evidenced by] bilateral amputees and kidney cancer." The intervention for this care plan read, "Physical assist as needed with all ADL's..." Review of the facility's bathing schedule indicated the assigned room for Resident #274 was scheduled for a bath on Mondays and Thursdays during the 3:00 p.m. - 11:00 p.m. shift. On 10/19/2023 at 4:28 p.m., the Director of Nursing (DON) and corporate clinical consultant were made aware of the above findings. They were asked to provide any information they had regarding baths/showers being provided for Resident #274, as the surveyor was not able to find any documentation. A review was conducted of the facility policy titled, "Activities of Daily Living (ADLs)." The policy read, ". 4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); i. Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly or as required by state law. " On 10/19/2023 at 5:25 p.., the Administrator was made aware of the above findings. No further information was provided.	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii)	F 687		

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F 687	Continued From page 77 §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to provide proper foot care to 1 resident (Resident #67) in a survey sample of 39 residents. The findings included: For Resident #67, the facility staff failed to have her seen by podiatry for cutting her toenails as she is diabetic and on an anti-coagulant medication for history of Transient Ischemic Attack (TIA). On 10/17/2023 at approximately 2:00 p.m., Resident #67 was observed in the hall sitting in her wheelchair wearing open toe sandals. Her toenails were clearly visible, and they were jagged and at least 1/4 inch long. Resident #67 has a Brief Interview of Mental Status (BIMS) score of 0/15 and could not follow the line of questions. On 10/18/2023 at approximately 11:00 a.m., an observation was made of Resident #67 sitting in	F 687	1. Resident # 67 is scheduled for Podiatry visit in November. 2. All Residents of the facility have the potential to be affected by these deficiencies. Facility wide audit of all Residents assessments of footcare will be completed by the DON/Designee. 3. Education will be provided to IDT, Clinical staff, and Therapy staff by the DON regarding the necessity of regular assessments of footcare and following care plans. 4. DON/Designee will complete 3 audits of new admissions weekly to determine the need for Podiatry services. The results of the weekly audits will be submitted to the QAPI committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. DOC- 12/5/23	12/5/2023

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F 687	Continued From page 78	F 687		

her wheelchair in her room and she was not wearing shoes or socks. Her toenails were clearly visible and had not been trimmed.

On 10/19/2023 at approximately 2:00 p.m., an interview was conducted with CNA C who was asked if residents get their nails cut by staff. CNA C stated the CNA assigned to the resident will clean and trim fingernails if they are not a diabetic or if they do not take blood thinners. She stated if they are diabetic or they are on blood thinners, the nurse must do it.

On 10/19/2023 at approximately 2:30 p.m., an interview was conducted with LPN E who stated that she personally does not cut the nails or toenails of any residents that are diabetic or on anti-coagulants. She stated she makes the unit manager or the DON aware, so they can be put on the podiatry list for feet, or the RN/DON can do the fingernails. When asked if she had looked at Resident #67's nails, she stated they needed to be trimmed, and she would notify the DON.

On 10/20/2023, a review of the clinical record was conducted. Resident #67 had not seen the podiatrist since her arrival at the facility in June.

On 10/20/2023, the podiatry list was reviewed and found that Resident #67 had not been on the list for July, August, September, or October. A fax was sent by the DON to add Resident #67 to the list for November.

On 10/20/2023 during the end of day meeting, the Administrator was made aware of the concerns.

No further information was provided.

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F 689	Continued From page 79	F 689	1. The items from resident #14s room were removed pending evaluation of self-administration. Both units were toured and any items that were unsafe or potential accident hazards were removed or corrected. 2. All residents of the facility have the potential to be affected by this alleged deficient practice. An in house audit was completed for of all resident rooms to ensure no other residents had medications at bedside. 3. Facility staff will be educated by the DON on potential accident hazards to include medications/treatments at bedside.	12/5/2023
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility documentation review, the facility staff failed to ensure 1 of 2 nursing units was safe and free of accident hazards. The findings included: The facility staff failed to ensure that one resident unit was free of accident hazards/over-the-counter medications, which were accessible to residents who are confused and wander. On 10/17/2023 at approximately 12:30 p.m., Surveyor C made observations on one of the nursing units. It was noted in Resident #14's room, multiple items were observed that could pose as a safety hazard to confused residents. The items included over-the-counter medications, Mucinex, Nauzene, Tylenol, and jock itch spray. During the above observation, it was noted there were residents who wander ambulating independently within the hall. During residents' interviews, Resident #38 verbalized there is a resident who wanders into her room and takes	F 689		

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F 689	Continued From page 80 her items. On 10/18/2023 during mid-morning, observations were made in Resident #14's room. During this observation, the Mucinex, Nauzene, Tylenol, and jock itch spray were all still present and accessible. In addition, Pepto Bismol was noted. On 10/19/2023 during the early afternoon, Resident #14 was visited in her room again. All the above noted medications were still present, and in addition, Preparation H cream was noted sitting on top of the 3-drawer storage bin. Resident #14 was asked about the items, and she said she puts the Preparation H on herself. When asked where she obtained the items from, the resident was unsure. On 10/19/2023 at 11:21 a.m., an interview was conducted with the Director of Nursing (DON). The DON said they do not have any residents who self-administer medications. When asked how would the medications that would be self-administered be stored, the DON said, "In a lock box." When asked why a lock box is used to store the medications, the DON said, "Because I wouldn't want anyone else to have access to it," and confirmed they do have residents that wander and go into other residents' rooms, and it would pose as a safety hazard. On the afternoon of 10/19/2023, the facility Administrator, Director of Nursing and Corporate staff were made aware that Resident #14 had multiple over-the-counter medications at the bedside. The Corporate Nursing Consultant advised Surveyor C, that the Administrator had removed 2 bottles of vodka from Resident #14's room earlier that day.	F 689	4. The facility Interdisciplinary Team (IDT) will complete Angel Rounds daily and audit resident rooms for cleanliness, homelike environment, privacy, and accommodation of needs, free of accident hazards, over-the-counter medication, and document on audit tool. Weekend supervisor/manager on duty on weekends. Rounds will be completed 3 times weekly. Angel rounds audits will be reviewed daily in the morning stand up meeting be turned into the facility Nursing Home Administrator. Results of the audits will be reported monthly by the NHA to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC – 12/5/23	

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F 689	Continued From page 81 On 10/20/2023 prior to conclusion of the survey, the facility staff provided the survey team with a listing of items removed from Resident #14's room. The list included, "Mucinex, Pepto Bismol, acne treatment, Preparation H gel, Tylenol, Diclofenac Gel, Preparation H cream, jock itch spray, Nauzene, Salonpas patches," which are all over-the-counter medications. No further information was provided.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to care plan for and provide appropriate dementia treatment and services for one resident, Resident #125, in a survey sample of 39 Residents. The findings included: Resident #125 was admitted to the facility on 09/28/2023 and discharged back to the hospital on 10/05/2023 for an infected surgical leg wound from fracture repair. He was readmitted on 10/11/2023 after a 6-day hospital stay. Resident #125's Diagnoses included but were not limited to: Hypertension, unspecified dementia	F 744	1. Residents #125 was evaluated by the attending physician and the psych NP and new orders were received for his psychotropic medication use. 2. Residents of the facility with dementia diagnosis and on psychotropic medications have the potential to be affected by this deficient practice. An audit of all residents with dementia and on psychotropic medications was conducted and reviewed for appropriate diagnosis, psych involvement, and last GDR attempt.	12/5/2023

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F 744	Continued From page 82 mild (without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety), osteoporosis with current pathological fracture left ankle and foot, altered mental status, bacteremia, and unspecified cirrhosis of liver. The resident had a POA for decision making. From the last observation date of 10/02/2023, the resident's MDS documented the resident as a BIMS score of 10 from a possible 15 points, and as mild to moderate cognitive impairment. The resident was able to actively take part in his mental evaluation, and by the date of survey on 10/17/2023 (15 days later), the resident had become completely disoriented. On 10/17/2023 at 12:30 p.m., the surveyor observed Resident #125 in bed lying flat on his back. The resident was picking at the bed linens and pulling on his hospital gown repeatedly. The surveyor asked him if he needed help and he replied in a stream of disjointed words in a rambling response.The surveyor asked Resident #125 his name, and other questions. The resident did not look up or respond to the surveyor, simply kept picking at the gown pulling it up and attempting to disrobe. On 10/18/2023 at 10:00 a.m., during a second observation of Resident #125, the resident was observed in bed with his eyes open, essentially unchanged from the first observation. The surveyor approached the resident and said "hello," and asked the resident his name, and other questions, the resident did not look at the surveyor, and was mumbling to himself. Review of the current care plan dated 09/28/2023, revised 10/05/2023 upon discharge	F 744	3. Licensed Nursing staff and prescribers of the facility will be educated by the DON on the facility policy for dementia care and services and psychotropic medication management policy. 4. The Director of Nursing will conduct weekly audits of a random sample of 5 residents weekly for psychotropic medications and appropriateness of their use. Results of the audits will be reported monthly by the DON to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC- 12/5/23	

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F 744	Continued From page 83	F 744		

to the hospital, but not revised on 10/12/2023 upon return to the facility, revealed only 3 care planned problem areas that could be related to dementia. In the first two focuses there are options given beside a direction for staff to "SPECIFY" which is to be observed for the individual resident. None were highlighted as individualized for Resident #125. The three care plan entries read:

"1. FOCUS. The (name) resident uses psychotropic medications r/t (related to) depression.

GOAL. The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment thru review date. Target date 12-27-23.

INTERVENTIONS. Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-shift (every shift). Consult with pharmacy, MD to consider dosage reductions when clinically appropriate at least quarterly. Monitor/record occurrence of for target behavior symptoms (SPECIFY: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression toward staff/others. Etc.) and document per facility protocol.

2. FOCUS. The resident has impaired cognitive function/dementia or impaired thought processes.

GOAL. The resident will remain oriented to (SPECIFY: person, place, situation, time) through the review date. Target date 12-27-23.

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F 744	Continued From page 84 INTERVENTIONS: Cue, reorient and supervise as needed. Monitor/document/report PRN (as needed) any changes in cognitive function, specifically changes in: decision making ability, memory, recall, and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. 3. FOCUS. The resident has potential for psychosocial well-being problem. GOAL. The resident will have no indications of psychosocial well-being problem by/through review date. Target date 12-27-23. INTERVENTIONS. Monitor/document resident feelings relative to isolation, unhappiness, anger, loss)." On 10/17/2023 and 10/18/2023, the resident was experiencing cognitive/behavioral impairment, was attempting to disrobe, and had inappropriate or absent responses to verbal communication. The resident was disoriented, unaware, could not express himself, nor understand/respond and take part in questioning. These behaviors were not monitored nor documented anywhere in the clinical record. There were no non-pharmacologic interventions care planned for this resident, and the interventions were not individualized for this resident. On 10/12/2023 at 8:00 p.m. nursing notes indicated Resident #125 was, "Very confused...unscrewed bed remote ...friend was going to come & pick him up shortly...Resident unplugged IV machine...had female visitor who stated he was very confused, and she couldn't	F 744		

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F 744	Continued From page 85 understand what he was talking about." Nursing indicated they were placing him on 1:1 for safety precautions. This was not care planned. On 10/17/2023 and 10/18/2023 interviews were conducted with staff nurses and CNA's (certified nursing assistants) who worked on both nursing units, and they stated that the Resident had become more confused during his stay. One staff member in particular who asked not to be identified, stated, "he had been restless and would try to get out of bed." The staff member stated they "had to calm him down so he wouldn't fall again and injure the leg further, and we just don't have enough people to sit with him 24/7." On 10/18/2023 in an interview with the Social Worker, when asked what should be in a Care Plan for patients with Dementia, he stated there should be non-pharmacological interventions for specific behaviors and activities specific to Residents with Dementia. On 10/17/2023 and 10/18/2023 at an end of day debriefing, the Corporate RN, Administrator and Director of Nursing (DON) were made aware of the findings. At the time of exit they stated there was no further information available to submit to surveyors.	F 744		
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	F 755	1. Residents #53's attending physician was notified about the ordered medications being unavailable and no new orders were given.	12/5/2023

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F 755	Continued From page 86 permits, but only under the general supervision of 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 interview, clinical record review, and facility documentation, the facility staff failed to provide medications as ordered by the physician to 1 resident (Resident #53) in a survey sample of 39 residents. The findings included: For Resident #53, the facility staff failed to administer Gabapentin as ordered by the physician.	F 755	2. All residents of the facility have the potential to be affected by this deficient practice. An audit was conducted by the director of nursing of all residents for the past 30 days for medications being unavailable. 3. Licensed Nursing staff of the facility will be educated by the DON on the facility policy for medication administration, accurate documentation in the MAR, medication availability, and reporting of medication errors. 4. The DON or designee will conduct medications pass observations 3 times weekly auditing that no medications are unavailable, and accurate documentation of administration in the EMAR. Results of the weekly audits/observations will be reported monthly to the QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. DOC- 12/5/23	

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F 755	Continued From page 87 On 10/29/2023 during clinical record review, it was found that the facility staff failed to acquire the medication, Gabapentin, for administration to Resident #53. Resident #54 had an order for Gabapentin as follows: "Gabapentin Oral Capsule 100 MG (Gabapentin) Give 1 capsule by mouth at bedtime related to OTHER IDIOPATHIC PERIPHERAL AUTONOMIC NEUROPATHY (G90.09) -Start Date 10/05/2023." The following excerpts are from the progress notes for Resident #53 regarding the Gabapentin: "10/13/2023 9:35 PM Gabapentin Oral Capsule 100 MG Give 1 capsule by mouth at bedtime related to OTHER IDIOPATHIC PERIPHERAL AUTONOMIC NEUROPATHY Medication on order from the pharmacy, signed prescription received." "10/15/2023 9:13 PM Medication on order from the pharmacy, signed prescription received. MD is aware." "10/17/2023 9:12 PM- Note Text: Gabapentin Oral Capsule 100 MG Give 1 capsule by mouth at bedtime related to OTHER IDIOPATHIC PERIPHERAL AUTONOMIC NEUROPATHY (G90.09) Resident medication is awaiting signed prescription be sent to the pharmacy. MD aware." "10/18/23 at 9:29 PM-Gabapentin Oral Capsule 100 MG Give 1 capsule by mouth at bedtime related to OTHER IDIOPATHIC PERIPHERAL AUTONOMIC NEUROPATHY (G90.09) -	F 755		

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F 755	Continued From page 88	F 755		

Medication has not been received from the pharmacy yet. Nurse called the pharmacy at [phone number redacted] to check the status of the medication order and was informed that the signed prescription was never received. Prescription re-printed and a message was sent to [MD name redacted] at [phone number redacted] to please fax the prescription to [phone number redacted]."

Resident #53 had the following order for Apixaban (also known as Eliquis, an anti-coagulant):

"Apixaban (an anti-coagulant) Tablet 5 MG Give 1 tablet by mouth two times a day related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA -Start Date_12/21/2022."

The following excerpts are from the progress notes for Resident #53 regarding the order for Apixaban:

"Effective Date: 09/02/2023 09:13 AM Type: Orders - Administration Note Text: Resident refused Apixaban related to surgery on the 7th. of Sept."

On 10/20/2023, an interview was conducted with the DON who stated, "Medications that are not signed off or not given should have documentation of physician notification and Resident Representative notification, and any medications marked as hold, should have a valid physician's order to hold."

On 10/20/2023 during the end of day meeting, the Administrator was made aware of the concerns.

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F 755	Continued From page 89 No further information was provided.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758	1. Resident #14 has been scheduled for psychotropic drug monitoring to assess for side effects. 2. All residents on psychotropic medications are potentially at risk for this deficient practice. Facility will conduct an audit of other residents on psychotropic medication to ensure there is appropriate monitoring of side effects. 3. Licensed Nursing Staff and all prescribers will be provided with education by the DON on indications for use and side effects of antipsychotic medication as well as the facility process for monitoring and documenting side effects.	12/5/2023

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F 758	Continued From page 90 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure that residents were free from unnecessary psychotropic medications, for one Resident (Resident #14) in a survey sample of 39 Residents. The findings included: For Resident #14, who was started on an antipsychotic medication and was noted with an increase in sleeping and difficulty arousing, there was no indication for the initiation of an antipsychotic medication, therefore rendering the medication unnecessary. On 10/17/23, Resident #14 was visited in her room by Surveyor C. Resident #14 was awake, able to engage in conversation with no difficulty and appeared to have some memory loss. There was no obvious significant hearing deficit noted. On 10/18/23, Surveyor C visited Resident #14's room on 3 occasions, once mid-morning, once	F 758	4. The Director of Nursing will conduct weekly audits of a random sample of 5 residents including any residents with new orders for psychotropic medications weekly for psychotropic medications, monitoring for side effects and appropriateness of their use. Results of the audits will be reported monthly by the DON to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. **5.** DOC – 12/5/23	

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F 758	Continued From page 91	F 758		

early afternoon and then again around 3:30 PM. Each time, Surveyor C knocked on the Resident's room door, entered the room and called the Resident's name. The Resident was observed laying on her bed asleep. Surveyor C got closer to the Resident and called her name again, Resident #14 did not arouse.

On 10/18/23 at approximately 3:30 PM, Surveyor C interviewed CNA D. CNA D was in the hallway, outside of Resident #14's room and was filling a water pitcher with ice. CNA D was asked about Resident #14 and asked if she normally sleeps a lot. Surveyor C went on to explain that she had attempted to visit the Resident on several occasions, but the Resident would not arouse. CNA D said he was in the hall filling the water pitcher to not awaken the Resident. He said that normally she is awake.

On 10/19/23, at approximately 8:30 AM, Surveyor C went to visit Resident #14 in her room again. Surveyor C knocked on the door, entered the room and called the Resident's name. Resident #14 did not respond. Surveyor C approached the bedside and observed Resident #14 asleep on top of the covers, with her dentures protruding from her mouth. Surveyor C again called Resident #14's name, with no response.

On 10/19/23 at approximately 9 AM, Surveyor C interviewed CNA B and CNA E. They were asked if Resident #14 usually sleeps a lot and is hard to arouse. They said, she does sleep at times but is easily aroused. They were informed that Surveyor C had made multiple attempts to visit the Resident yesterday and again this morning, but the Resident was asleep and not responding to her name being called. They stated this was

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F 758	Continued From page 92 not the Resident's normal behavior, but she had awakened for breakfast. On 10/19/23, an interview was conducted with CNA F. CNA F was asked about Resident #14. CNA F said he wasn't too familiar with the Resident's pattern but knew she stayed in her room a lot and would doze on and off at times. On 10/18/23-10/19/23, a clinical record review was conducted. A progress note dated 10/16/23, read, "Resident was seen by her outside PCP today. New order for Sulfamethoxazole 400 mg- Trimethoprim 80 mg, 1 tab every 8 hours x 7 days. Also an increase in Quetiapine/Seroquel to 50 mg once a day at bedtime". Review of the Medication Administration Record (MAR) for October 2023 revealed that Resident #14 was not receiving Seroquel prior to 10/16/23. Resident #14 did receive a dose on 10/17/23 and 10/18/23. The MAR read, "Quetiapine Fumarate Oral Tablet, 25 MG (Quetiapine Fumarate), Give 1 tablet by mouth at bedtime for Anxiety related to major depressive disorder, recurrent, unspecified; Generalized Anxiety Disorder". Review of the progress notes revealed no evidence of any behaviors in the past 30 days that would have precipitated the medication change. Resident #14 was seen by psychiatric services on 10/16/23. The "Psychological services progress note" read, " ...Intervention: Assessed current mood and anxiety symptoms to ascertain current emotional functioning. Gave evidence-based	F 758		

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F 758	Continued From page 93 suggestions on what to do and conveyed approval of patient's thoughts and/or behaviors. Patient's Response to Intervention: [Resident #14's name redacted] presented as less anxious today. She reported that she has been practicing thinking more positively and focusing on good things to decrease her anxiety and manage her mood. Marvetta responded well to her cognitive reframing being reinforced. Plan For Next Session: Continue to normalize any grief [Resident #14's name redacted] maybe experiencing and assist her managing her anxiety. Session Schedule: 1x a Week". The psychological practitioner had no indication that the initiation of an antipsychotic medication was needed or recommended, notated in the progress note. On the afternoon of 10/19/23, during an end of day meeting, the facility Administrator, director of nursing and corporate staff was made aware of the above concern that Resident #14 was displaying significant somnolence and had a recent medication change that may be a contributing factor. A copy of the physician progress notes from 10/16/23, was requested since it was not in the clinical record. On 10/20/23, during the morning, Resident #14 was visited in her room and was sitting at the bedside and awaiting her breakfast. She was talkative and able to engage in conversation. On the morning of 10/20/23, Surveyor C again requested the physician progress note from 10/16/23. A clinical record review was conducted again and revealed that following the end of day meeting held on 10/19/23, the facility staff had completed an "SBAR Communication Form",	F 758		

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F 758	Continued From page 94 which indicated Resident #14 had a change in "Altered level of consciousness", which was reported to the physician. In response to this, an order was received to change the dosage of the Seroquel to decrease it to 25 mg daily, at bedtime. On 10/20/23, in the afternoon, the facility staff provided Surveyor C with the physician progress note from 10/16/23. It was reviewed and there was no indication for the medication Quetiapine, other than diagnosis listed on the "Report of Consultation" form that included, "compulsive behavior, and generalized anxiety". There were no other details given as to why the Quetiapine/Seroquel was being ordered. Review of the "Nursing Drug Handbook" revealed on pages 478-479, revealed the following information with regards to Quetiapine/Seroquel. "Indications & Dosage: Management of signs and symptoms of psychotic disorders...". No further information was provided.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761	1. The undated bottle of Tubersol Solution was thrown away at the time of finding. 2. All medication refrigerators and carts are potentially at risk for having undated, opened multi-use dose vials of medication.	12/5/2023

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F 761	Continued From page 95 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility documentation, the facility staff failed to appropriately label medication with accepted professional principals in 1 of 2 medication refrigerators. The findings included: For the medication refrigerator located on the skilled unit, the staff failed to date when opened a multi-use vial of Tubersol solution used for Tuberculin testing. On 10/19/2023 at approximately 4:00 p.m., an inspection of the medication room and refrigerator was conducted. LPN F was asked what was missing on the multi-use vial of Tubersol found in the refrigerator. LPN F looked at the bottle and stated the date should have been placed on the label when the vial was opened. When asked why that should happen, LPN F stated, "The vial is only good for 30 days. If you do not label it, you do not know when it was	F 761	3. Licensed nursing staff will be educated by the DON on the protocol to date vials of multi-dose use vials when opened. 4. Director of Nursing or designee will audit medication refrigerators and carts weekly for undated medication. Results of the audits will be reported monthly by the DON to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC – 12/5/23	

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F 761	Continued From page 96 opened and therefore you will not know when the expiration date is." According to the manufacturer instructions on the product: "Sanofi Pasteur - TUBERSOL® Package Insert. A vial of TUBERSOL which has been entered and in use for 30 days should be discarded." On 10/20/2023 during the end of day meeting, the Administrator was made aware of the concerns. No further information was provided.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812	1. The machine has been checked and fixed. 2. All residents are at risk from this potentially deficient practice.	12/5/2023

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F 812	Continued From page 97 Based on observation and staff interview, the facility staff failed to heat sanitize dishware on rinse cycle at an adequate temperature in the industrial dish washing machine, potentially impacting 70 of 72 residents in the facility. The machine was restored to sanitize rinse temperature on the third day of survey in accordance with the professional standards for food service safety. The findings included: The industrial dish machine only reached a temperature of 150 to 160 degrees at the manifold where the temperature gauge is located, and it should be at 180 degrees for high temperature sanitizing of dishware to prevent food borne illness. For 2 days, during observations on 10/17/23 and 10/18/23, the staff had no temperature monitoring strips to ascertain if the machine would actually reach a temperature of 160 degrees at the rack or 180 degrees at the manifold. The Corporate Dining Director was present and interviewed by the surveyor on 10/19/23. The Corporate Dining Director stated that a new dish machine was being ordered, and the facility had placed a call to a repair service to get the dish machine fixed that day. He further stated they would be using paper and plastic products for meals until it was fixed, and also using the three compartment sink to chemically sanitize cooking pans and utensils. On the third day, the temperature sensor strips were obtained and the machine had been fixed. No further information was provided.	F 812	3. Dietary staff will be educated by the NHA regarding the measures to take if the machine does not reach sanitizing temperature to include the use of paper and plastic products and use of 3 compartment sink to chemically sanitize cooking pans and use of temperature sensitive strips. 4. Administrator or designee will perform weekly checks of temperature logs and spot readings on sanitize temperature for rinse cycle. Results of the audits will be reported monthly by the DON to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance. 5. DOC – 12/5/23	

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F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope.	F 865	1. The facility held a QAPI committee 11/27/23 with the Regional Director of Operations and Regional Nurse Consultant and reviewed the QAPI plans for Calls bells, Immunizations, and Abuse. 2. All residents have the potential to be affected by this alleged deficient practice. A QAPI program that addresses areas identified (call bells, grievances, abuse protocol, reporting of abuse, infection control systems that include immunizations, etc.) will be maintained through resolution. 3. The Health Quality Innovators (HQI) will educate the QAPI Committee on duties and compliance with maintaining the QAPI program.	12/5/2023

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F 865	Continued From page 99 A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;	F 865	**4.** The Regional Support Staff/Designee will review the QAPI program documentation monthly for 6 months to ensure that the QAPI program is maintained as mandated. Administrator/Designee will correct any variances identified until substantial compliance is achieved. Results of audits will be shared with the QAPI committee. Any patterns or trends will be reported to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. DOC – 12/5/23	

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F 865	Continued From page 100 §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to maintain an effective Quality Assurance and Performance Improvement (QAPI) program, having the potential to affect all 72 residents residing in the facility. The findings included: The facility staff failed to maintain an effective QAPI program that was sustained during transitions in leadership and staffing, regarding call bells, abuse protocol, and resident and staff	F 865		

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F 865	Continued From page 101 immunizations. Throughout the survey conducted 10/17/2023 - 10/20/2023, the survey team inspected and investigated the facility's systems and processes regarding correcting previously cited deficiencies and resident care concerns. It was noted the facility had several systemic failures and remained out of compliance in several areas that had previously been cited as deficient during a standard survey conducted 04/11/2023 - 04/13/2023. 1. The facility staff failed to maintain an effective QAPI program regarding their resident call bell system and staff response to call bells. On 10/17/2023, the survey team noted that two residents (Residents #70 and #274), who had no other means to call facility staff for assistance, did not have a call bell in reach. Another resident (Resident #59) was noted to have a call bell that was not functioning. Review of the facility grievances revealed concerns expressed by Resident #54 of his call bell not being answered timely and being told if he put his call bell on staff would not answer it. Review of the facility's policy titled, "Answering the call light," it was noted, "...QAPI. 1. Resident/resident representatives concerns regarding timeliness of answering call bells will be referred to the Director of Nursing, Grievance officer and/or administrator for investigation and follow up. 2. Grievances regarding call bell response time will be monitored through the facility Quality Assurance Performance Improvement Committee."	F 865		

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F 865	Continued From page 102 2. The facility staff failed to maintain an effective QAPI program regarding their abuse protocol and policy. It was noted that during a standard survey conducted at the facility 04/11/2023 - 04/13/2023, the facility failed to report an allegation of neglect. As part of their plan of correction they stated the following, ". 3. The leadership of the facility have been provided education on the [corporate ownership name redacted] Abuse and neglect policy by the regional nurse consultant. The Director of Nursing will provide campus wide education on [corporate ownership name redacted] Abuse and Neglect policy. 4. The facility Interdisciplinary Team (IDT) will complete an audit of all FRI for 8 weeks. Results of the audits will be reported monthly by the NHA [nursing home administrator] to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance." On 10/17/2023, a review of the facility grievance log revealed on 07/20/2023, Resident #54 was threatened by a CNA who stated, "If you ring that call bell, I am NOT going to answer it." This grievance was written in the grievance book by the Social Worker (Employee F). A review of the complaint/grievance report read as follows: "Resident was wanting air conditioner turned up and felt like he was abruptly handled. Stated that aid told him if he puts his call light on, they will not answer it. Upset and smelled of urine. [dated 7/20/23].	F 865		

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F 865	Continued From page 103 Resident was saturated and upset about getting a shower to be cleaned up. He is ok now. [dated 7/20/23] Resident given shower and is ok at this time. No issues after shower. [signed by unit mgr. dated 7/20/23]." The facility staff had failed to identify the allegation of abuse and neglect as such and responded to it as a service concern. The facility staff failed to conduct an investigation, report the incident, and take measures to protect the resident from any alleged perpetrators while an investigation was conducted. There was also evidence that Resident #14 had been the victim of financial exploitation while a resident of the facility. The facility staff had conducted an investigation and involved outside agencies to include the Ombudsman and Adult Protective Services. Resident #14 was found to have been exploited by a family member, who was also a resident of the facility. Despite having knowledge of Resident #14 being a victim of financial exploitation, they continued to allow Resident #14's perpetrator to have unrestricted access to her, as evidenced by, the facility Administration indicated that Resident #14 was found to have vodka in her room during the survey and it was removed by the facility Administrator. The facility administration stated they felt the family member, who was previously found guilty of financial exploitation, had provided it to Resident #14. Review of the facility's policy titled, "Abuse Prevention Program," was conducted. An excerpt from this policy read, ". 9. Establish and implement a QAPI review and analysis of abuse	F 865		

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F 865	Continued From page 104 incidents; and implement changes to prevent future occurrences of abuse." 3. The facility staff failed to maintain oversight from the QAPI committee to ensure ongoing infection control systems and procedures were sustained during changes in staffing. It was noted during a standard survey conducted at the facility 04/11/2023 - 04/13/2023, the facility failed to maintain an effective infection control program based on nationally approved standards for immunization(s) for residents and facility staff. As part of their plan of correction they indicated, "2...The facility completed a facility wide audit of resident immunizations. The DON or designee will complete an audit of all residents to ensure education was provided on the benefits and potential side effects of the influenza immunization and the pneumococcal vaccines. In addition to the education the facility will offer the immunization and vaccines to the residents. 3. The Interdisciplinary team of the facility will be educated by the Director of Nursing or designee on the company policy and CDC guidance for Immunizations and vaccines. 4. The Facility will audit the status of 3 residents weekly for 8 weeks, and all new admissions. New Admissions will also be provided the education on benefits and potential side effects of the immunization and vaccines. Results of the audit will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance." During this survey, a sample of 5 recently admitted residents was selected for immunization review. All 5 were noted to be deficient regarding being provided education and being offered	F 865		

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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 865	Continued From page 105 immunization for flu or pneumonia. On 10/20/2023 at 1:58 p.m., an interview was conducted with the facility Administrator and Corporate Nurse Consultant, Employee C. During this interview, the QAPI program/plan was reviewed. The Administrator and Employee C stated the purpose of the QAPI program is to identify anything from the previous month and implement system changes to bring the facility into compliance. They indicated, "The organization has a standardized system to identify issues." When asked if previously survey results are reviewed, Employee C stated, "It does include survey results from past surveys and if we wrote a plan of correction, we designate that action to our QA, and they monitor ongoing compliance. If we feel we meet substantial compliance, we take it off" [meaning the QAPI committee stops the monitoring of that item]. The facility Administrator was asked to reference their previously submitted and approved plan of correction for the survey ending 04/13/2023 regarding resident immunizations. The Administrator read the plan of correction and was asked if the QAPI committee provided oversight? Employee C said, "The reality is the plan we developed incorporated the Infection Preventionist Nurse, when that position turned over, it appears we did not adjust our plan. When the position turned over, we didn't go back and identify that." Employee C was asked, "Is it fair to say, you made some changes, and the results would have been talked about for 3 months?" He said, "I'm thinking we resolved both of them in July. We felt the process was hard wired and the process was	F 865		

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	495235	A. BUILDING _____ B. WING _____	10/20/2023

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F 865	Continued From page 106 effective. We would have fixed it if we had known it. It could have been something that was missed. When that role [Infection Preventionist] transitioned, it fell through the cracks." Review of the facility policy titled, "Quality Assurance Performance Improvement (QAPI) Committee," was conducted. Excerpts from this policy read as follows, "The facility will maintain systems and processes to ensure that the quality assurance/performance improvement program identifies and addresses issues and/or risks and that implements corrective action plans as necessary. All appropriate and reasonable efforts will be made, and resources provided to maintain compliance with applicable regulations for nursing facilities and needs of residents. ..... The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to resident based on performance indicator data, and resident, resident representative, provider and staff input, and other information....3. iii. Action plans, corrective and preventative, will be developed and monitored for quality improvement based on identified opportunity. After implementing those actions, the facility will monitor and measure the success, and track performance to ensure that improvements are realized and sustained....13. The QAPI program is sustained during transitions in leadership and staffing." No further information was provided.	F 865		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		

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F 883	Continued From page 107 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 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;	F 883	1. Residents #124, 125, 274, 275 and 276 were offered influenza and pneumococcal vaccines and documented in the medical record. 2. All residents of the facility have the potential to be affected by this deficient practice. An audit of all active resident flu and pneumococcal vaccine status was conducted. 3. All licensed staff of the facility will be provided education by the DON on the facility policies for Influenza and Pneumococcal vaccines and how it should be screened on admission and documented in the medical record. 4. The Director of nursing will audit 3 new admission charts weekly for Influenza and Pneumococcal vaccine status weekly. The DON will report the findings of their weekly audits weekly to the QAPI committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5. DOC- 12/5/23	12/5/2023

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F 883	Continued From page 108 (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 influenza and pneumococcal vaccines for 5 residents (Residents #124, #125, #274, #275, and #276), in a survey sample of 5 residents reviewed for immunizations. The findings included: 1. The facility staff failed to provide education of the risks/benefits about influenza immunization, and offer flu vaccines for Residents #125, #274, #275, and #276. On 10/18/2023, clinical record reviews were performed and revealed the following: Residents #125, #274, #275, and #276, had no immunization information under the immunization tab of their clinical record. The miscellaneous tab and progress notes were reviewed, and revealed no evidence of the residents' immunization status regarding the flu	F 883		

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F 883	Continued From page 109 and had no evidence that education had been provided or the vaccine offered. On 10/19/2023 at 4:28 p.m., Surveyor C met with the Director of Nursing (DON), who was also the facility's Infection Preventionist. During the above interview, the DON was asked to access each of the residents' clinical records and identify their vaccine status regarding the flu. The findings were as follows: a. Resident #125 was admitted to the facility on 09/28/2023. The DON confirmed he had not been educated or offered the flu vaccine and his current immunization status was unknown. b. For Resident #274, who was admitted to the facility on 09/27/2023, there was no information regarding the flu vaccine noted. c. For Resident #275, the DON confirmed the resident was admitted to the facility on 09/27/2023. The DON also confirmed the resident's immunization status for flu was unknown, and they had not been educated nor offered the vaccine. d. For Resident #276, who was admitted to the facility on 09/22/2023, the facility had no information regarding the flu vaccine status, being educated, or offered the vaccine. 2. The facility staff failed to provide education of the risks/benefits about pneuococcal immunization, and offer pneumococcal vaccines for Residents #124, #125, #274, #275, and #276. On 10/18/2023, clinical record reviews were performed and revealed the following: Residents #124, #125, #274, #275, and #276,	F 883		

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F 883	Continued From page 110 had no immunization information under the immunization tab of their clinical record. The miscellaneous tab and progress notes were reviewed and revealed no evidence of the residents' immunization status regarding pneumonia vaccines, and had no evidence that education had been provided or the vaccine offered. On 10/19/2023 at 4:28 p.m., Surveyor C met with the Director of Nursing (DON), who was also the facility's Infection Preventionist. The DON accessed each of the residents' clinical records (Residents #124, #125, #274, #275, and #276), and confirmed they did not know the residents' pneumonia immunization status and had no evidence of the residents being educated and/or offered the vaccine. On 10/19/2023 at 4:28 p.m., the DON was asked, "Why is it important to know someone's immunization status?" The DON stated, "You want to know if they are protected from whatever, you don't want to administer a vaccine if they are allergic to it or have already had it, and because we live in a community lifestyle, we want to keep people as protected as possible." The DON stated on admission the facility should identify the resident's immunization status, educate them on vaccines, and offer any vaccines the resident is eligible for. The DON was asked to explain the process about immunizations. The DON stated, "I am the only one with access to the VIIS [Virginia Immunization Information System] system, so I do it in the first couple of days. I look to see their immunization status for COVID, pneumonia and	F 883		

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F 883	Continued From page 111	F 883		

flu. We are doing the flu vaccines right now." The DON also stated she has the flu vaccine in-house and on hand and can administer it when a resident requests and/or consents to it.

The facility policy titled, "Influenza Vaccination," was received and reviewed. Excerpts from this policy read as follows: "All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility will provide pertinent information about the significant risks and benefits of vaccine to staff and residents (or residents' legal representatives); for example, risk factors that have been identified for specific age groups or individuals with risk factors such as allergies or pregnancy. 1. Residents and employees of the long-term care facility will be offered the influenza vaccination upon initial admission to the nursing home in accordance with the guidelines set forth by the Center for Disease Control and/or ACIP [Advisory Committee on Immunization Practices]."

The Advisory Committee on Immunization Practices gives guidance in their document titled, "Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP)-United States, 2023-24." The recommendations read, ". Summary of Recommendations. Groups recommended for vaccination: Routine annual influenza vaccination is recommended for all persons aged = 6 months who do not have contraindications....Adults Aged = 65 Years: ACIP recommends that adults aged = 65 years preferentially receive any one of the

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F 883	Continued From page 112 following higher dose or adjuvanted influenza vaccines: quadrivalent high-dose inactivated influenza vaccine (HD-IIV4), quadrivalent recombinant influenza vaccine (RIV4), or quadrivalent adjuvanted inactivated influenza vaccine (aIIV4). If none of these three vaccines is available at an opportunity for vaccine administration, then any other age-appropriate influenza vaccine should be used." Accessed online at: https://www.cdc.gov/flu/pdf/professionals/acip/acip-2023-24-Summary-Flu-Vaccine-Recommendations.pdf The facility policy titled, "Pneumococcal Vaccine," was reviewed. The policy read, "1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 2. Residents of the long-term care facility will be offered the pneumococcal vaccination upon initial admission to the nursing home in accordance with the guidelines set forth by the Center for Disease Control and/or ACIP. 3. Before offering pneumococcal immunization, each resident or the resident's legal representative will receive education regarding the benefits and potential side effects of the immunization." On 10/19/2023 during an end of day meeting, the facility Administrator, Director of Nursing, and Corporate staff were made aware of the above findings. No further information was provided.	F 883		

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F 887	Continued From page 113	F 887	1. The facility educated and offered residents 125, 274, 275, and 276 the COVID vaccine per CDC guidelines. 2. All residents of the facility have the potential to be affected by this deficient practice. An audit of all active staff and residents to ensure that COVID-19 vaccines have been offered and documented in their personnel files. 3. In-service education to be provided by the DON to the all the staff of the facility on the importance of COVID-19 vaccinations and the potential risk and benefits of becoming fully vaccinated and up to date. 4. The facility ICP will audit 3 new hires weekly and all new admissions to ensure that they have been screened for vaccination status and have been offered education on COVID-19 vaccinations. The results of the weekly audits will be submitted monthly to the QAPI Committee monthly x 3 months. The QAPI committee is responsible for the on-going monitoring of compliance. 5. DOC- 12/5/23	12/5/2023
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the	F 887		

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F 887	Continued From page 114 benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide education and offer COVID-19 vaccines for 4 residents (Residents #125, #274, #275, and #276) in a survey sample of 5 residents reviewed for immunizations and 5 staff (Staff #1, #2, #3, #4 and #5). The findings included: 1. For Residents #125, #274, #275 and #276, the facility staff failed to provide COVID-19 immunization, to include education of risks/benefits about COVID-19 immunization. On 10/18/2023, a clinical record review was conducted of each of the residents' clinical charts. There was no information noted that indicated the	F 887		

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F 887	Continued From page 115 residents' current COVID-19 immunization status, no evidence they had been educated on the risk/benefits of immunization, and no evidence they had been offered the COVID-19 immunization. On 10/19/2023 at 4:28 p.m., an interview was conducted with the Director of Nursing (DON) who accessed the clinical records for Residents #125, #274, #275, and #276 and verified the findings. The DON confirmed there was no information regarding the residents' COVID-19 immunization status, nor any evidence of any education or offer to receive the COVID-19 immunization following admission to the facility. During a survey entrance conference, the facility's policy regarding COVID-19 immunizations was requested and received. A review of the facility policy entitled, "COVID-19 Vaccinations for Residents," was conducted. It stated under the subtitle, "Specific Procedures/Guidance," item 1, "Prior to admission, the facility will validate COVID-19 vaccination status. 2. Resident/resident representatives will be educated on: a. risks/benefits of COVID-19 vaccination...b. current CDC guidelines for vaccination of residents for COVID-19 and; c. Symptoms, risks and benefits associated with the COVID-19 virus. 3. Residents will be encouraged to accept COVID-19 vaccinations in accordance with CDC guidance.". The Centers for Disease Control and Prevention (CDC) document titled, "CDC COVID-19 Vaccination Program Provider Requirements and Support," dated 10/06/2023, gives guidance to providers. The document read, "On Monday, Sept. 11, 2023, the FDA took action authorizing	F 887		

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F 887	Continued From page 116 and approving the updated 2023-2024 monovalent XBB.1.5 variant mRNA COVID-19 vaccines by Moderna and Pfizer-BioNTech. On September 12, 2023, CDC recommended use of these updated 2023-2024 COVID-19 vaccines in all individuals ages 6 months and older. And, on October 3, 2023, FDA authorized the updated 2023-2024 monovalent XBB.1.5 variant Novavax COVID-19 Vaccine, Adjuvanted, which is recommended by CDC for use in individuals 12 years and older." Accessed online at: https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html#print The U.S. Food and Drug Administration (FDA) document titled, "Novavax COVID-19 Vaccine, Adjuvanted Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) Authorized for Individuals 12 Years of Age and Older," was accessed. It read, "On October 3, 2023, the Food and Drug Administration amended the emergency use authorization (EUA) of Novavax COVID-19 Vaccine, Adjuvanted to include the 2023-2024 formula. The Novavax COVID-19 Vaccine, Adjuvanted, a monovalent vaccine, has been updated to include the spike protein from the SARS-CoV-2 Omicron variant lineage XBB.1.5 (2023-2024 formula). The Novavax COVID-19 Vaccine, Adjuvanted (Original monovalent) is no longer authorized for use in the United States. Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is authorized for use in individuals 12 years of age and older as follows: Individuals previously vaccinated with any COVID-19 vaccine: one dose of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is administered at least 2 months after	F 887		

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F 887	Continued From page 117 receipt of the last previous dose of an original monovalent (Original) or bivalent (Original and Omicron BA.4/BA.5) COVID-19 vaccine. Individuals not previously vaccinated with any COVID-19 vaccine: two doses of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) are administered three weeks apart. Immunocompromised individuals: an additional dose of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) may be administered at least 2 months following the last dose of a COVID-19 vaccine (2023-2024 Formula). Additional doses of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) may be administered at the discretion of the healthcare provider, taking into consideration the individual's clinical circumstances. The timing of the additional doses may be based on the individual's clinical circumstances." Accessed online at: https://www.fda.gov/vaccines-blood-biologics/coronavirus-covid-19-cber-regulated-biologics/novavax-covid-19-vaccine-adjuvanted On 10/19/2023 during the end of day meeting, the facility Administrator, Director of Nursing and corporate staff were made aware of the findings. No further information was provided. 2. For facility Staff #1, #2, #3, #4, and #5, the facility staff failed to maintain documentation that staff were provided education on the risks/benefits of the COVID-19 vaccine and were offered the vaccine, or information on obtaining the vaccine. On 10/19/2023 at 4:28 p.m., an interview was conducted with the Director of Nursing (DON).	F 887		

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	495235	A. BUILDING _____ B. WING _____	10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSBURG POST ACUTE & REHABILITATION	1235 S MOUNT VERNON AVENUE WILLIAMSBURG, VA 23185

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F 887	Continued From page 118 The DON was given the names of the staff sample being reviewed for immunizations and asked to provide any evidence she had regarding their immunization status and education of immunization benefits and risks. On the morning of 10/20/2023, the DON provided Surveyor C with the staff immunization information she had on file. It included the following: a. For Staff #1, a copy of the staff's COVID-19 vaccination record card was provided that was emailed to the human resources director that morning. It indicated that Staff #1 had received 2 doses of a COVID-19 vaccine in 2021. There was no evidence of any education, offer, or information to obtaining COVID-19 booster vaccines. b. For Staff #2, a copy of the staff member's COVID-19 vaccine record card was submitted that indicated she had received 2 doses of the COVID-19 vaccine in 2021. There was no evidence submitted regarding education, offer, or information on how to obtain COVID-19 booster vaccines. c. For Staff #3, a copy of the staff member's COVID-19 vaccine record card was submitted that indicated she had received 2 doses of the COVID-19 vaccine in 2021. There was no evidence submitted regarding education, offer, or information on how to obtain COVID-19 booster vaccines. d. For Staff #4, a copy of the staff member's COVID-19 vaccine record card was submitted that indicated she had received 3 doses of the COVID-19 vaccine, with the last dose being	F 887		

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F 887	Continued From page 119 administered 03/18/2022. There was no evidence submitted regarding education, offer, or information on how to obtain COVID-19 booster vaccines. e. For staff #5, no information was submitted. In the early afternoon of 10/20/2023, the DON was asked to clarify if she had any additional information to show the employees had been educated on, offered, or given information on how to obtain the 2023-2024 Formula COVID-19 vaccine. The DON stated she had nothing further to submit. No facility policy regarding COVID-19 immunizations for facility staff was provided to the survey team. The Centers for Disease Control and Prevention (CDC) document titled, "CDC COVID-19 Vaccination Program Provider Requirements and Support," dated 10/6/23, gives guidance to providers. The document read, "On Monday, Sept. 11, 2023, the FDA took action authorizing and approving the updated 2023-2024 monovalent XBB.1.5 variant mRNA COVID-19 vaccines by Moderna and Pfizer-BioNTech. On September 12, 2023, CDC recommended use of these updated 2023-2024 COVID-19 vaccines in all individuals ages 6 months and older. And, on October 3, 2023, FDA authorized the updated 2023-2024 monovalent XBB.1.5 variant Novavax COVID-19 Vaccine, Adjuvanted, which is recommended by CDC for use in individuals 12 years and older." Accessed online at: https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html#print	F 887		

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F 887	Continued From page 120 The U.S. Food and Drug Administration (FDA) document titled, "Novavax COVID-19 Vaccine, Adjuvanted Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) Authorized for Individuals 12 Years of Age and Older" was accessed. It read, "On October 3, 2023, the Food and Drug Administration amended the emergency use authorization (EUA) of Novavax COVID-19 Vaccine, Adjuvanted to include the 2023-2024 formula. The Novavax COVID-19 Vaccine, Adjuvanted, a monovalent vaccine, has been updated to include the spike protein from the SARS-CoV-2 Omicron variant lineage XBB.1.5 (2023-2024 formula). The Novavax COVID-19 Vaccine, Adjuvanted (Original monovalent) is no longer authorized for use in the United States. Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is authorized for use in individuals 12 years of age and older as follows: Individuals previously vaccinated with any COVID-19 vaccine: one dose of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is administered at least 2 months after receipt of the last previous dose of an original monovalent (Original) or bivalent (Original and Omicron BA.4/BA.5) COVID-19 vaccine. Individuals not previously vaccinated with any COVID-19 vaccine: two doses of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) are administered three weeks apart. Immunocompromised individuals: an additional dose of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) may be administered at least 2 months following the last dose of a COVID-19 vaccine (2023-2024 Formula). Additional doses of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) may be	F 887		

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F 887	Continued From page 121 administered at the discretion of the healthcare provider, taking into consideration the individual's clinical circumstances. The timing of the additional doses may be based on the individual's clinical circumstances." Accessed online at: https://www.fda.gov/vaccines-blood-biologics/coronavirus-covid-19-cber-regulated-biologics/novavax-covid-19-vaccine-adjuvanted On 10/20/2023 during the end of day meeting, the facility Administrator, Director of Nursing and corporate staff were made aware of the findings. No further information was provided.	F 887		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility staff interview, and facility documentation review, the facility staff failed to ensure a functioning call bell was present for one resident (Resident #59) in a survey sample of 39 residents. The findings included: For Resident #59, the facility staff failed to ensure	F 919	1. Resident #59 resident call light was replaced. 2. All residents of the facility have the potential to be affected by this deficient practice. The Administrator/Designee will perform an audit of all resident's call lights and their function. Any malfunction call lights can have been replaced with fully functional call lights.	12/5/2023

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F 919	Continued From page 122 a call bell was present and functioning in the bathroom. On 10/17/2023 at 1:49 p.m., an interview was conducted with CNA B. CNA B was asked about the call bells, to explain their purpose, where they are located, etc. CNA B stated, "The call bell is how the residents let us know if they need something." On 10/18/2023 at 8:30 a.m., an interview was conducted with Resident #59. During this interview, Resident #59 said that her call bell in the bathroom does not work. She did acknowledge she has had falls previously in the bathroom. Surveyor C went to the bathroom and pulled the string/pull cord, which did not engage the call bell/light and auditory alarm for staff. Resident #59 reported the call bell had not worked for about a month, which was the length of time she had been in that room. On 10/18/2023, a clinical record review was conducted of Resident #59's chart. This review included a care plan revision dated 10/12/2023, which read, "The resident has an ADL [activities of daily living] self-care performance deficit AEB [as evidenced by] need for limited assist with ADL completion." One of the associated interventions read, "Encourage the resident to use bell to call for assistance." There was an additional care plan focus area with a revision date of 01/30/2023, that read, "The resident has had an actual fall with minor injury 12/2022. Additional risk related to sleep aid, incontinence with diuretic use, and polyneuropathy." The interventions for this focus area read, "Call bell within reach." Additional clinical record review was conducted,	F 919	3. The Administrator/Designee will in-service all staff on reporting and identifying malfunction call lights and equipment to Administrator/Designee. 4. The Administrator/Designee will audit call lights and their function weekly for 8 weeks. Any issues will be addressed immediately by Administrator/Designee and appropriate actions will be taken. The Administrator/Designee will identify and trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. DOC- 12/5/23	

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F 919	Continued From page 123 which included the review of progress notes and assessments. There was no indication that Resident #59 had sustained any recent falls in the bathroom related to the inability to call for assistance. Resident #59 was interviewed, and she said there was one time she needed to call for help to get off the toilet, but was unable to since the call bell would not work but had not fallen or had any injury as a result. On 10/19/2023 at approximately 2:00 p.m., Surveyors C and E, interviewed LPN G. LPN G said the call bell is used for the resident to alert facility staff if they need assistance. LPN G was asked to pull the cord of the call bell in Resident #59's bathroom and see if it would work. LPN G did and confirmed the call bell would not engage by pulling the string, which is how the resident would use the bell if sitting on the toilet and needed assistance. On 10/19/2023 at 2:15 p.m., the facility Administrator was made aware of the call bell not working in Resident #59's room, she went to the room with Surveyors C and E, and confirmed the findings. The Administrator stated that monthly call bells audits are conducted. On 10/19/2023 at 3:11 p.m., the Administrator provided call system monthly audit forms, which indicated the room's call lights were functioning properly. The form had the month and year and no date as to when the audit was completed. On the afternoon of 10/19/2023, the facility Administrator was observed working on the call bell in Resident #59's bathroom. The facility policy titled, "Answering the Call	F 919		

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F 919	Continued From page 124 Light," was provided and reviewed. The policy read, "The facility will maintain a functional call light system and will make all reasonable efforts to ensure timely responses to the resident's requests and needs. 7. Report all defective call lights to the licensed nurse and the maintenance promptly." No further information was received.	F 919		