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	345342	A. BUILDING _____ B. WING _____	C 03/29/2023

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted from 3/20/2023 to 3/29/2023. The facility was found in compliance with the requirement CFR 483.75, Emergency Preparedness. Event ID # G07511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey were conducted from 3/20/2023 to 3/29/2023. The following intakes were investigated: NC00196415 and NC00192541. 1 of 3 allegations resulted in a deficiency. Intake NC00192541 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.12 at tag F610 at scope and severity L The tag F610 consituted Substandard Quality of Care. The Immediate Jeopardy began on 2/16/2022 was removed on 3/25/2023. An extended survey was conducted. The Statement of Deficiencies was amended on 4/17/23; F610 was deleted and tag F607 was added.	F 000		
F 607 SS=L	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		3/29/23

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

Electronically Signed | 04/19/2023

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F 607	Continued From page 1 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, Police Department Detective, resident and staff interviews the facility failed to implement their abuse policies and procedures by failing to immediately initiate preventative and protective measures to safeguard all residents from exploitation and misappropriation of property when the facility became aware of an allegation of the Social Services Coordinator exploiting 2 residents at the Assisted Living Facility (ALF) operated by the same company and on the same campus as the skilled nursing facility (SNF). There was a high likelihood of misappropriation of property and/or exploitation leading to the loss of financial resources and irreplaceable personal belongings	F 607	1. The facility completed a mandatory in-service for 100% Big Elm employees on March 24, 2023 regarding misappropriation and exploitation of a resident. Employees who have not completed the in-service by April 26, 2023 will not be allowed to work their next scheduled day until they complete the required training. The facility reviews this information for all new employees at orientation. The facility administrator has been in-serviced by the executive director on March 24, 2023 on conducting	

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for all 45 residents who resided in the SNF. These losses would cause a reasonable person severe psychosocial harm with feelings of hopelessness, despair, anger, anxiety, humiliation, shame and/or embarrassment.

Immediate Jeopardy began on 2/16/2022, when the facility failed to immediately implement measures to protect all residents from exploitation and misappropriation when they discovered the Social Services Coordinator had misappropriated property from 2 ALF residents who resided on the same campus. The Immediate Jeopardy was removed on 3/25/2023 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of F (no actual harm with potential for more than minimal harm that is not immediate Jeopardy) to ensure education and monitoring systems put into place are effective.

Findings included:

The Facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy Statement, which was reviewed and revised on 3/2018, indicated, in part, the facility will ensure all residents are protected from the possibility of abuse or the potential for further abuse. The policy further indicated that needed investigations will be conducted with residents' safety as the foremost concern in order to protect the resident from future harm.

A Personnel Change Form dated 7/6/2021 indicated the Social Services Coordinator was promoted from her Medication Aide position at the

investigations related to the facility misappropriation and documentation required to show efforts with aspects of the investigation to include interviewing residents and documentation.

On March 28, 2023 the Administrator has completed an audit of current employee background checks to identify if there are any other Department Managers who may have been promoted and have a criminal history that may warrant concern and address accordingly.

2. The facility completed a mandatory in-service for all Big Elm employees on March 24, 2023 on misappropriation and exploitation of a resident. Employees who have not completed the in-service by April 26, 2023 will not be allowed to work their next scheduled day until they complete the required training. The facility reviews this information for all new employees at orientation.

3. The facility administrator has been in-serviced by the executive director on March 24, 2023 on conducting investigations related to the facility misappropriation and documentation required to show efforts.

4. The non-compliance referenced in the 2567L was an atypical situation. Administrator has reviewed investigative efforts and process including comprehensive supportive documentation and reporting requirements with the QAPI Committee. Any future investigations of

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F 607	Continued From page 3 ALF to the Social Services Coordinator position at the Skilled Nursing Facility. An observation on 3/20/2023 at 9:30 am revealed the skilled nursing section of the facility was 0.3 miles from the assisted living section of the facility and both were located on the same campus. The Administrator was interviewed on 3/21/2023 at 2:08 pm and stated the Social Services Coordinator was hired as a Medication Aide (MA) at the facility's ALF on 5/4/2021 and was promoted to the Social Services Coordinator position at the SNF on 7/6/2021. The Administrator stated the employees from the SNF and the ALF could work at both facilities. The Administrator stated the Director of Nursing (DON) received a phone call on 2/16/2022 from a resident who resided at the ALF and the resident told the DON the Social Services Coordinator had taken a $50 gift card and had not returned it. The Administrator stated she and DON spoke with the Social Services Coordinator about the card because staff members were not allowed to take money or gift cards from residents, and they were not allowed to shop for residents. The Administrator stated they began an investigation and interviewed the residents of the ALF on 2/17/2022. The Administrator stated on 2/17/2022 another resident at the ALF reported she gave her bank card and pin number to the Social Services Coordinator and there was money missing from her personal bank account. The Administrator stated they called the police on 2/17/2022. An interview was conducted with the Director of Nursing (DON) on 3/21/2023 at 1:23 pm and she stated that on 2/16/22 one ALF resident reported	F 607	allegations of misappropriations will be reviewed by the Administrator and/or Executive Director to assure a proper investigation was documented. Furthermore, the Social Worker will interview five alert and oriented residents monthly for allegations or signs of misappropriation and/or exploitation for a period of twelve months. Results of these interviews will be documented on a QA Audit tool and reported to the Administrator and any concerns will be addressed immediately. The QAPI Committee will include any future investigations as a continuous area of focus indefinitely during QAPI meetings.	

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that the Social Service Coordinator had taken their $50 gift card. She reported that on 2/17/22 the facility became aware of another ALF resident who had money taken from personal bank account by the Social Service Coordinator.

During a follow up interview with the DON on 3/23/2023 at 3:40 pm, she stated she and the Administrator had interviewed a few of the residents at the Skilled Nursing Facility (SNF), but not all the residents that were cognitively intact when they realized two residents from the ALF had money misappropriated. The DON also stated they did not document which residents were interviewed and she could not remember who she had interviewed. The DON provided a census for 2/16/2022 with the names of residents of the SNF with the alert and oriented residents highlighted but she was not able to state which residents were interviewed. The census had 45 residents listed and 25 residents were highlighted as alert and oriented.

On 3/23/2023 at 3:05 pm a follow up interview was conducted with the Administrator, and she stated they had interviewed some of the residents of the SNF and she thought she had interviewed 3 residents at the SNF, but they had not documented which residents were interviewed. The Administrator stated she thought the DON and Resident Care Coordinator had assisted with interviewing the SNF residents. The Administrator stated they had interviewed only the residents that they thought the Social Services Coordinator had visited.

On 3/23/2023 at 3:20 pm an interview was conducted with the Resident Care Coordinator who stated after the ALF resident reported the

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Social Services Coordinator took her $50 gift card another ALF resident came to her and reported the Social Services Coordinator had her bank card and pin number and money was missing from her account. The Resident Care Coordinator stated the second resident from the ALF had about $200 dollars withdrawn from her bank account. The Resident Care Coordinator stated she did not remember anyone interviewing the residents at the SNF after the Social Services Coordinator was terminated on 2/16/2022 and she had not assisted with resident interviews at the SNF.

The Executive Director (ED) of the facility was interviewed by phone on 3/22/2023 at 1:46 pm and he stated he was the Administrator at the time the Social Services Coordinator was hired for a Medication Aide position at the facility's ALF. The ED stated the facility had completed a background check for the Social Services Coordinator on 5/4/21 that had shown she had felony charges in the past of felony to obtain property under false pretense, felony of forgery, felony of robbery with dangerous weapon, felony identity theft, and felony conspiracy. He also stated the charges were over 10 years old, and the Social Services Coordinator had explained the charges were due to a domestic situation.

On 3/23/2023 at 5:47 pm the Administrator provided a Plan of Correction for Misappropriation of Property indicated to be for the SNF and ALF (per the Administrator) which began on 2/16/2022. The Administrator stated the facility had not interviewed all the residents that were alert and oriented and had not notified the responsible parties of residents that were cognitively impaired. The Administrator also

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revealed the facility did not do any ongoing monitoring because the Social Services Coordinator was terminated. She explained the facility felt there wasn't anything to monitor after the termination occurred. The plan of correction provided by the Administrator stated the facility had investigated and substantiated a misappropriation of resident property by an employee, the Social Services Coordinator, involving two ALF residents. The employee in question was terminated because of the investigation. As a corrective action the facility conducted education on Abuse, Neglect and Misappropriation of Property with all staff. The in-service was conducted on 3/1/2022 by the Staff Educator and was attended by all staff. The Staff Educator reinforced resident's rights and what constitutes Misappropriation as well as the obligation to report any suspected misappropriation. The facility provided the in-service attendance records for the abuse education which was conducted on 3/1/2022. The facility did not provide audits for monitoring of residents for abuse or misappropriation, or interviews with the residents who resided in the SNF when the misappropriation was reported on 2/16/2022.

A news article from the Salisbury Post dated 8/28/2022 indicated the former Social Services Coordinator from the facility was arrested for 3 counts of felony exploitation of an elder or disabled adult and 1 count of felony identity theft after a 6-month investigation. The Social Services Coordinator allegedly withdrew $45,000 from Resident #15' life savings over a period of several months while the Social Services Coordinator was living in Resident #15's house. The article indicated Resident #15 was a SNF

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resident.

On 3/21/23 at 1:12pm an interview was conducted with Resident #15 who resided at the SNF. She verified the Social Services Coordinator had exploited and stole thousands of dollars from her. She stated the Social Services Coordinator had tricked her into giving her account information. Resident #15 also stated she did not know if the Social Services Coordinator took the money from her account before or after she was terminated from the facility.

The Nurse Aide Registry reviewed on 3/23/23 indicated the following:

The Social Services Coordinator had 1 substantiated finding(s) of Fraud Against a Resident, which occurred while the individual was employed in a Nursing Facility. This information was entered on the Registry on 01/25/2023.

The Social Services Coordinator had 1 substantiated finding(s) of Misappropriation of Resident Property, which occurred while the individual was employed in a Nursing Facility. This information was entered on the Registry 01/25/2023.

The Social Services Coordinator had 1 pending investigation(s) for an allegation of Fraud Against a Resident and 1 pending investigation(s) of Misappropriation of Resident Property.

During an interview with the Detective from the Kannapolis Police Department on 3/28/2023 at 5:39 pm he stated the Social Services Coordinator was arrested and charged with

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Exploitation of a Disabled or Elderly Adult for taking funds from Resident #15's private bank account. The Detective stated the Social Services Coordinator had coerced Resident #15 into allowing her to live in her home and the Social Services Coordinator obtained bank account information from the home that allowed her to add herself to Resident #15's account. The Detective stated Resident #15 had several thousands of dollars stolen by the Social Services Coordinator. The Detective also stated he would not doubt if there were other residents that were exploited at the Skilled Nursing Facility but Resident #15 suffered the most loss.

The Administrator was notified of the Immediate Jeopardy on 3/23/2023 at 5:47 pm.

On 3/25/23 the facility provided the following plan for immediate jeopardy removal:

Identification of recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of non-compliance.

On 2/16/2022 an adult care home bed resident reported to the Director of Nursing that she had given the social worker (the "Terminated Social Worker") a gift card to pay bills and the bills were not paid. The Administrator immediately began an investigation and interviewed the resident and the Terminated Social Worker. Upon admitting to taking the resident's gift card, the Terminated Social Worker was terminated to safeguard the other residents from the possibility of further misappropriation. A 24-hour report was filed with the Health Care Personnel Registry ("HCPR") on February 17 and a 5 day investigation was completed which provided information detailing

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the use of the gift card and the inappropriate use of another adult care home bed resident's bank card.

The facility took the following additional steps to safeguard residents:

1. Ten of fourteen alert and oriented skilled nursing residents were interviewed by the Administrator and Director of Nursing on 2/17/2022 regarding any unauthorized use of personal property.

2. On March 1, 2022, all Staff were trained on abuse, neglect, misappropriation, and exploitation by Staff Development

3. The Activities Director discussed misappropriation, exploitation, and who to report any suspicions to during the Resident Council Meeting held in March 2022 to all residents in attendance. No concerns of misappropriation or exploitation were reported at that time.

4. The facility Administrator and Business Office Manager conducted an audit of Resident Trust accounts on 3/29/2022, to ensure all accounts were accurate. No discrepancies or mishandling of funds were identified.

Several days after attending the 3/1/2022 in-service the Maintenance Director approached the Director of Nursing and informed her that the Terminated Social Worker was renting a house from Resident #15. At that time the Administrator and Director of Nursing interviewed Resident #15 who stated that she did allow the Terminated Social Worker to rent the house of her deceased husband, but she was unaware of money missing from her savings account. The Director of Nursing assisted Resident #15 in contacting her sister due to the Director of Nursing's knowledge of the Terminated Social

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Worker's previous misappropriation. As a result of this conversation, Resident #15's sister agreed to come to the facility to discuss this matter in person. During the in-person discussion, (on or about March 10) Resident #15's sister expressed a concern that the former Terminated Social Worker was living at the resident's house. The Director of Nursing advised her to review any external accounts that the Terminated Social Worker may have gained access to while living at the resident's house. In front of Resident #15, the Director of Nursing, Unit Manager, and sister contacted the bank to which point the police were notified and a report filed. The Administrator and Executive Director were notified, and the discussion was had whether or not to complete a 24 hour initial report and a 5 day working report. The decision was made by the Executive Director that it was reasonable not to complete a 24-hour report since the allegations involved a former employee and a criminal investigation was ongoing by the police department there was no specific allegation as to what if any property was misappropriated and the facility was not privileged to any personal information. The facility did make efforts to protect Resident #15 and others on the information from the Maintenance Director about the former employee renting and living in the resident's house. Administrator and Director of Nursing interviewed nine alert and oriented residents who were residents when the Terminated Social Worker worked at the Facility. At that time, all interviewed residents stated they had no concerns regarding any of their personal property being misappropriated and no concerns about exploitation. The police were notified and as aforementioned, the employee had been terminated in February 2022, over a month before the alleged incident.

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On 8/26/2022 the Administrator received a call from the local Police Department that a former employee had been arrested in connection with a case involving Resident #15 and the case involved a Terminated Social Worker who had been terminated on 2/16/2022. The police department stated that he could not share information as it was an ongoing investigation. The facility was unaware of any details of allegations and the account was an outside account, not managed by the facility. The Administrator was contacted by the healthcare personnel registry to ask questions regarding the news report. At that time, it was recommended that a 24-hour report and investigation be completed which the Administrator did on 8/31/2022 even though the facility felt it could not adequately investigate the incident as this was an external matter which was being handled by the police department and not associated with the workplace. The Terminated Social Worker had not been employed by the facility for over six months; therefore, the residents were protected from any further misappropriation/exploitation. The facility mailed a letter from the Executive Director on 9/1/2022 to all responsible parties as well as self-responsible residents informing them of the alleged misappropriation and exploitation and requesting that they notify the facility of any concerns regarding their accounts.

The Resident #15 was interviewed by Administrator on August 26 2022 after the facility was contacted by the police department and the resident stated that she allowed the Terminated Social Worker to rent the house of her deceased husband. She stated she was unaware of money missing from her savings account. Later a news

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report was on television where it disclosed an alleged amount however the facility is unaware of the details as of 3/24/2023.

The current facility Social Worker (the "Current Facility Social Worker") has contacted the responsible parties for non-interviewable residents for interviews to inquire about the integrity of their property and exploitation. This was completed on 3/24/2023.

All alert/oriented residents were interviewed regarding misappropriation and exploitation by the Current Facility Social Worker on 3/24/2023.

Specify the action the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring and when the action will be complete. 100% of staff were notified by the Administrator and Director of Nursing of the issues involving the Terminated Social Worker and were advised to report to administration any issues involving suspected misappropriation or exploitation of residents on 03/24/2023.

In service training was conducted by Administrator and Director of Nursing to 100% of staff to discuss issues related to handling of resident funds, misappropriation of resident funds, and how and when to reports suspicions of abuse, neglect, and exploitation on 03/24/2023.

The Administrator has been in-serviced on the investigation of misappropriation of resident property and exploitation by the Executive Director on 3/24/2023 to include reviewing the investigation process. This includes interview of alert and oriented residents, what to do for

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non-interviewable residents and documentation of efforts during the investigation. The education to Administrator included the need to provide protection to residents once an allegation is made to prevent further incidents.

All staff were educated on Misappropriation and Exploitation policy and procedure to include what to observe for as evidence of possible exploitation and misappropriation and reporting.

Administration will be in-serviced by the administrator on 3/24/2023. Staff were asked to observe for signs such as residents upset, missing items, and secretive behavior of other staff when interacting with residents.

All future newly hired staff will receive training during orientation.

The Administrator is responsible for overall immediate jeopardy removal.

Alleged Date of IJ Removal: 3/25/2023

On 3/28/2023, the facility's credible allegation for immediate jeopardy removal was validated by the following:
-Review of the education provided to all staff related to misappropriation of resident funds, abuse, neglect, and exploitation.
-Interview with SW, nursing managers, housekeepers, therapists, and nursing staff to review education provided and procedure for identifying misappropriation, abuse, neglect, and exploitation.
-Review of the interviews conducted by the facility with alert and oriented residents.
-Review of audits completed by the facility.

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F 607	Continued From page 14 -Review of the interviews conducted by the facility with the Responsible Parties of residents that were not alert and oriented. The facility's date of the immediate jeopardy removal plan of 3/25/2023 was validated on 3/28/2023.	F 607		
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 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;	F 623		3/29/23

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(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 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

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F 623	Continued From page 16 (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 Record review and staff interviews the facility failed to provide a notice of transfer/discharge to the Resident or the Office of the State Long Term Care Ombudsman when the resident discharged from the facility to the hospital for 1 of 1 resident reviewed for hospitalization (Resident # 35). The findings included: Resident #35 was admitted to the facility on 4/22/21. She was noted as being her own	F 623	1. On March 29 2023 facility provided Notice of Transfer/Discharge to resident #35 for her recent hospital stay and the notice was also emailed to ombudsman. 2. The facility conducted an audit of all resident discharges for the past 30 days on March 23 2023 and appropriate Notice of Discharge or Transfer was provided to residents and/or Responsible Parties and also ensured a copy was emailed to Ombudsman. Facility completed this	

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F 623	Continued From page 17 responsible person. A quarterly Minimum Data Set dated 3/1/23 coded Resident #35 as being cognitively intact. A review of Resident #35's record revealed she had been discharged to the hospital on the following dates: 10/5/22, 12/10/22 and 2/22/23. No notice of transfer/discharge form was discovered as submitted to Resident #35 or to the Office of the State Long Term Care Ombudsman. An interview was completed with the Social Worker (SW) on 3/22/23 at 2:18 PM who stated that she would send a notice of transfer/discharge form for any discharge in the community including the facility's retirement center but not to the hospital. The SW stated that she was new to the position and was not aware that when a resident would go to the hospital a transfer/discharge notice was needed. An interview was completed with the Administrator on 3/22/23 at 2:44 PM who stated that a notice of transfer discharge should be completed for every single discharge regardless of where they are going, and this would include a hospital.	F 623	corrective action and as of March 29, 2023 facility was in compliance with this requirement.In addition, the administrator provided in-service education to the facility Social Worker and to all nursing staff regarding the requirements of notification of Discharge/transfer on March 23 2023. 3. In this instance the Social Worker was educated on March 23, 2023 by the Administrator as to the need to send the notice of discharge/transfer to the resident/responsible party and ombudsman at discharge to the hospital. 4. The facility will monitor its compliance through a series of audits of discharged residents and their notification requirements. The Director of Nursing, Unit Manager and Weekend Supervisor will be responsible for conducting audits of discharged/transferred residents to ensure proper Notice of Discharge/Transfer requirements are met. Audits will be completed weekly for four weeks, monthly for three months and quarterly for one year thereafter. Data from audits will be reported to Administrator and QA Committee where corrective actions taken as necessary. The administrator is responsible for overall compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		3/29/23

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F 656	Continued From page 18 §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 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	F 656		

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F 656	Continued From page 19 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a comprehensive care plan for 2 of 2 residents reviewed for Level II Preadmission Screening and Resident Review (PASRR) (Resident #6 and Resident #39). Findings included: 1. Resident #6 was admitted to the facility on 09/08/22 with diagnoses that included epilepsy and bipolar disorder. Review of a comprehensive Minimum Data Set (MDS) assessment dated 09/14/22 revealed Resident #6 had no cognitive impairment and was noted as currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or related condition. The Level II PASRR Conditions were not indicated. Review of the comprehensive care plans for Resident #6, most recently updated on 02/20/23, did not reveal a care plan was in place addressing his identified Level II PASRR status. An interview conducted with the MDS nurse on 03/21/23 at 3:38 PM revealed she was not aware that a care plan was needed for the Level II PASRR status for Resident #6. On 03/23/23 at 9:35 AM an interview with the	F 656	1. The facility Minimum Data Set (MDS) Coordinator updated the MDS and Care Plan of residents #6 and #39, to include their serious mental illness and/or intellectual disability or related conditions for a level II PASRRs were correctly reflected on MDS and appropriately care planned on March 21 2023. 2. The facility administrator in-serviced the Minimum Data Set Coordinator on the requirements of care planning related to PASRRs and what needs to be included in that documentation. The facility Minimum Data Set (MDS) Coordinator and Social Service Worker reviewed all residents MDS and Care Plans on March 21, 2023 to assure that their MDS correctly reflected any Level II PASRR and all conditions leading to a Level II PASRR were properly Care Planned. 3. The facility did implement a systemic change to assist in the tracking of individuals with level II PASRRs. Newly admitted residents will have their Pre-Admission Screening and Resident Review completed and reviewed by Social Worker utilizing North Carolina Uniform Screening Tool. Data will be	

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F 656	Continued From page 20 Administrator revealed care plans needed to be resident specific and updated as required. 2. Resident # 39 was admitted to the facility on 03/22/22 with diagnoses that included bipolar disorder and intellectual disability. Review of an annual comprehensive Minimum Data Set (MDS) assessment dated 02/17/23 revealed Resident #39 had significant cognitive impairment and was noted as currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or related condition. The Level II PASRR Conditions noted Intellectual Disability. Review of the comprehensive care plans for Resident #39, most recently updated on 02/17/23, did not reveal a care plan was in place addressing his identified Level II PASRR status. An interview conducted with the MDS nurse on 03/21/23 at 3:38 PM revealed she was not aware that a care plan was needed for the Level II PASRR status of Resident #6. On 03/23/23 at 9:35 AM an interview with the Administrator revealed care plans needed to be resident specific and updated as required.	F 656	communicated with Interdisciplinary Team during the daily clinical meeting and copy will be provided to MDS Coordinator to ensure that the residents' MDS reflects any Level II PASRR and the Care Plans correctly address the conditions leading to the Level II PASRR. MDS Coordinator is responsible for completing the MDS and developing Care Plans for each resident. 4. Staff Developer will conduct audits of MDS and Care Plans to assure correct PASRR information is reflected on MDS and that all Level II PASRRs are properly care planned. Quality Assurance Audits will be conducted weekly for four weeks, monthly for three months, and then quarterly thereafter. Results of audits will be reported to Administrator and reviewed with QAPI Committee during the monthly Quality Assurance meeting where corrective actions will be taken as identified.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		3/29/23

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F 812	Continued From page 21 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to date thawing food items in one of one walk-in refrigerator when they were removed from the freezer. This practice had the potential to affect food served to residents. The findings included: 1. An initial observation of the walk-in refrigerator conducted on 3/20/23 from 10:02 AM to 12:17 PM with the Dietary Manager (DM) revealed the following food items did not have a date to indicate when the item was pulled from the freezer or a use by date: - Four - five-pound bags of frozen egg scrambled thawing in box - Raw flattened chicken breasts in a plastic bag approximately 10 pieces - Box of flattened chicken breasts in the box - One box of bacon with approximately one pound of bacon remaining - 15-pound box of bacon date put in freezer	F 812	1. The items identified were immediately corrected by the Dietary Manager on March 20 2023 during the inspection process to ensure the thawing food was properly stored and labeled with defrost date as well as a use-by date. 2. In addition to the aforementioned, the walk-in cooler was inspected by the Dietary Manager and Administrator on March 20 2023 to assure all food was properly stored and labeled. 3. On March 20 2023 the Administrator in-serviced the Dietary Manager on proper food storage, thawing and labeling requirements. The Dietary Manager provided an in-service to all dietary staff on March 20, 2023 regarding proper storage, thawing and labeling with thaw date and use-by date. The facility will utilize quality assurance efforts to monitor and achieve substantial compliance.	

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F 812	Continued From page 22 - 10-pound box of Sausage patty links - 20-pound box of beef stew meat still frozen - Two pounds of cooked roast beef slices An interview was completed with the DM on 3/20/23 at 10:19 AM who stated that when items are pulled from the freezer there should be a label to indicate the day the item was pulled from the freezer, and a use by date. The item should be used within a 72-hour period once thawed. The DM stated that food is rarely left over as he orders food every Wednesday and Saturday. DM explained that food for today Monday 3/20/23 came in on Saturday as food is used quickly within 3-4 days from when it arrives, so he knew exactly when the food was put into the refrigerator. An interview was completed with the Administrator on 3/23/23 at 11:02 AM who stated that she would expect the food which was pulled from the freezer to have a date of when it was taken out of the freezer and a use by date.	F 812	4. The facility's dietician will conduct weekly audits for three months and monthly thereafter for a period of one year to review the walk-in cooler to ensure proper thawing, storage and labeling of all food. The results of these audits will be reviewed and corrective actions taken as necessary to ensure compliance.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and	F 867		4/17/23

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resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to

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determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data

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F 867	Continued From page 25 collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observation and staff interviews the facility's Quality Assurance and Performance Improvement Committee (QAPI) failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification survey of 10/29/2021 in the area of kitchen sanitation, food procurement, storage, preparation and service and cited during the recertification survey of 3/29/23. The continued failure of the facility during two surveys of record in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. This tag is cross referred to: F812-Based on observation, staff interviews and record review the facility failed to date thawing	F 867	1. The facility's Executive Director reviewed the facility quality assurance program related to food storage and has in-serviced the administrator on April 17, 2023 on steps to take to ensure compliance. The QA Committee has developed a Quality Improvement Audit form to monitor this area of deficiency. This tool will be used by the Facility Dietician weekly and a written report will be provided to Administrator. Any areas of non-compliance will be addressed by Dietician with Dietary Manager and corrected immediately. These results will be reported by dietician during monthly QAPI meetings. 2. The facility's Executive Director and	

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F 867	Continued From page 26 food items in the walk-in refrigerator when they were removed from the freezer. This practice had the potential to affect food served to residents. During the facility's recertification survey on 10/29/2021 F812 was cited for failure to maintain refrigerator temperatures below 41 degrees Fahrenheit in their walk-in refrigerator. On 3/23/2023 at 5:47 pm the Administrator provided the facility's Quality Assurance and Performance Improvement Committee (QAPI) minutes and stated the committee meets monthly and works on issues brought to the committee by their Quality Indicator report. She stated the facility strived to improve any issues brought to the committee through their Quality Indicators, staff concerns and satisfaction surveys, and any grievance from residents or family members.	F 867	Administrator reviewed the facility's overall Quality Assurance program on April 17, 2023. The facility's QAPI program was reviewed with the QA Committee, including but not limited to the Medical Director, Director of Nursing, Dietician and Pharmacist to enhance performance improvement auditing activity for past non-compliant areas, to take action, and to achieve compliance. 3. In review of the non-compliance area in the prior year, it was related to our walk-in cooler that had a mechanical issue and had to be replaced which was completed in 2021. The area noted in the 2567L was not a mechanical issue but a labeling and storage. The facility has modified its QA Audit tool in April 2023 to ensure that both mechanical and operational compliance is monitored and achieved. The QA Audit tool will be completed by Executive Director to assure the QAPI meetings address areas or past non-compliance, and effective performance improvement tools are put in place. 4. The QA Audit forms completed by Dietician will be reviewed in the facility's monthly QAPI meetings. Results of the audits will be monitored by the Administrator and reported to the Executive Director and actions taken as necessary to ensure compliance. These actions may include increased auditing, re-education of staff, and disciplinary action as necessary.	

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F 867	Continued From page 27	F 867	The administrator is responsible for overall compliance.	
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 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	F 883		3/29/23

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F 883	Continued From page 28 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 include documentation in the medical record education regarding the benefits and potential side effects of the Influenza and Pneumococcal immunization, and if residents received the Influenza or Pneumococcal immunization or did not receive the Influenza Pneumococcal immunization due to medical contraindication or refusal for 4 of 5 residents reviewed for infection control (Resident #149, #11, #42, and #34). The findings included: 1.a. Resident #11 was admitted to the facility 7/17/2022. A review of the medical record revealed an immunization record with Tuberculosis (TB) testing documented, without	F 883	1. The Facility has reviewed its influenza and pneumococcal immunization records for residents #149, #11, #42, and #34. These immunization records (which were being held in the infection control office) were placed in the residents medical records by the infection control nurse. In addition, the Director of Nursing in-serviced Infection Control Nurse on proper immunization record and education placement as part of the residents medical record. 2. The Facility Infection Control Nurse reviewed influenza and pneumococcal immunization records for all current residents on March 29, 2023. Six of forty residents' immunization records were	

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F 883	Continued From page 29 TB test results. No documentation was found related to education regarding the benefits and potential side effects of the immunizations, or influenza or pneumonia immunization status. Unit Manager (UM)#1 located the admission paperwork, in the Admissions office, that had documentation that Resident #11 declined influenza and pneumonia vaccines on 11/1/2022. UM #1 was interviewed on 3/22/2023 at 3:00 PM. UM#1 reported the documentation for Resident #11 was in the admission office. UM#1 reported that she was not aware the immunization records should be in the medical record. 1.b. Resident #34 was admitted to the facility 8/18/2021. A review of the medical record revealed the immunization record did not include information related to Influenza and pneumonia immunization, no documentation was found related to education regarding the benefits and potential side effects of the immunizations, or influenza or pneumonia immunization status. UM #1 was unable to locate the immunization records for Resident #34. The Administrator found the immunization records for Resident #34 in the admission department. The immunization record documented Resident #34 received the influenza immunization 10/27/2022, the pneumonia immunization 3/5/2018. 1.c. Resident #42 was admitted to the facility 1/3/2023. A review of the medical record revealed an immunization record with TB testing and results documented. No documentation was	F 883	placed in the residents' medical records by the infection control nurse. 3. The systemic change is more related to education of storage for the immunizations by the Director of Nursing to the Infection Control Nurse which took place on March 23, 2023. It is the policy of the facility to keep these records in the residents' medical record and re-education of this policy with QAPI efforts should achieve compliance. 4. The facility's Director of Nursing and/or Unit Manager will conduct quality assurance audits of medical records to assure immunization records and education are included as part of the physical medical record. These audits will be conducted weekly for four weeks, monthly for three months, and quarterly thereafter. The audits and their findings will be reviewed and corrective actions taken as necessary to achieve compliance. Administrator is responsible for overall compliance.	

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F 883	Continued From page 30	F 883		

found related to education regarding the benefits and potential side effects of the immunizations, or influenza or pneumonia immunization status.

UM #1 was unable to locate the immunization records for Resident #42.

The Administrator found the immunization records for Resident #42 in the Admission department. The immunization record documented Resident #42 declined the influenza and pneumonia immunization on 1/3/2023.

1.d. Resident #149 was admitted to the facility 3/7/2023. A review of the medical record revealed no information was documented on the immunization record. No documentation was found related to education regarding the benefits and potential side effects of the immunizations, or influenza or pneumonia immunization status.

UM #1 located the admission paperwork that had documentation that Resident #149 declined the influenza and pneumonia immunization on 3/7/2023. Documentation on the admission paperwork indicated Resident #149 had received the influenza immunization in September 2022.

UM #1 was interviewed on 3/22/2023 at 3:00 PM. UM #1 reported the documentation was in the Admission office. UM #1 reported she was unable to locate immunization record information for Resident #34 or #42. UM #1 reported sometimes the Infection Control nurse kept the immunization records in her office. UM#1 reported that she was not aware the immunization records should be in the medical record.

On 3/22/2023 at 4:14 PM, the Infection Control

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F 883	Continued From page 31 nurse was interviewed. The Infection Control nurse reported that she was not aware that the immunization records should be in the medical records for each resident including education related to the benefits or potential side effects of the vaccines. The Infection Control nurse reported she had been keeping their immunization records in her office. The Director of Nursing (DON) was interviewed on 3/23/2023 at 11:25 AM. The DON reported she was aware the immunization information needed to be in the resident medical records. The DON explained the Infection Control nurse was keeping copies of the immunization records in her office, and the Admission Department was keeping the original copy of the immunization records in their office The DON reported that the medical record for each resident should have accurate and up to date immunization information. The Administrator was interviewed on 3/23/2023 at 1:17 PM. The Administrator reported that the Admissions Department and the Infection Control nurse were keeping different parts of the immunization records in their respective offices and neither department was aware the immunization records were required to be in the medical record.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member	F 887		3/29/23

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F 887	Continued From page 32 is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related	F 887		

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F 887	Continued From page 33 to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include the status for COVID-19 vaccination in the medical record, failed to include education regarding the benefits or potential side effects of the COVID-19 vaccination, and failed to document COVID-19 vaccination declinations for 3 of 5 resident reviewed for infection control (Resident #11, #42, #149). The findings included: 1.a. Resident #11 was readmitted to the facility 7/17/2022. A review of the medical record revealed an immunization record with Tuberculosis (TB) testing documented, without TB test results. No documentation was found related to COVID-19 immunization status or education regarding the benefits or potential side effects of the COVID-19 vaccination. Unit Manager (UM)#1 located the admission paperwork, in the Admissions office, that had documentation that Resident #11 declined COVID-19 immunization on 11/1/2022. UM #1 was interviewed on 3/22/2023 at 3:00 PM.	F 887	1. The Facility has reviewed its Covid-19 immunization records for residents #11, #42, and #149. These immunization records (which were being held in the infection control office and admissions documentation) were placed in the residents' medical records by the infection control nurse. 2. The Facility Infection Control Nurse reviewed Covid-19 immunization records for all current residents on March 29, 2023. All of the residents' Covid-19 immunization records were moved to the residents' medical records by the infection control nurse. 3. The systemic change is more related to education of storage of the immunization records by the Director of Nursing to the Infection Control Nurse which took place on March 23, 2023. It is the policy of the facility to keep these records in the residents' medical record and re-education of this policy with QAPI efforts should achieve compliance.	

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F 887	Continued From page 34 UM#1 reported the documentation for Resident #11 was in the admission office. UM#1 reported that she was not aware the immunization records should be in the medical record. 1.b. Resident #42 was admitted to the facility 1/3/2023. A review of the medical record revealed an immunization record with TB testing and results documented. No documentation was found related to COVID-19 immunization status or education regarding the benefits or potential side effects of the COVID-19 vaccination. UM #1 was unable to locate the immunization records for Resident #42. The Administrator found the immunization records for Resident #42 in the admission department. The immunization record documented Resident #42 received the COVID-19 immunization 2/20/2021, 3/10/2021, and 11/19/2021. 1.c. Resident #149 was admitted to the facility 3/7/2023. A review of the medical record revealed no information was documented on the immunization record. No documentation was found related to COVID-19 immunization status or education regarding the benefits or potential side effects of the COVID-19 vaccination. UM #1 located the admission paperwork that had documentation that Resident #149 declined the COVID-19 immunization on 3/7/2023. Documentation on the admission paperwork indicated Resident #149's family member would bring in her COVID-19 immunization record with the administration dates of the immunization.	F 887	4. The facility's Director of Nursing and/or Unit Manager will conduct quality assurance audits of medical records to assure immunization records and education are included as part of the physical medical record. These audits will be conducted weekly for four weeks, monthly for three months, and quarterly thereafter. The audits and their findings will be reviewed and corrective actions taken as necessary to achieve compliance. The administrator is responsible for overall compliance.	

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F 887	Continued From page 35	F 887		

UM #1 was interviewed on 3/22/2023 at 3:00 PM. #1 reported the documentation was in the admission office. UM #1 reported she was unable to locate immunization record information for Resident #34 or #42. UM #1 reported sometimes the Infection Control nurse kept the immunization records in her office. UM#1 reported that she was not aware the immunization records including education regarding the benefits or potential side effects of the COVID-19 immunization should be in the medical record.

On 3/22/2023 at 4:14 PM, the Infection Control nurse was interviewed. The Infection Control nurse reported that she was not aware that the immunization records including education regarding the benefits or potential side effects of the COVID-19 immunization should be in the medical records for each resident. The Infection Control nurse reported she had been keeping their immunization records in her office.

The Director of Nursing (DON) was interviewed on 3/23/2023 at 11:25 AM. The DON reported she was aware the immunization information needed to be in the resident medical records. The DON explained the Infection Control nurse was keeping a copy of the immunization records in her office, and the admission department was keeping the original copy of the immunization records in their office. The DON reported that the medical record for each resident should have accurate and up to date immunization information.

The Administrator was interviewed on 3/23/2023 at 1:17 PM. The Administrator reported that the admissions department and the Infection Control nurse were keeping different parts of the

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F 887	Continued From page 36 immunization records in their respective offices and neither department was aware the immunization records were required to be in the medical record.	F 887		