STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345315	A. BUILDING _____ B. WING _____	C 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF LUMBERTON	1170 LINKHAW ROAD LUMBERTON, NC 28358

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unnanounced recertification and complaint investigation survey was conducted on 05/22/2023 through 05/25/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3IF411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/22/2023 through 05/25/2023. Event ID# 3IF411. The following intake was investigated NC00201303. 3 of the 3 allegations did not result in deficiency.	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 (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	F 623		5/26/23

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

Electronically Signed | 06/18/2023

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F 623	Continued From page 1	F 623		

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 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

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F 623	Continued From page 2 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 § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and Ombudsman interview the facility failed to notify the Regional Ombudsman of discharge to the hospital for 2 of 2 residents reviewed for discharge (Resident #34, Resident # 41).	F 623	Social Worker notified Ombudsman via email on 5/25/2023 of Residents #34 and #41 discharges. Any resident that discharges to the	

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F 623	Continued From page 3 The findings included: 1. Resident #34 was admitted 1/18/23 and discharged to the hospital on 1/24/23. An interview on 5/25/23 at 1:20 PM, the Social Worker (SW) stated she did not notify the Regional Ombudsman of Resident #34's discharge to the hospital on 1/24/23. She stated she was not sure if was the Business Office Managers' or her responsibility to notify the Regional Ombudsman. An interview on 5/25/23 at 1:26 PM the Human Resources staff stated she did not send any list to the Ombudsman; she thought the Social Worker did. An interview on 5/25/23 at 1:36 PM the Regional Ombudsman revealed she had not been receiving a list of residents who were sent to the hospital. An interview on 5/25/23 at 1:58 PM the Administrator stated he thought Human Resources was sending the resident list to the Ombudsman every month. An interview on 5/25/23 at 3:30 PM the Admission Coordinator stated that she reviewed her emails and had no record the Ombudsman received notification of residents sent out to the hospital. 2. Resident #41 was admitted to the facility on 12/22/22 and discharged to the hospital on 03/25/23. Record review revealed no documentation that	F 623	hospital has the potential to be affected. Social Worker completed a 100% audit dating back to facility opening on 12/14/2023 and notified Ombudsman via email on 5/25/2023 of all facility resident discharges. LNHA and Social Worker met with facility Ombudsman on 5/25/2023 regarding her policy on facility notification of discharges and noted she wants discharges sent to her once per month. Social worker and/or designee will notify ombudsman via email once per month of all facility resident discharges. Social worker and/or designee will monitor monthly for two months that ombudsman receives facility discharges via email. Results will be taken to QAPI to determine compliance. Completion Date: 5/26/23	

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F 623	Continued From page 4 the Ombudsman was notified of Resident 41's discharge to the hospital on 03/25/23. An interview on 05/25/23 at 1:20 PM, the Social Worker stated she did not notify the Regional Ombudsman of Resident #41's discharge to the hospital on 03/25/23. She stated she was not sure if it was the Business Office Manager or her responsibility to notify the Regional Ombudsman. An interview on 05/25/23 at 1:26 PM the Human Resources staff stated she did not send any list to the Ombudsman regarding residents discharged to the hospital. She stated she thought the Social Worker did. An interview on 05/25/23 at 1:36 PM the Regional Ombudsman revealed she had not been receiving a list of residents who were discharged to the hospital. An interview on 05/25/23 at 1:58 PM the Administrator stated he thought Human Resources was sending the resident list to the Ombudsman every month. An interview on 05/25/23 at 3:30 PM the Admission Coordinator stated she reviewed her emails and had no record the Ombudsman received notification of residents discharged to the hospital.	F 623		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 636		5/26/23

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functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the

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F 636	Continued From page 6 timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete comprehensive assessments within the 14-day required timeframe for 3 of 15 residents (Resident #17, Resident #42, and Resident #5) reviewed for comprehensive Minimum Data Set (MDS) assessments. Findings included: 1. Resident #17 was admitted to the facility on 04/28/2023. Resident #17's admission MDS dated 05/04/2023 was completed on 05/15/2023. An interview with the MDS Nurse was conducted on 05/25/2023 at 1:25 P.M. The MDS Nurse stated that she got behind completing the MDS assessments when she was the interim Director of Nursing (DON). She stated the current DON was hired in February and she had not had a chance to catch the assessments up to date yet.	F 636	MDS Coordinator completed a 100% audit of scheduled comprehensive assessments to ensure timely completion on 5/25/2023. All facility residents have the potential to be affected. MDS Coordinator educated by LNHA on 5/25/2023 regarding timely completion of comprehensive assessments within the 14 days required timeframe. Director of Nursing and/or designee will monitor comprehensive assessments completed weekly for 2 weeks and monthly for 2 months to ensure timely completion within 14 days required timeframe. Results will be taken to QAPI to determine compliance. Completion Date: 5/26/23	

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An interview was conducted with the DON on 05/25/2023 at 3:35 P.M. The DON stated the MDS Nurse was the interim DON until she was hired in February. She further stated the MDS Nurse had gotten behind with the MDS assessments and she was trying to get them submitted within the required timeframe.

2. Resident #42 was admitted to the facility on 02/01/2023. Resident #42's admission MDS dated 02/09/2023 was completed on 02/28/2023.

An interview was conducted with the MDS Nurse on 05/25/2023 at 1:25 P.M. The MDS stated that she got behind completing the MDS assessments when she was the interim DON. She stated the current DON was hired in February and she had not had a chance to catch the assessments up to date yet.

An interview was conducted with the DON on 05/25/2023 at 3:35 P.M. The DON stated the MDS Nurse was the interim DON until she was hired in February. She further stated the MDS Nurse had gotten behind with the MDS assessments and she was trying to get them submitted within the required timeframe.

3. Resident #5 was admitted to the facility on 01/21/2023. Resident #5's admission MDS dated 01/30/2023 was completed on 02/20/2023.

An interview with the MDS Nurse was conducted on 05/25/2023 at 1:25 P.M. The MDS Nurse stated that she got behind completing the MDS assessments when she was the interim Director of Nursing (DON). She stated the current DON was hired in February and she had not had a chance to catch the assessments up to date yet.

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F 636	Continued From page 8 An interview was conducted with the DON on 05/25/2023 at 3:35 P.M. The DON stated the MDS Nurse was the interim DON until she was hired in February. She further stated the MDS Nurse had gotten behind with the MDS assessments and she was trying to get them submitted within the required timeframe.	F 636		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Medical Director, and Psychiatrist interviews, the facility failed to initiate psychiatric services according to the level 2 PASRR (Preadmission Screening Resident Review - a required screening to ensure residents with serious mental illness, intellectual,	F 644	Resident #1 was evaluated by Psych-FNP on 5/27/2023. Any resident that admits to the facility with a Level II PASARR has the potential to be affected.	5/27/23

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F 644	Continued From page 9 or developmental disabilities received appropriate placement and services) for 1 of 3 residents (Resident #1) reviewed for PASRR compliance. Findings included. Resident #1 was admitted to the facility on 01/23/23 with diagnoses including Schizophrenia and Bipolar. Review of the Level 2 PASRR determination notification dated 02/01/23 revealed that based on the evaluation and recommendations Resident #1 was to receive specialized psychiatric services provided by a psychiatrist. The Minimum Data Set (MDS) admission assessment dated 02/25/23 revealed Resident #1 was cognitively intact. She was currently considered by the state level II PASRR process to have serious mental illness. She exhibited no physical or verbal behaviors, and no rejection of care. A care plan dated 02/25/23 revealed Resident #1 had a Level C PASRR. (Level C PASRR requires specialized services to be provided to the resident). The goal of care was Resident #1 would be maintained at the highest potential mental and functional level, and to prevent avoidable decline. Interventions included to administer medications as ordered. Observe changes in mental or physical status, and update the physician as needed. The PASRR level would be re-evaluated as indicated and resident's needs will be met. Provide Psychiatric services as recommended by the physician. Resident #1 would receive the services needed.	F 644	Social worker and Director of Nursing educated on 5/25/2023 by LNHA regarding PASARR and Assessments related to Level 2 PASARR. Social Worker completed a facility wide audit on 5/25/2023 of all resident's with a Level 2 PASARR to ensure coordination of any required services completed. Social worker to provide DON and/or designee a copy of the PASARR LEVEL II recommendation for implementation. Director of Nursing and/or designee to monitor new admissions with level 2 PASARRs weekly for two weeks and monthly for two months. Results will be taken to QAPI to determine compliance. Completion Date: 5/27/23	

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F 644	Continued From page 10	F 644		

During an interview on 05/23/23 at 12:05 PM the Minimum Data Set (MDS) nurse stated Resident #1 was to receive specialized psychiatric services due to having a level C PASRR requirement and a diagnosis of mental illness. She stated Resident #1 had not been receiving psychiatric services since admission and thought it was due to the consent form that had not been signed for Resident #1 to receive services by their psychiatric provider.

During an interview on 05/23/23 at 12:30 PM the Social Worker stated she was in charge of managing the PASRR process at the facility. She stated Resident #1 had not received specialized psychiatric services since admission due to the psychiatric provider notifying the facility that the appropriate consent to treat had not been signed by Resident #1 or her Responsible Party (RP). The Social Worker stated Resident#1's RP signed a consent form on admission for her to receive mental health services. She stated she didn't understand why the consent was insufficient for the psychiatric provider and psychiatric services should have been provided to Resident #1 upon PASRR notification on 02/1/23. She stated consent forms to provide physician and mental health services at the facility were obtained by the Admission Coordinator upon admission.

During an interview on 05/24/23 at 1:09 PM the Admission Coordinator stated Resident #1's RP signed the provider agreement to receive psychiatric services on 01/23/23.

During an interview on 05/24/23 at 1:00 PM the Medical Director stated he routinely evaluated Resident #1. He stated her mood was stable, and

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F 644	Continued From page 11 she would eventually be seen by their psychiatric provider but stated Resident #1 had no behaviors that warranted an immediate need for psychiatric services. A phone interview was conducted on 05/24/23 at 2:27 PM with the Psychiatrist. She stated she was just informed on Friday 05/19/23 through email that Resident #1 along with other residents needed to be evaluated. She stated it was never communicated to her scheduler that Resident #1 needed an evaluation and therefore she was not aware until 05/19/23. She stated Resident #1 not being evaluated sooner was due to miscommunication. During an interview on 05/25/23 at 12:30 PM Resident #1 indicated she did not know if she had spoken to a psychiatrist since she had been in the facility. During an interview on 05/25/23 at 1:28 PM the Director of Nursing (DON) stated she was not aware of the specialized services that were required by PASRR for Resident #1. She stated she would begin reviewing PASRR requirements with the Social Worker. She stated Resident #1 should have received psychiatric services according to her PASRR determination.	F 644		
F 758 SS=E	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:	F 758		6/17/23

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F 758	Continued From page 12	F 758		

(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 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

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THE CARROLTON OF LUMBERTON	1170 LINKHAW ROAD LUMBERTON, NC 28358

(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 758	Continued From page 13 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Consultant Pharmacist and Psychiatrist interviews, the facility failed to 1.a) provide an indication for an antipsychotic medication (Thiothixene-prescribed for treatment of Schizophrenia) b) complete an Abnormal Involuntary Movement Scale (AIMS) assessment which is used for medication monitoring to assess for side effects of antipsychotic medications for 1 of 5 residents (Resident #41). 2) Include a stop date for an as needed psychotropic medication for 1 of 5 residents (Resident # 42) reviewed for unnecessary medications. Findings included. 1.a) Resident #41 was admitted to the facility on 12/22/22 with diagnoses including mood disorder, depression, cognitive communication deficit, and failure to thrive. The hospital discharge summary dated 12/22/22 for Resident #41 revealed Thiothixene 2 milligram (mg) capsules, take 4 mgs by mouth every night-patient reported medication. There was no diagnosis listed for this medication on the hospital discharge summary. A review of the physician orders for Resident #41 revealed an order dated 12/22/22 for Thiothixene (antipsychotic) capsules. Give 4 milligrams (mg) by mouth at bedtime for Mood. The Minimum Data Set (MDS) admission assessment dated 12/28/22 revealed Resident	F 758	AIMS for Resident #41 completed by MDS Coordinator on 5/25/2023. Indication for antipsychotic medication for resident #41 completed by 6/16/2023. Stop date on Psych med for Resident #42 completed by DON on 5/25/2023. All facility residents on an antipsychotic medication has the potential to be affected. DON and MDS Coordinator educated on 5/25/2023 on AIMS completion requirements for residents on Antipsychotics. DON educated on 5/25/2023 related to stop dates required for pysch medications by Clinical Nurse Consultant. Facility licensed nurses were educated on 6/1/23 and 6/3/23. MDS Coordinator completed 100% facility audit of all residents on antipsychotics to ensure each had an AIMS assessment on 5/25/2023. DON completed an audit of all residents on psych medications to ensure stop dates were in place on 5/25/2023. MDS Coordinator and/or designee to monitor all new admissions that admit on an antipsychotic will have an AIMS completed weekly for two weeks and monthly for two months. Results will be taken to QAPI to determine compliance. DON and/or designee will monitor all new	

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F 758	Continued From page 14 #41 had moderately impaired cognition and required extensive two-person assistance with activities of daily living (ADLs). She had no behaviors and no rejection of care. She received an antipsychotic medication on 7 of 7 days during the assessment period. A care plan dated 01/05/23 revealed Resident #41 was at risk for adverse reactions related to Polypharmacy (use of multiple medications to treat a condition). The goal of care included to remain free of adverse drug reactions. Interventions included in part; the physician and Consulting Pharmacist would review for: duplicate medications or prescriptions, proper dosing, timing and frequency of administration, adverse reactions, and supporting diagnosis. The monthly Medication Regimen Review (MRR) dated 02/25/23 conducted by the Consultant Pharmacist revealed a note sent to the physician stating Resident #41 received the antipsychotic medication, Thiothixene. The current diagnosis was for "mood", the recent psychiatric consult did not address this other than stated this was prescribed for mood/depression. Per the manufacturer, the labeled indication is for Schizophrenia, and off label for BPSD (Behavioral and Psychological Symptoms of Dementia (BPSD-refers to the spectrum of non-cognitive and non-neurological symptoms of dementia, such as agitation, aggression, psychosis, and depression). This is an older high potency antipsychotic and carries a greater risk for side effects such as EPS (extrapyramidal side effects-drug induced movement disorders). Please add the supporting diagnoses to the medical record. The Psychiatric providers note dated 03/13/23 in	F 758	pysch medication orders weekly for two weeks and monthly for two months to ensure stop dates. Results taken to QAPI to determine compliance. Completion Date: 6/17/23	

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response to the MRR conducted on 02/25/23 revealed, no changes at this time. Resident (#41) was only seen by the Psychiatrist twice. Will continue to evaluate and follow up with the family for additional background to determine if the medication is needed.

The Psychiatrist evaluation note dated March 2023 read in part; Resident #41 had a diagnosis of Depression and was prescribed Wellbutrin (antidepressant) and Thiothixene (antipsychotic). Resident #41 denied any new or worsening mood symptoms. Thiothixene, an antipsychotic was prescribed with no history of schizophrenia noted during chart review. Will continue to evaluate the need for Thiothixene. No changes today.

A review of Resident #41's electronic medical record on 05/24/23 revealed no additional supporting diagnoses was added for the use of the antipsychotic medication Thiothixene.

During an interview on 05/24/23 at 1:12 PM the Consultant Pharmacist stated she sent a recommendation with the monthly MRR dated 02/25/23 with recommendations to the provider regarding CMS (Centers for Medicare & Medicaid) guidelines stating that medications should be supported by an indication for use and to add the supporting diagnoses for the antipsychotic medication Thiothixene. She stated the Psychiatrist did address the recommendation that was sent on 02/25/23 by stating she would continue to evaluate the resident but indicated no supporting diagnosis was added. The Consultant Pharmacist stated at this time Resident #41 remained on Thiothixene daily which could potentially be an unnecessary medication without a supporting diagnosis.

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During a phone interview on 05/24/23 at 2:54 PM the Psychiatrist stated she had evaluated Resident #41 on five occasions since her admission in December 2022. She stated she made several attempts to contact Resident#41's Responsible Party (RP) to discuss the indication for Thiothixene but has had no response from the RP. She stated she did not want to discontinue the medication until she determined why and how long Resident #41 had been receiving it since she had been on the medication prior to admission to the facility and to the hospital. She stated she was scheduled to evaluate Resident #41 next week and would continue to try and contact the RP.

During an interview on 05/25/23 at 1:00 PM the Director of Nursing (DON) stated she received the monthly pharmacy reviews sent by the Consultant Pharmacist and indicated she was responsible for addressing the recommendations for nursing and the additional recommendations were forwarded to the providers. She stated she thought the Psychiatrist had addressed the Pharmacy Consultants recommendations and stated she was not aware that the Psychiatrist could not get in touch with the Residents RP to get more information on why she was on Thiothixene. She stated Resident #41's RP visited the facility regularly and she would contact the RP to get additional information that was needed and would communicate with the Psychiatrist. She indicated due to the family being in the facility regularly they should have followed up with the RP by this point to determine why the resident was on this medication.

b) A review of the physician orders for Resident

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#41 revealed an order dated 12/22/22 for Thiothixene (antipsychotic) capsules. Give 4 milligrams (mg) by mouth at bedtime for Mood.

A review of Resident #41's electronic medical record from 12/22/22 through 05/24/23 did not indicate any information regarding the completion of an AIMS assessment since admission to the facility.

During an interview on 05/23/22 at 10:51 AM Nurse #5 stated she was recently assigned to Resident #41's hall and had not observed any abnormal movements related to receiving an antipsychotic medication. She indicated she had not completed an AIMS assessment for Resident #41. She indicated the nurse, or the Director of Nursing completed AIMS assessments.

During an interview on 05/24/23 at 1:12 PM the Consultant Pharmacist stated the AIMS assessment was part of medication monitoring. She stated a baseline AIMS assessment was usually completed upon admission and then repeated in 6 months. If the dosage was increased or a new antipsychotic was added, then a new AIMS assessment would be required. She stated she sent a recommendation on last months (April) MRR to complete an AIMS assessment and thought the assessment should be completed by now.

During an interview on 05/25/23 at 1:00 PM the Director of Nursing (DON) stated an AIMS assessment should have been completed soon after admission to establish a baseline and then should be repeated every 6 months. She indicated she or the residents assigned nurse would complete the AIMS assessment. She

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indicated the facility just reopened 6 months ago and there was work to be done to get processes in place including ensuring AIMS assessments were completed. She indicated it was an oversight.

2) Resident #42 was admitted to the facility on 2/1/2023 with diagnoses which included dementia with behavioral disturbance and anxiety disorder.

A Physician's order dated 04/28/2023 for lorazepam (a medication to treat anxiety) 2milligram (mg) per milliliter (ml) % gel. Apply to inner wrist topically every 8 hours as needed for anxiety/agitation without a stop date.

Record review of the Medication Administration Record (MAR) for May 2023 revealed Resident #42 was administered lorazepam on 5/1/23 at 12:33 AM, 5/4/23 at 7:13 AM, 5/5/23 at 7:18 AM, 5/17/23 at 4:55 PM, 5/18/23 at 7:51 AM, 5/19/23 at 11:01 AM, 7/22/23 at 7:30 AM, 5/23/23 at 3:21 AM.

Review of the admission Minimum Data Set (MDS) assessment dated 02/09/2023 revealed Resident #42 was severely cognitively impaired, and he had received an antianxiety medication for 5 days during the assessment period.

Review of Resident # 42's care plan initiated

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F 758	Continued From page 19 02/01/2023 revealed a plan of care for antianxiety medication with the goal for resident to be free from discomfort or adverse reactions to anti-anxiety therapy through the review date. Interventions included administering antianxiety medications as ordered by the physician and monitoring for side effects and effectiveness every shift. An interview was conducted with the Pharmacy Consultant on 05/24/23 at 10:36 A.M. The Pharmacy Consultant stated she was aware that as needed psychotropic medications required a stop date. She further stated that she had addressed the medication not having a time specified duration on the medication regimen review (MRR) provided to the facility dated 04/28/2023. The Pharmacy Consultant stated she expected the MRR recommendations to be addressed by the time the of the next review date (approximately 30 days). She stated in the case of a psychotropic medication not having a stop date the recommendation should be addressed sooner than 30 days. An interview was conducted with the Director of Nursing (DON) on 05/25/23 at 3:40 P.M. The DON stated the process breakdown was the nursing staff should have double checked for a stop date and caught that it did not have a stop date.	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	F 761		5/26/23

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F 761	Continued From page 20 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and Pharmacy Consultant interviews the facility failed to store controlled substances in a permanently affixed compartment of the refrigerator in the only medication storage room currently in use at the facility. Findings included: An observation of the locked medication storage room was conducted with the Director of Nursing (DON) on 05/23/2023 at 1:16 P.M. The refrigerator was not locked and contained 1 small metal box locked with a small padlock and it was not permanently affixed to the refrigerator and 1 small metal box locked with a small padlock	F 761	Maintenance Director affixed box in the medication refrigerator on 5/25/2023. All residents with refrigerated controlled medictions could have been affected. LNHA and DON educated on affixed compartment on 5/25/2023 by facility Pharmacist. LNHA and/or designee will monitor to ensure box is still affixed weekly for two week. Results taken to QAPI to determine compliance. Completion Date: 5/26/23	

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attached and it was permanently affixed to the refrigerator. The small metal box that was not permanently affixed contained a single dose of liquid lorazepam (an antianxiety medication) intramuscular (IM)/intravenous (IV) 2 milligram (mg) per milliliter (ml). The DON stated the small metal box that was not permanently affixed to the refrigerator contained a controlled medication for a specific resident and the key was kept by the nurse on the 300 Hall. She further stated the permanently affixed small metal box contained the facility's emergency controlled medications that needed to be kept in the refrigerator, and the key was locked in the emergency medication supply machine located in the storage room. The DON indicated the medications in the facility's emergency controlled medication box were not for specific residents and did not need to be counted by the nursing staff because the machine kept track of who accessed and removed the medications.

An interview with Nurse #1 was conducted on 05/23/2023 at 2:07 P.M. Nurse #1 confirmed the key to the small metal box that was not affixed to the refrigerator was in her possession on the key ring that also contained the keys to the medication cart on her hall. She further stated that controlled substances were counted at the change of shift between the nurse going off shift and the nurse coming on shift, and this included counting the controlled medication in the unsecured medication box in the refrigerator.

An interview with Nurse #2 was conducted on 05/24/2023 at 10:24 A.M. Nurse #2 stated each morning the night shift nurse and the day shift nurse checked the metal box and confirmed the controlled medication was in the box.

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Review of the Facility's Controlled Medication log for controlled medications verified the controlled medications were counted and documented every shift by 2 nurses.

An interview was conducted with the Pharmacy Consultant on 05/24/2023 at 10:40 A.M. The Pharmacy consultant stated that the controlled medication in the metal box that was not secured to the refrigerator was for a specific resident. She further stated that the emergency medication supply machine located in the medication storage room was not set up to dispense medications for specific residents. The Pharmacy Consultant stated that the key to the metal box that was not secured was kept by the nursing staff to make it easier for them to access the medication when it was needed for that specific resident. She further stated the facility's emergency controlled medications that needed to be refrigerated were kept in the locked permanently secured box in the refrigerator, and they were accessed by requesting that specific medication. The Pharmacy Consultant indicated the vial of lorazepam that was kept in the metal box that was not secured to the refrigerator was double locked by the door to the medication storage room and the lock on the metal box and this was done based on the Pharmacy's interpretation of the regulation for controlled medication storage.

An interview with the DON was conducted on 05/25/2023 at 3:18 P.M. The DON stated that she had verbalized concerns with the Pharmacy regarding the controlled medication process. She further stated that the metal box was now permanently affixed to the refrigerator.

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F 842	Continued From page 23	F 842		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		6/4/23

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F 842	Continued From page 24 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to maintain an accurate Medication Administration Record (MAR) for 1 of 16 residents (Resident #205). Findings included: Resident #205 was admitted to the facility on 05/23/2023 with diagnoses to include chronic	F 842	Nurse educated immediately on 5/25/2023 regarding appropriate documentation requirements by DON. Nurse called MD and pharmacy on 5/25/2023 to ensure medication was on hold and would be at the facility on 5/25/2023.	

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F 842	Continued From page 25 obstructive pulmonary disease (COPD) and chronic kidney disease. Review of the admission orders dated 05/23/2023 for Resident #205 revealed an order for Incruse Ellipta inhalation aerosol powder breath activated 62.5 micrograms (mcg) (Umeclidinium Bromide) 1 puff inhale orally one time a day related to COPD. There was not a Minimum Data Set (MDS) assessment completed for Resident #205 because he was a new admission. An observation of Nurse #1 administering medications to Resident #205 was conducted on 05/25/2023 at 09:06 AM. Resident #205 was not administered an inhaler during the observation. Review of Resident #205's May 2023 MAR revealed Incruse Ellipta inhalation aerosol powder breath activated 62.5 mcg (Umeclidinium Bromide) 1 puff inhale orally one time a day related to COPD was documented as given by Nurse #1 on 05/24/2023 and 05/25/2023. An interview was completed with Nurse #1 on 05/25/2023 at 12:21 P.M. Nurse #1 stated Resident #205 was not administered the Ellipta inhaler this morning (05/25/2023) or yesterday morning (05/24/2023) because it had not been delivered by the pharmacy yet. She further stated that she didn't know why she had documented on the MAR that the Ellipta was administered to Resident #205. Nurse #1 indicated that she had documented in error that the Ellipta inhaler was administered. An interview was conducted with the Director of Nursing (DON) on 05/25/2023 at 3:25 P.M. The	F 842	All residents have the potential to be affected. DON educated all nurses regarding appropriate medication documentation and policy on 6/1/23 and 6/3/23. DON and/or designee will monitor one resident's MAR at random once weekly for 2 weeks and monthly for two months. Results taken to QAPI to determine compliance. Completion Date: 6/4/23	

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F 842	Continued From page 26 DON stated Nurse #1 should not have documented on the MAR that the Ellipta inhaler was administered to Resident #205. She further indicated that a medication was not supposed to be signed off by the nurse unless it was given.	F 842		
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 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;	F 880		6/4/23

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F 880	Continued From page 27 (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 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to follow the manufacturer's guidelines for cleaning and disinfection of a blood glucose meter which was	F 880	Nurse was educated immediately on 5/25/2023 regarding appropriate cleaning of a blood glucose meter by DON. Resident #205 received resident specific	

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F 880	Continued From page 28 stored in the medication cart after use for 1of 1 resident observed for blood glucose monitoring (Resident #205). Findings included: Review of the facility's policy "Blood Glucose (Sugar) Monitoring" implemented December 2022, read in part to "follow manufacturer's directions for use and care of the glucose meter." The blood glucose meter manufacturer's instructions for cleaning and disinfecting the meter revised August 2015, indicated the blood glucose meter could only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. The meter should be cleaned and disinfected after use on each patient. The instructions listed Environmental Protection Agency (EPA) registered wipes that had been tested and approved for cleaning and disinfecting the blood glucose glucometer. The instructions further read the wipes listed had been shown to be safe for use with the monitor, and to read the wipes manufacturer's instructions prior to using. An observation of the 300 Hall medication cart occurred on 05/25/2023 at 09:05 A.M. There were 2 containers of disinfectant wipes on the medication cart, one container's indication for use was on hands and the other container of wipes was for use on hard nonporous surfaces. The container for hand sanitizing wipes read in part that they do not kill fungi or viruses and were for sanitizing hands. The other container of wipes was indicated for use on hard nonporous surfaces. The container indicated the wipes were EPA approved to kill viruses and disinfect hard	F 880	blood glucose meter on 5/25/2023. DON completed facility audit of blood glucose meters on nurses carts and removed on 5/25/2023. DON provided all resident's requiring a blood glucose meter, their specific meter placed in their room. DON educated all licensed nurses on appropriate cleaning of a blood glucose meter on 5/25/2023, 6/1/2023, and 6/3/2023. DON and/or designee will monitor a nurse at utilize a blood glucose meter and cleaning once weekly for two weeks and then once monthly for two months. Results taken to QAPI to determine compliance. Completion Date: 6/4/23	

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F 880	Continued From page 29	F 880		

nonporous surfaces and the required "contact time" (the amount of time the object needs to remain wet after cleansing with wipe) was 2 minutes.

An observation on 05/25/2023 at 09:06 A.M. of Nurse #1 revealed she gathered the necessary supplies, went into Resident #205's room and obtained his blood sugar. She exited the room and returned to the medication cart in the hall. Nurse #1 was observed to remove a hand sanitizing wipe from the container and proceed to wipe down the glucometer for approximately 30 seconds and then placed it on a tissue to air dry.

An interview with Nurse #1 was completed on 05/25/2023 at 10:29 A.M. Nurse #1 stated there were no other residents who required blood sugars obtained on her shift. She further stated that the other diabetic residents had their own blood glucose monitoring kit and glucometer. Nurse #1 indicated that she learned to use hand sanitizing wipes on glucometers and to let it dry for 3-5 minutes at another facility she previously worked for.

An interview with the Director of Nursing (DON) occurred on 05/25/2023 at 10:39 A.M. The DON confirmed the other residents with a diagnosis of diabetes on the 300 Hall had their own personal glucometers. She further stated that the glucose monitoring kits with glucometers were kept in the medication storage room. The DON stated that Resident #205 should have had his own glucometer kit since he was admitted on 05/23/2023. She further stated that the facility policy was for the glucometers to be cleaned per manufacturer's instructions. The DON indicated that the breakdown in the process was probably

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F 880	Continued From page 30 just a lack of education for infection control on the part of Nurse #1. She stated that Nurse #1 had been educated on Infection Control polies when she was in orientation prior to having an assignment on the floor. The DON further stated that Nurse #1 needed to be reeducated on the facility's infection control policies.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		6/24/23

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F 883	Continued From page 31 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to administer the pneumococcal vaccine after obtaining informed consent for 4 of 5 residents (Resident #7, #6, #1, #16) and offer and obtain consent for 1 of 5 residents (Resident #24) reviewed for immunizations. Findings included. A review of the facility's "pneumococcal vaccine" policy revised 09/14/22 read in part; each resident would be assessed for pneumococcal immunization upon admission. Each resident	F 883	Resident's #7,6,1,16 were scheduled on 6/16/2023 for the administration of the pneumococcal vaccine by 6/24/2023. Consent was obtained for Resident #24 on 6/16/2023. All residents have the potential to be affected. Facility wide audit completed on 6/16/2023 by medical records designee.	

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F 883	Continued From page 32 would be offered a pneumococcal immunization unless it was medically contraindicated, or the resident had already been immunized. A pneumococcal vaccine was recommended for all adults 65 years and older, and for adults 19 to 64 years old who had certain chronic medical conditions including in part; heart disease, lung disease, renal failure, diabetes, or other risk factors. a. Resident #7 was admitted to the facility on 04/07/23 with diagnoses including dementia, renal disease, and hypertension. A review of Resident #7's medical record revealed a vaccine consent form was signed on 04/07/23 authorizing Resident #7 to receive the pneumococcal vaccine. The Minimum Data Set (MDS) admission assessment dated 04/13/23 revealed Resident #7 had moderately impaired cognition. She was over the age of 65 and the pneumococcal vaccine was not up to date and was not offered. A review of Resident #7's medical record on 05/25/23 did not indicate any information regarding the administration of the pneumococcal vaccine or any contraindication in receiving the vaccine. b. Resident #6 was admitted to the facility on 01/20/23 with diagnoses including heart failure, diabetes, and lung disease. A review of Resident #6's medical record revealed a vaccine consent form was signed on 01/20/23 authorizing Resident #6 to receive the pneumococcal vaccine.	F 883	DON educated all licensed nurses appropriate policy on administering pneumococcal vaccine and consent for residents on 6/1/2023 and 6/3/2023. Newly admitted residents will be educated and assessed for eligibility of pneumococcal vaccine. All residents will be re-educated and assessed annually. DON and/or designee will monitor compliance for pneumococcal immunization administration and consent on all new admissions for two weeks and monthly for two months. Results taken to QAPI to determine compliance. Completion Date: 6/24/23	

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F 883	Continued From page 33	F 883		

The Minimum Data Set (MDS) admission assessment dated 01/27/23 revealed Resident #6 was cognitively intact. She was not over the age of 65 but had chronic medical conditions including heart disease, lung disease, and diabetes. The pneumococcal vaccine was not up to date and was not offered.

A review of Resident #6's medical record on 05/25/23 did not indicate any information regarding the administration of the pneumococcal vaccine or any contraindication in receiving the vaccine.

During an interview on 05/25/23 at 12:00 PM Resident #6 stated she signed a vaccine consent form on admission and had not received the pneumococcal vaccine but would have if she was eligible.

c. Resident #1 was admitted to the facility on 01/23/23 with diagnoses including vascular disease, multiple sclerosis, and malnutrition.

A review of Resident #1's medical record revealed a vaccine consent form was signed on 01/23/23 authorizing Resident #1 to receive the pneumococcal vaccine.

The Minimum Data Set (MDS) admission assessment dated 02/25/23 revealed Resident #1 was cognitively intact. She was not over the age of 65 but had chronic medical conditions and the pneumococcal vaccine was not up to date and was not offered.

A review of Resident #1's medical records on 05/25/23 did not indicate any information

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F 883	Continued From page 34	F 883		

regarding the administration of the pneumococcal vaccine or any contraindication in receiving the vaccine.

During an interview on 05/25/23 at 12:30 PM Resident #1 stated she did not recall getting any vaccine at this facility. She indicated she would receive the pneumococcal vaccine if it was offered.

d.Resident#16 was admitted to the facility on 03/17/23 with diagnoses including diabetes.

A review of Resident #16's medical record revealed a vaccine consent form was signed on 03/17/23 authorizing Resident #16 to receive the pneumococcal vaccine.

The Minimum Data Set (MDS) admission assessment dated 03/24/23 revealed Resident #16 was cognitively impaired. He was 64 years old with a chronic medical condition. The pneumococcal vaccine was not up to date and was not offered.

A review of Resident #16's medical record on 05/25/23 did not indicate any information regarding the administration of the pneumococcal vaccine or any contraindication in receiving the vaccine.

e. Resident #24 was admitted to the facility on 02/02/23 with diagnoses including heart failure, renal disease, and lung disease.

A review of Resident #24's medical record revealed a vaccine consent form dated 03/08/23 with Resident #24's name on it was signed by a facility representative but was not signed by the

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F 883	Continued From page 35	F 883		

resident or the RP (Responsible Party).

The Minimum Data Set (MDS) admission assessment dated 02/08/23 revealed Resident #24 was cognitively intact. She was over the age of 65 and the pneumococcal vaccine was not up to date and was not offered.

A review of Resident #24's medical records on 05/25/23 did not indicate any information regarding the administration of the pneumococcal vaccine or any contraindication in receiving the vaccine.

During an interview on 05/25/23 at 12:45 PM Resident #24 stated her family member was in charge of her medical decisions but stated she would have taken the pneumococcal vaccine if it had been offered to her.

An interview was conducted on 05/25/23 at 1:17 PM with the Director of Nursing (DON). She stated she was also the Infection Control Nurse and was responsible for ensuring residents received their immunizations. She stated she was aware that the pneumococcal vaccines for some of the residents were not up to date. She stated she began working at the facility in February 2023 and was in the process of catching up the pneumococcal immunizations. She stated they were currently working on ways to improve their process to determine which residents were up to date, and if they were eligible to receive the vaccine and then making sure they provided the vaccine to the residents. She stated vaccine consent forms were obtained by the Admissions Coordinator on admission and the consents were given to her. She would then get the vaccine sent from Pharmacy and get a second consent form

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F 883	Continued From page 36 signed by the resident or their RP and provide education before administering the vaccine. She stated she had not had enough time to determine who needed the vaccine and get the pneumococcal vaccines up to date for those residents who were eligible. She stated more work needed to be done to improve the process.	F 883		