STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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E 000	Initial Comments An unannounced Recertification survey was conducted on 9/25/22 through 9/29/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # YF5A11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/25/22 through 9/29/22. Event ID# YF5A11 . 1 of 27 complaint allegations was substantiated with deficiency, Intake NC00192252 1 of 27 complaint allegations was substantiated without deficiency, Intake NC00189709 25 of 27 complaint allegations were unsubstantiated, Intakes #NC00186410, NC00191666, NC00193136, NC00193211, NC00192697, NC00192386, NC00190569, NC00190078, NC00189630, NC00189002, NC00190920, NC00193552	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		10/25/22

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

Electronically Signed | 10/21/2022

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(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in

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F 623	Continued From page 2	F 623		

completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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F 623	Continued From page 3 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, family interview and staff interview, the facility failed to provide written notice of discharge to the resident or resident representative for a facility-initiated discharge to the hospital for 3 of 5 residents reviewed for hospitalization (Resident # 190. Resident #339 and Resident #192). 1. Resident #190 was admitted to the facility on 5/25/20 with diagnoses that included diabetes, hypertension, osteoarthritis and periprosthetic fracture of right knee. Resident #190 transferred back to hospital on 6/1/22. Review of nursing progress note dated 5/16/22, revealed Resident #190 was sent to the hospital for complaint of pain following a fall on 5/14/22 in her right knee. She was not able to bear weight on her right leg. Resident was evaluated by the nurse practitioner (NP). Order was received to send resident to DRH-ED for further evaluation on 5/16/22. Review of Nurse Practitioner note dated 6/1/22 revealed Resident #190 was sent to the hospital for new inability to straighten right leg at knee joint after extensive surgical procedure. Patient complains of extensive pain to lower one third of the incision particularly over tibial tuberosity. Plan to send patient to ER for urgent evaluation of displacement of the fracture repair. Review of the medical record revealed no written notice of transfer to the hospital was provide to the resident or resident representative or the ombudsman for the transfer on 5/16/22 or 6/1/22.	F 623	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The social workers completed a 30-day look back on resident transfers/discharges 10/10/2022 to ascertain that residents had received proper transfer discharge notices. there were 11 identified residents who did not receive proper notice. Letters were sent to the 11 identified residents and/or representatives 10/12/2022. The Administrator completed education with the social workers on the regulation as it relates to proper notice requirements for transfer/discharges. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Social Worker #1 will be responsible for sending notices out and Social Worker #2 will follow up on every transfer/discharge of residents as soon as identified and send the transfer/discharge notice to the appropriate resident representative and maintain a copy of the notice in Transfer/Discharge binder. Address what measures will be put in	

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F 623	Continued From page 4 A telephone interview was conducted on 9/26/22 at 1:54 PM, the daughter stated she had not received written notice of the transfer to hospital from the facility. The ombudsman was unavailable for interview. An interview was conducted on 9/28/22 at 12:56 PM, Social Worker #2 stated they were responsible for notifying resident/resident representative in writing of transfer to the hospital and notify the ombudsman monthly of any hospital admissions. Review of the social workers tracking system there was no ((NC Medical Emergency Transfer Letter) notification letter or appeals right form provided to the resident or family. There was no documentation on the May 2022 or June 2022 monthly notification to the ombudsman that included Resident #190. Social Worker #1 verified the ombudsman or family had not been informed in writing of the transfer for Resident #190. An interview was conducted on 9/28/22 at 1:30 PM, the Administrator stated the social workers was responsible for notifying the family via letter of any transfer/ discharges to the hospital and provide the appeals right form. The social workers were also responsible for sending a monthly list of residents to the ombudsman of any resident that transferred to hospital. 2. Resident #339 was readmitted to the facility on 4/27/22 with diagnoses that included metabolic encephalopathy, bipolar disorder, and malignant neoplasm of the liver and brain. Review of a nurse's note dated 5/24/22 revealed	F 623	place or systemic changes made to ensure that the deficient practice will not recur: Social Worker #2 will complete audits on hospital transfer/discharges weekly x 4 weeks and then monthly x 2 months. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The social workers will review the plan during monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee.	

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Resident #339 was sent to the hospital for evaluation due to worsening alert mental status.

Resident #339 was discharged to the hospital on 5/24/22 and did not return back to the facility. No written notice of transfer was documented to have been provided to the resident or resident representative.

During an interview on 09/28/22 at 2:54 PM, Social Worker (SW)#1 indicated they were responsible for notifying resident/resident representative in writing of transfer to the hospital and notify the ombudsman monthly of any hospital admissions. SW #1 stated she was unsure if a notification letter or appeals right form was sent to the resident's responsible party when the resident was transferred to the hospital in May 2022. SW further stated she was unable to find the documentation that indicated the resident's representative was notified in writing of the reason for transfer to the hospital. SW indicated a copy of transfer notice was sent to the ombudsman at the end of the month.

During an interview on 09/28/22 at 3:11 PM, the Administrator stated that notices of transfer/discharge should be sent to the resident and/or resident's representative when a resident was transferred to the hospital. The administrator further stated the Ombudsman was notified at the end of the month, in writing every time a resident was transferred or discharged from the facility. The Administrator indicated the social workers were responsible for notifying the family via letter of any transfer/ discharges to the hospital and provide the appeals right form.

3. Resident #192 was admitted to the facility on 6/21/21 with diagnoses that included diabetes

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F 623	Continued From page 6 and multiple fractures. He was discharged to the hospital on 5/4/22. A nurse progress note dated 5/4/22 revealed Resident #192 was sent to the hospital for evaluation of a change in condition. Resident #192 did not return to the facility after being transferred to the hospital. A review of the medical record revealed no written notice of discharge was provided to the resident or resident representative for Resident #192's hospital transfer on 5/4/22. During an interview with Social Worker (SW) #2 on 9/29/22 at 9:30 AM, he stated he was not working at the facility at the time of Resident #192's transfer to the hospital. SW #2 verified a written notification had not been provided to the resident or family. During an interview with the Administrator on 9/29/22 at 11:15 AM, she stated there was a transition period where there was not a SW during the time Resident #192 was transferred to the hospital. She stated the written notification was missed for Resident #192 and it should have been sent.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		10/25/22

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F 656	Continued From page 7 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews the facility failed to develop and implement an individualized person-center care	F 656	Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 656	Continued From page 8 plan for 1 of 1 resident reviewed for smoking (Resident #132). The findings included: Resident #132 was admitted to the facility on 8/25/22 with diagnoses including hypertension and diabetes mellitus. A smoking evaluation dated 8/26/22 revealed Resident #132 had been assessed as a safe smoker. An interview was conducted with Resident #132 on 9/28/22 at 11:15 AM. He stated when he entered the facility, he was a smoker. A review of care plans developed for Resident #132 revealed no care plan had been developed for smoking. On 9/28/22 at 11:25 AM an interview was conducted with the MDS Nurse. He stated Resident #132 was not coded for tobacco use and a care plan for smoking was not triggered. He stated a care plan for smoking should have been developed for Resident #132. The Administrator was interviewed on 9/29/22 and 11:09 AM and she stated Resident #132 should have been care planned for smoking.	F 656	practice: The MDS nurses initiated a care plan for smoking on 9/28/2022 for Resident #132. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The MDS nurses completed an audit on 9/28/2022 to identify residents that smoke and validate that the residents identified have a care plan. There were no other residents identified without a care plan for smoking. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Administrator provided education on 10/12/2022 for the MDS nurses regarding initiation of comprehensive care plans to reflect the residents care and needs. The MDS nurses will initiate and update comprehensive care plans within 21 days of admission, or when a change is identified that requires a care plan revision. The IDT team will review and update the care plans at least quarterly to reflect the current care and needs of the residents. Indicate how the facility plans to monitor	

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F 656	Continued From page 9	F 656	its performance to make sure solutions are sustained. The Quality Assurance nurse or designee will audit 5 residents charts a week for 4 weeks then 10 charts a month for 2 months to validate that comprehensive care plans are initiated and reflect the residents current needs and care. The Quality Assurance nurse or designee will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Quality Assurance nurse or designee will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge	F 661		10/25/22

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F 661	Continued From page 10 medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Rowland, Pamela E. Based on record review and staff interviews, the facility failed to complete a recapitulation of stay at the facility for 1 of 1 resident reviewed for discharges (Resident #191). Findings included: Resident #191 was admitted to the facility on 3/22/22 with diagnoses that included dementia and chronic kidney disease. Resident #191 ' s admission Minimum Data Set dated 3/28/22 coded her cognitively intact. The MDS coded the resident as required extensive assistance with most activities of daily living and having the expectation to be discharged to the community. Review of Resident #191 ' s closed record revealed she was discharged to another facility on 6/06/22. Further review of closed records revealed the facility failed to complete a recapitulation of Resident #191 ' s stays in the facility.	F 661	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The social workers completed an audit of transfers/discharges within the past 30 days and found 24 of 24 discharge summary assessments opened with 8 of 24 being incomplete. The administrator provided education on 10/13/2022 to the IDT on accuracy and completion of the Discharge summary assessment. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The social workers will follow up on every transfer/discharge of resident as soon as identified to be sure that the discharge summary is completed by the IDT team	

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F 661	Continued From page 11 On 9/28/22 at 4:28 PM an interview was conducted with the Director of Nursing, and she stated they had a virtual discharge meeting with the family and physician. She stated a recapitulation of stay was not completed for Resident #191.	F 661	and maintain copy in resident record Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Social Workers will complete weekly audits x 4 weeks; then monthly x 2 months. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The social workers will review the plan during monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		10/25/22

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F 688	Continued From page 12 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, and record review, the facility failed to apply a left hand palm guard for 1 of 1 resident reviewed for a range of motion (Resident #159). Findings included: Resident #159 was admitted on 4/21/22. A review of his Quarterly Minimum Data Set assessment, dated 8/30/22, indicated his intact cognition. Resident ' s diagnoses included left hand contracture and quadriplegia (paralysis of four limbs). Review of Resident 159 ' s plan of care, dated 7/15/22, revealed his limited physical mobility due to left hand contracture with appropriate goals and interventions, including splinting to the left upper extremity. Review of the physician ' s orders for Resident #159 revealed the order, dated 2/10/22, for palm guard to left upper extremity. The palm guard can be doffed daily for hygiene and reapplied post hygiene. Record review revealed the occupational therapy discharge summary, dated 2/10/22, indicated that Resident #159 was not receptive to wearing the left-hand splint. He will use the palm guard. The staff is to donn and doff left hand palm guard and provide hygiene daily. Resident #159 was able to doff the palm guard on his own. The occupational	F 688	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #159 was screened and treated by Occupational Therapist on 2/10/2022 to review range of motion and splinting. Order was written incorrectly in PCC so the order dropped off and was missed. The therapist discovered an erroneous order and it was discontinued. Chart was reviewed, therapist interviewed and resident should have been wearing palm guard. New order was obtained on 9/27/2022. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Rehab Director completed an audit on 9/27/2022. There were 17 residents were identified to have splints in place and care planned but order not written. All residents were evaluated and orders completed for resident current plan of care. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur:	

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	345434	A. BUILDING _____ B. WING _____	C 09/29/2022

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F 688	Continued From page 13 therapy staff trained the nursing staff to apply palm guard. Review of the Treatment Administration Records (TAR) for September 2022 revealed no documentation that Resident #159 received left hand palm guard applications. Records review of the nurses ' notes for September 2022 revealed no palm guard application documentation for Resident #159. On 9/25/22 at 10:15 AM, during the observation/interview, Resident #159 was in bed, well dressed and groomed. The resident did not have a palm guard on his left hand at the observation time. The resident was alert, oriented and indicated that he did not receive a palm guard today and could not recall when he used a palm guard last time. On 9/25/22, during the continuous observation from 11:55 AM to 3:15 PM, Resident #159 was in bed with no palm guard on his left hand. The resident confirmed that nobody applied it today. On 9/26/22, during the observation at 7:55 AM and 11:45 AM, Resident #159 was in bed with no palm guard on his left hand. The resident confirmed that nobody applied it today. On 9/26/22 at 11:10 AM, during an interview, Rehabilitation Director indicated that Resident #159 received occupational therapy for left hand contracture, including splinting, and was discharged to the Functional Maintenance Program on 2/10/22. The resident preferred to use a palm guard instead of a hand splint. The therapy staff trained the floor nurse to apply the	F 688	The Interim Director of Nursing provided education on 10/20/2022 for the licensed nurses and CNAs, regarding the Functional Maintenance program, which includes communication of the program and documentation. Newly hires nurses and CNAs will be educated during new hire orientation. When a resident has an order for a functional maintenance program, the nurse will write an order on the Functional Maintenance grid form and will communicate to the CNA regarding the program need and the CNA will document on the grid form. The Unit Coordinators will review all residents that are on the program monthly to assure the program remains appropriate and make recommendations/referral as necessary to reduce/maintain of improve function. Indicate how the facility plans to monitor its performance to make sure solutions are sustained The Unit Managers/QA Nurse will audit 10 residents weekly x 4 weeks, then 20 residents monthly for 2 months to validate that splinting and ROM is occurring and that the CNAs are documenting the ROM and splinting on the Functional Maintenance grid form. The Unit Managers/QA Nurse will review the audits monthly to identify patterns/trends and will adjust the plan as	

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F 688	Continued From page 14 palm guard on his left hand daily as tolerated and check the skin before and after the procedure. On 9/27/22 at 1:25 PM, during an interview, Nurse #10 indicated that Resident #129 had a left hand contracture and received a palm guard to his left hand. The nurse aides were responsible for daily palm guard application and monitoring of the skin condition. The nurses documented the left hand palm guard application in the TAR. Nurse #10 stated he did not check if Resident #159 received his left-hand palm guard today. On 9/27/22 at 1:45 PM, during an interview, Nurse Aide #2 indicated that she was assigned to work with Resident #159 this shift and was not aware of his palm guard application requirements. Nurse Aide #2 explained that she did not check the assignment at the beginning of the shift and missed the palm guard application for Resident #159. On 9/27/22 at 2:30 PM, during an interview, the Interim Director of Nursing indicated that the therapy department discharged residents to the Functional Maintenance Program and trained the nurse and nurse aides to continue the correct palm guard application regiment. The nurse aides could check the assignment sheet and clarify the palm guard application with the nurse. The nurse aide documented the palm guard applications in the Kiosk (computer) and reported if the resident refused it to the nurse. The nurses documented the palm guard application in the TAR. On 9/27/22 at 3:50 PM, during an interview, the Administrator expected the staff to follow the orders and plan of care for the splint/palm guard application and document it appropriately in the	F 688	necessary to maintain compliance. The Unit Managers/QA Nurse will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	

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F 688	Continued From page 15 TAR.	F 688		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the area surrounding the dumpster free of debris for 1 of 1 dumpster observed. The findings included: During an observation of the dumpster area on 9/26/22 at 1:23 PM one disposable glove, was in front of the dumpster and multiple plastic forks, spoons, straws/paper, Styrofoam ice cream cups were observed beside the dumpster. During an observation of the dumpster area on 9/27/22 at 8:13 AM 4-5 broken eggshells were observed under the front end of the dumpster. Multiple plastic forks, spoons, straws/paper, Styrofoam ice cream cups and assorted papers were observed beside and behind the dumpster. On 9/28/22 and on 9/29/22 the dumpster was observed to be in the same condition. In an interview on 9/29/22 at 9:26 AM the certified dietary manager indicated when the dumpster is picked up, it could be at mealtimes and kitchen staff are not available at that time to clean up the area. 09/29/22 09:31 AM the Corporate Clinical Consultant indicated staff normally kept the dumpster area clean and the area should be	F 814	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility's Maintenance Director cleaned around the dumpster area on 9/29/2022 to ensure that the area was free from garbage and refuse and items disposed of properly. The Administrator educated the Dietary Manager and Maintenance Director regarding keeping dumpster are clean and garbage and refuse disposed of properly on 9/29/2022. The Administrator educated the Housekeeping Department on 10/12/2022 of the importance of making sure that garbage is disposed of properly and the dumpster area is free of debris. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The residents were not affected by the alleged deficient practice. The	10/25/22

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F 814	Continued From page 16 clean.	F 814	Administrator reviewed the grievance log for the month of September 2022 and there were no grievances from residents related to the dumpster area. The was no evidence of a pest investation or sightings at the dumpster area. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Dietary Manager, Maintenance Director and/or Housekeeping Director will check the dumpster area 5 x week for 4 weeks then weekly x 2 months to ensure that the dumpster area remains free of debris and garbage is disposed of properly. Indicate how the facility plans to monitor its performance to make sure solutions are sustained The Dietary Manager, Maintenance director and/or Housekeeping Director will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		10/25/22

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F 867	Continued From page 17 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility's quality assurance (QA) program failed to implement, monitor, and revise as needed the action plan developed for the recertification surveys dated 3/5/20 and 8/12/21, complaint survey dated 12/14/21 in order to achieve and sustain compliance. This was for recited deficiencies on a recertification survey on 9/29/22. The deficiencies were in the areas of infection control policies and procedures, splint application, accuracy coding of the Minimum Data Set, and development of a care plan. The continued failure during federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: F880: Based on record review, observation, and staff interviews, the facility failed to implement the Centers for Disease and Prevention (CDC) guidelines for Personal Protective Equipment (PPE) when: 1) Nursing Assistant (NA) #20 exited a COVID positive resident ' s room (Resident #539) and failed to remove and discard her N95 mask and sanitize eye protection prior to entering a non-isolation room of a resident who was not COVID positive (Resident #540); and 2) Nurse #12 collected COVID-19 nasopharyngeal specimens while within 6 feet of the Director of Nursing without donning a gown. This was for 2 of 2 staff observed for infection control practices. The facility was in COVID-19 outbreak status. During the previous infection control survey on	F 867	F 641/656 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The MDS nurses initiated a care plan for smoking on 9/28/2022 for Resident #132. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The MDS nurses completed an audit on 9/28/2022 to identify residents that smoke and validate that the residents identified have a care plan. There were no other residents identified without a care plan for smoking. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Administrator provided education on 10/12/2022 for the MDS nurses regarding initiation of comprehensive care plans to reflect the residents care and needs. The Regional Director of Clinical services provided education on 10/19/2022 for the QAPI team consisting of the	

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F 867	Continued From page 18 12/14/21, the facility failed to follow CDC guidance regarding the use of Personal Protective Equipment (PPE) for counties of high and substantial county transmission rates when Nurse #1 failed to wear eye protection when observed assisting 1 of 1 resident with feeding, when Nurse Aide (NA) #1 and NA #2 failed to wear eye protection when observed transferring 1 of 1 resident from the chair to the bed using the mechanical lift, and when NA #1 and Nurse #2 were observed assisting 1 of 1 resident with incontinent care. These practices had the potential to affect all residents who received care from the nursing staff. During the previous infection control survey on 4/9/20, the facility failed to maintain social distancing for 11 residents on the memory care unit, and residents in the common area. This failure occurred during the COVID-19 pandemic. F688: Based on observations, resident interviews, staff interviews, and record review, the facility failed to apply a left-hand palm guard for 1 of 1 resident reviewed for a range of motion (Resident #159). During the previous annual recertification survey on 3/5/20, the staff failed to apply a right-hand splint for 1 of 2 residents reviewed for a range of motion. F641: Based on record review, staff, and resident interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident reviewed for smoking (Resident #132). During the previous annual recertification survey on 8/12/21, the facility failed to accurately code the Minimum Data Set (MDS) for 5 of 35 residents reviewed.	F 867	Administrator, Director of Nursing, QA Nurse, MDS Coordinators, Social Workers, Activities Director, Unit Managers regarding QAPI; how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance. The MDS nurses will initiate and update comprehensive care plans within 21 days of admission, or when a change is identified that requires a care plan revision. The IDT team will review and update the care plans at least quarterly to reflect the current care and needs of the residents. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The Quality Assurance nurse or designee will audit 5 residents charts a week for 4 weeks then 10 charts a month for 2 months to validate that comprehensive care plans are initiated and reflect the residents current needs and care. The Quality Assurance nurse or designee will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Quality Assurance nurse or designee will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	

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F 867	Continued From page 19 F656: Based on record review, staff, and resident interviews, the facility failed to develop and implement an individualized person-center care plan for 1 of 1 resident reviewed for smoking (Resident #132). During the previous annual recertification surveys on 8/12/21, the facility failed to develop a care plan in the areas of smoking and CPAP (continuous positive airway pressure) management for 2 of 35 residents reviewed, and on 3/5/20, the facility failed to develop a care plan for nutrition for 2 of 5 residents, reviewed for nutrition. During an interview on 09/29/22 at 12:00 PM, the Administrator indicated that all the citations would be reviewed, and a plan of correction would be put in place. The administrator continued that the Quality Assistance and Assurance (QAA) committee met regularly, identified areas of concern, conducted the root cause analysis, created the plan of correction, and discussed the outcome. The Interdisciplinary Team will continue monitoring until the deficient area concerns will be resolved.	F 867	F Tag 880 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Administrator provided education on 9/25/2022 for NA #20 regarding changing N95 mask and disinfecting eyewear after a COVID 19 resident encounter. No negative effects for Resident #539 were identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents have the potential to be affected by the alleged deficient practice of failure to properly don an N95 and disinfecting eyewear after COVID 19 resident encounter. No negative effects was identified. The Administrator, Director of Nursing and Unit Managers will complete education for all staff by October 17, 2022 regarding the proper donning and doffing of N95 mask and disinfecting eyewear after a COVID 19 resident encounter. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Regional Director of Clinical services provided education on 10/19/2022 for the	

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F 867	Continued From page 20	F 867	QAPI team consisting of the Administrator, Director of Nursing, QA Nurse, MDS Coordinators, Social Workers, Activities Director, Unit Managers regarding QAPI; how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance. The Director of Nursing, and Unit Managers will observe 10 staff members weekly x 4 weeks, then 20 staff members monthly x 2 months to validates that staff members are donning and doffing PPE and disinfecting eyewear appropriately after each COVID 19 resident encounter. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The Director of Nursing will review the plan during monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Administrator provided education to Nurse #12 on 9/29/2022 regarding the proper PPE use when performing nasopharyngeal testing. There were no negative effects for staff tested for Nurse #12 not wearing a gown while performing nasopharyngeal test.	

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F 867	Continued From page 21	F 867	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Staff and residents have the potential to be affected by the alleged deficient practice for gown not being worn while performing nasopharyngeal testing. No negative effects were identified. The Administrator and Director of Nursing completed education for all staff who perform nasopharyngeal testing by October 20, 2022 on proper PPE to wear during testing to include gloves, gown, and eyewear. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur The Director of Nursing and Unit Managers will observe 10 staff tests weekly x 4 weeks, then 20 staff test monthly x 2 months to validate that testing staff are wearing appropriate PPE. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The Director of Nursing will review the plan monthly during the QAPI meeting, and the audits will continue at the discretion of the QAPI committee.	

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F 867	Continued From page 22	F 867	F Tag 688 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #159 was screened and treated by Occupational Therapist on 2/10/2022 to review range of motion and splinting. Order was written incorrectly in PCC so the order dropped off and was missed. The therapist discovered an erroneous order and it was discontinued. Chart was reviewed, therapist interviewed and resident should have been wearing palm guard. New order was obtained on 9/27/2022. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Rehab Director completed an audit on 9/27/2022. There were 17 residents were identified to have splints in place and care planned but order not written. All residents were evaluated and orders completed for resident current plan of care. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Interim Director of Nursing provided education on 10/20/2022 for the licensed nurses and CNAs, regarding the Functional Maintenance program, which	

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F 867	Continued From page 23	F 867	includes communication of the program and documentation. Newly hires nurses and CNAs will be educated during new hire orientation. The Regional Director of Clinical services provided education on 10/19/2022 for the QAPI team consisting of the Administrator, Director of Nursing, QA Nurse, MDS Coordinators, Social Workers, Activities Director, Unit Managers regarding QAPI; how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance. When a resident has an order for a functional maintenance program, the nurse will write an order on the Functional Maintenance grid form and will communicate to the CNA regarding the program need and the CNA will document on the grid form. The Unit Coordinators will review all residents that are on the program monthly to assure the program remains appropriate and make recommendations/referral as necessary to reduce/maintain of improve function. Indicate how the facility plans to monitor its performance to make sure solutions are sustained The Unit Managers/QA Nurse will audit 10 residents weekly x 4 weeks, then 20 residents monthly for 2 months to validate that splinting and ROM is occurring and that the CNAs are documenting the ROM and splinting on the Functional	

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F 867	Continued From page 24	F 867	Maintenance grid form. The Unit Managers/QA Nurse will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Unit Managers/QA Nurse will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. All the above mentioned F tags will be reviewed for a 6 month period of time in monthly QAPI meeting to assure continued compliance	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		10/25/22

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	345434	A. BUILDING _____ B. WING _____	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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F 880	Continued From page 25	F 880		

arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 26 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to implement the Centers for Disease and Prevention (CDC) guidelines for Personal Protective Equipment (PPE) when: 1) Nursing Assistant (NA) #20 exited a COVID positive resident ' s room (Resident #539) and failed to remove and discard her N95 mask and sanitize eye protection prior to entering a non-isolation room of a resident who was not COVID positive (Resident #540); and 2) Nurse #12 collected COVID-19 nasopharyngeal specimens while within 6 feet of the Director of Nursing without donning a gown. This was for 2 of 2 staff observed for infection control practices. The facility was in COVID-19 outbreak status. Finding Included: The facility COVID-19 policy read in part, "This facility shall follow current guidelines and recommendations to ensure the facility is prepared to respond to the threat of COVID-19". 1.) Resident #539 tested positive for COVID-19 on 9/15/22. Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic Guidance updated 9/23/22 recommends "Healthcare personnel who enter the room of a patient with suspected or confirmed	F 880	The Administrator provided education on 9/25/2022 for NA #20 regarding changing N95 mask and disinfecting eyewear after a COVID 19 resident encounter. No negative effects for Resident #539 were identified. Current facility residents have the potential to be affected by the alleged deficient practice of failure to properly don an N95 and disinfecting eyewear after COVID 19 resident encounter. No negative effects was identified by review of resident testing. The Administrator, Director of Nursing and Unit Managers completed education for all staff on October 17, 2022 regarding the proper donning and doffing of N95 mask and disinfecting eyewear after a COVID 19 resident encounter. The Director of Nursing, and Unit Managers will observe 10 staff members weekly x 4 weeks, then 20 staff members monthly x 2 months to validates that staff members are donning and doffing PPE and disinfecting eyewear appropriately after each COVID 19 resident encounter.	

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F 880	Continued From page 27 COVID-19 infection adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gowns, gloves, and eye protection". Also, "During the care of a patient with SARS-CoV-2 infection, facemask should be removed and discarded after the patient care encounter and a new one should be donned". The county transmission level was high as indicated by the COVID-19 Data Tracker on 9/24/22. On 09/25/22 at 12:20 PM an observation was made of NA #20 entering Resident #539 ' s room with gown, gloves, and eye protection on. Signage was noted on Resident #539 ' s door and instructed staff to wear gown, gloves, eye protection and an N95 mask before entering the room. On 9/25/22 at 12:25 PM, NA #20 was observed exiting Resident #539 ' s room with a N95 mask and eye protection. The gown had been removed before exiting into the hallway. She was observed performing hand hygiene and then knocking on Resident #540 ' s door, a room not requiring full PPE. She did not enter Resident #540 ' s room. An interview was conducted with NA #20 on 9/25/22 at 12:26 PM and she stated she went into Resident #539 ' s room to put a gown on him. She stated she saw the sign on the door but did not know if the resident was COVID positive or just on isolation. She stated she was unaware she needed to change her mask and sanitize her eye protection when exiting a resident room who had tested positive for COVID-19.	F 880	The Director of Nursing will review the plan during monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee. The Administrator provided education to Nurse #12 on 9/29/2022 regarding the proper PPE use when performing nasopharyngeal testing. There were no negative effects for staff tested for Nurse #12 not wearing a gown while performing nasopharyngeal test. Staff and residents have the potential to be affected by the alleged deficient practice for gown not being worn while performing nasopharyngeal testing. No negative effects were identified. The Administrator and Director of Nursing completed education for all staff who perform nasopharyngeal testing on October 20, 2022 on proper PPE to wear during testing to include gloves, gown, and eyewear. The Director of Nursing and Unit Managers will observe 10 staff tests weekly x 4 weeks, then 20 staff test monthly x 2 months to validate that testing staff are wearing appropriate PPE. The Director of Nursing will review the plan monthly during the QAPI meeting, and the audits will continue at the discretion of the QAPI committee.	

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On 9/25/22 at 12:28 an observation was made of PPE hanging on Resident #539 ' s door to include N95 mask, gowns, gloves, and disposable stethoscopes.

2.) The CDC guidance entitled, "Interim Guidance for Collecting, Handling, and Testing Clinical Specimen for COVID-19," updated 7/15/22 stated for healthcare providers collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain, and use recommended PPE, which includes an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a gown.

An observation of COVID-19 staff testing took place on 9/29/22 at 10:30 AM. Nurse #12 was observed performing hand hygiene and putting on gloves. She was wearing a N95 mask and eye protection. Nurse #12 was observed conducting a nasopharyngeal swab on the Director of Nursing (DON). Nurse #12 was not wearing a gown and was standing within 6 feet of the DON. She was observed taking off her gloves and performing hand hygiene. No gowns were observed in the testing area.

Nurse #12 was interviewed on 9/29/22 at 10:33 AM. She was asked if she was aware a gown was required while performing a nasopharyngeal swab and while within 6 feet of the staff member. Nurse #12 indicated she was aware a gown was required, and she was unable to explain why she had not donned the gown when collecting the specimen for the DON.

A second interview was conducted with the Nurse

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F 880	Continued From page 29 #12 on 9/29/22 at 10:52 AM. She stated she was nervous, and she knew she was supposed to be wearing a gown while performing nasopharyngeal.	F 880		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)	F 888		10/25/22

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F 888	Continued From page 30 (1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;	F 888		

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(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

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F 888	Continued From page 32 Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop policies and procedures that required new hires to be fully vaccinated for COVID-19. The facility ' s policy indicated that new hires were required to have received a minimum of the first does of a two-dose COVID-19 vaccine series prior to providing any care, treatment, or other services for the facility or its residents. This deficient practice had the potential to affect all 188 residents at the facility. Finding Included: The facility ' s "Covid-19 Vaccine" policy dated 12/28/21 read in part, "All facility staff are required to be fully vaccinated by the regulatory deadline (NC-reference QSO-22-07-ALL) [a CMS memo outlining staff COVID-19 vaccination requirements]. New hires will be subject to the same requirements as current staff and must have received, at a minimum, the first dose of a two-dose COVID-19 vaccine or a one-dose COVID-19 vaccine by the regulatory deadline or prior to providing any care, treatment, or other services for the facility and/or residents."	F 888	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Regional Clinical Director provided education on 9/29/2022 for the Administrator, Administrator assistant, and Director of Nursing regarding the revised QSO for COVID-19 vaccine, that reflects that staff must be fully vaccinated or have an approved medical or religious exemption prior to providing any care, treatment or services for the facility or its residents. The facility policy 'Covid-19 Vaccine" was revised on 10/18/2022 to reflect the current regulation that requires facility staff to be fully vaccinated for Covid019 or have an approved medical or religious exemption prior to providing any care, treatment or services for the facility or its residents. Address how the facility will identify other	

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F 888	Continued From page 33 A review of the facility ' s COVID-19 Staff Vaccination Matrix revealed the facility met the staff vaccination requirement. An interview was held with the Administrator on 9/29/22 at 11:18 AM and she was unable to explain why their COVID-19 Vaccine policy did not align with the regulation. She indicated that the facility had still met the requirement for staff vaccinations.	F 888	residents having the potential to be affected by the same deficient practice: Facility residents were at risk. Facility staff were fully vaccinated at time of survey and continues to be fully vaccinated. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The facility policy "Covid-19 Vaccine" was revised on 10/18/2022 to reflect the current regulation that requires facility staff to be fully vaccinated for Covid-10, or have an approved medical or religious exemption prior to providing care, treatment or services for the facility staff or its residents. The Regional Clinical Director provided education on 9/29/2022 for the Administrator, Administrator assistant, and Director of Nursing regarding the revised QSO for COVID-19 vaccine, that reflects that staff must be fully vaccinated or have an approved medical or religious exemption prior to providing any care, treatment or services for the facility or its residents. Indicate how the facility plans to monitor its performance to make sure solutions are sustained The Administrator or Administrator	

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F 888	Continued From page 34	F 888	Assistant will audit/validate for 3 months, that new hires are fully vaccinated or has an approved medical or religious exemption prior to providing any care, treatment or services for the facility or its residents. The Administrator or Administrator assistant will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator or Administrator assistant will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	