STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345078	A. BUILDING _____ B. WING _____	C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND FARMS	200 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/19/24 through 8/22/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # G0UV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/19/24 through 8/22/24. Event ID# G0UV11. The following intake was investigated NC00211449. 2 of the 2 complaint allegations did not result in a deficiency.	F 000		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not	F 726		9/20/24

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

Electronically Signed | 09/06/2024

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F 726	Continued From page 1 limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide competent nursing staff when 2 of 4 nursing staff (Nurse #1 and Medication Aide #1) were not educated on the facility's glucometer disinfection policy and procedures. Findings included: a. An observation was conducted on 8/21/24 at 4:30 PM of Nurse #1 performing a blood glucose check. After performing the blood glucose check Nurse #1 returned the glucometer to the top drawer of the medication cart without disinfecting the glucometer. An interview with was conducted on 8/21/24 at 4:40 PM with Nurse #1. She said she had not cleaned the glucometer after performing the blood glucose check because she had not been aware that she needed to do so. Nurse #1 said she had worked at the facility for about 3 months and that she had not received education or training on glucometer disinfection. Nurse #1's employee file revealed there was no record of education on glucometer disinfection.	F 726	This Plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that deficiencies exist or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by Federal and State Law. Nurse # 1 is no longer is employed by the facility to complete the education or the competency. Medication Aide # 1 received the education on the facility□s glucometer proper disinfection policy and procedures with our Director of Nursing on August 22, 2024. All licensed nurses and Medication Aides will be educated on the facility□s glucometer proper disinfection policy and procedures by the Staff Development Coordinator/designee and do a return demonstration competency on cleaning of the glucometer by September 19, 2024.	

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F 726	Continued From page 2 b. An interview was conducted with Medication Aide #1 on 8/22/23 at 9:44 AM. She said that she had worked at the facility as a Medication Aide for about a year and a half. Medication Aide #1 said she was assigned to the back azalea hall and that she currently did not have any residents on her assigned hall who received capillary blood glucose checks. She said that glucometers were assigned for individual resident use and were labeled with the resident's name. Medication Aide #1 said glucometers were stored in the top drawer of the medication cart. She said that during her orientation on the medication cart she had been told to clean glucometers after each use. Medication Aide #1 said that she had been told she could use a disinfectant wipe or an alcohol wipe to clean the glucometer. Medication Aide #1 said she used an alcohol prep pad to wipe off the glucometer after using it. She said she used the alcohol prep pad because it was right there on the medication cart and convenient. Medication Aide #1's employee file revealed there was no record of education on glucometer disinfection. An interview was conducted with the Director of Nursing (DON) on 8/22/24 at 10:52 AM. The DON stated she was unable to provide training records on glucometer disinfection for Nurse #1 and Medication Aide #1. She said there were not records Nurse #1 or Medication Aide #1 had received training on glucometer disinfection. The DON stated that nursing staff should be educated during new hire orientation and annually on glucometer disinfection procedures. The DON explained the Staff Development Coordinator completed new hire orientation and nurse education. She said that education on glucometer	F 726	Any employee not receiving education/competency by that date will be required to complete it prior to their next shift. The Staff Development Coordinator will add this education and competency to the new hire orientation checklist and the yearly required education and competency for licensed nurses and medication aides. The Director of Nursing will audit all newly hired licensed nurses and medication aides weekly for eight weeks to ensure that they have completed the training and competency. Audit results will be reported at the monthly Quality Assurance Performance Improvement committee by the Director of Nursing. The Quality Assurance Performance Improvement Committee will assess and modify the action plan as needed to ensure continued compliance. The completion date is September 20, 2024	

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F 726	Continued From page 3 disinfection was currently not in place. The DON stated that education on glucometer disinfection had used to be part of the facility's new hire nurse orientation, and she was unsure how it had fallen out of the orientation process. The Staff Development Coordinator (SDC) was unavailable for interview. An interview was conducted with the Administrator on 8/22/24 at 12:37 PM. The Administrator stated that education on glucometer disinfection should be completed during new hire orientation. She said there had been a turnover in the SDC position and that may be why the education on glucometer disinfection had been missed in the new hire orientation process.	F 726		
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,	F 880		9/20/24

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F 880	Continued From page 4 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; (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.	F 880		

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F 880	Continued From page 5 §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 observations, record review, and staff interviews the facility failed to implement their policy and procedures for glucometer disinfection when Nurse #1 failed to disinfect a resident (Resident #201) glucometer after performing a capillary blood glucose test. This deficient practice occurred for 1 of 1 resident (Resident #201) reviewed for infection prevention and control. The findings included: The facility policy dated 5/29/24 and entitled "Glucometer Disinfection" read in part: The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne disease to resident and employees. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against Human Immunodeficiency Virus (HIV) (blood borne virus), Hepatitis C (blood borne virus), and Hepatitis B (blood borne virus). Glucometers will be cleaned and disinfected after each use and according to manufacturer's	F 880	Resident 201 was discharged from the facility on September 4, 2024 after a short-term rehab stay. All residents have the potential to be affected by the same deficient practice if they are to have blood glucose monitoring. An audit was completed on August 23, 2024 by the Resident Care Coordinator. The audit revealed that two other residents had ordered blood glucose monitoring. One resident was discharged on September 4, 2024 after a short-term rehab stay. The other resident will have their glucometer cleaned after each use as determined by the manufacturer□s recommendations. The Staff Development Coordinator/Infection Preventionist received training by the Director of Nursing on August 28, 2024 on the Glucometer Disinfection Policy and the manufacturers cleaning and disinfecting guidelines. All licensed nurses and medication aides will receive education and competency by September 19, 2024 on the facility□s	

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F 880	Continued From page 6 instructions regardless of whether they are intended for single resident or multiple resident use. The glucometer User Instruction Manual read in part: Clean the outside of the meter with a damp cloth only. Dirt, dust, blood, control solution, or water entering the meter could cause damage. Do not store your meter or test strips near bleach or cleaners that contain bleach. An observation was completed on 8/21/22 at 4:40 PM of Nurse #1 performing a blood glucose test for Resident #201. Nurse #1 removed the glucometer from the top drawer of her medication cart. The glucometer was stored in the manufacturer's zippered storage bag and labeled with Resident #201's name. Nurse #1 gathered supplies (an alcohol pad, lancet, and test strips). Nurse #1 was accompanied as she carried the glucometer and supplies down to Resident #201's room. After entering the room, the nurse put the glucometer and supplies down on the resident's bed. While wearing gloves, the nurse wiped the resident's finger with an alcohol pad, used a lancet to obtain a drop of blood from her finger and applied the blood to the test strip inserted into the glucometer. Once the blood glucose results were obtained, Nurse #1 discarded the trash and lancet, and returned to the medication cart with the glucometer. She placed the glucometer back into the manufacturer's zippered storage bag and zipped the bag closed and returned the glucometer to the top drawer of the medication cart. There were disinfectant wipes present in the bottom drawer of the medication cart. An interview was performed with Nurse #1 on 8/21/24 at 4:30 PM. Nurse #1 said that	F 880	glucometer proper disinfection policy and procedures on cleaning of the glucometer after each use by the Staff Development Coordinator/designee. Any nurse or medication aide not receiving this education/competency by that date will be required to complete it prior to their next shift. This education and competency has been added to the new hire checklist for licensed nurses and medication aides. The Staff Development Coordinator/designee will audit glucometer cleaning and disinfecting 5x a week for four weeks to ensure compliance with the manufacturer□s recommendations for cleaning and disinfecting after each use by using the Super Sani-Cloth Germicidal Disposable wipes. Audit results will be reported at the monthly Quality Assurance Performance Improvement committee by the Staff Development Coordinator/designee. The Quality Assurance Performance Improvement Committee will assess and modify the action plan as needed to ensure continued compliance. The completion date is September 20, 2024	

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F 880	Continued From page 7	F 880		

glucometers were for individual use and not shared. Nurse #1 stated that she had never been told she needed to clean/ disinfect the glucometer after it had been used. Nurse #1 said she had not received any education from the facility on glucometer cleaning/ disinfection procedures. Nurse #1 stated that she had not cleaned/disinfected the glucometer after performing Resident #201's because it was an individual glucometer, and she had not been aware that she needed to do so.

An interview was performed with the Director of Nursing (DON) on 8/22/24 at 10:52 AM. The Director of Nursing stated that glucometers needed to be disinfected after each use regardless of if they were for individual use because they were touched by staff and could cause the transmission of blood borne pathogens. The DON explained that the manufacturer instructions for the current glucometer the facility used said to clean the glucometer with a damp cloth, because the glucometer was intended for home use. She said that the facility should clean/ disinfect glucometers per manufacturer instructions and that the facility should use a glucometer that could be cleaned/ disinfected according to manufacture instructions using an environmental protective agency (EPA) approved product that was effective against blood borne pathogens.

An interview was conducted with the Administrator on 8/22/24 at 12:37 PM. The Administrator stated that glucometers should be disinfected after each use. She said an EPA approved disinfectant should be used to disinfect the glucometer after each use to kill blood borne pathogens.

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F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility 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	F 883		9/19/24

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F 883	Continued From page 9 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, resident and staff interviews the facility failed to administer a pneumococcal vaccine to a resident who had consented for the vaccine to be administered. This deficient practice occurred for 1 of 5 residents reviewed for Pneumococcal Immunizations (Resident #18). The findings included: Resident #18 was admitted to the facility on 12/23/23. The quarterly Minimum Data Assessment (MDS) dated 7/17/24 revealed Resident #18 was cognitively intact. It was not documented on the MDS that she had received the pneumonia vaccine. Review of Resident #18's medical record revealed a form titled "Resident Vaccine Consent Form". The pneumococcal vaccine was marked	F 883	On July 18, 2024, a consent was obtained for the Pneumonia Vaccine for Resident 18 and the vaccine was administered on August 30, 2024. An audit of residents in the facility was performed by Staff Development Coordinator on August 29, 2024, to ensure that pneumonia vaccines were offered, consents/declines obtained, and the vaccine was administered when clinically indicated. In the audit, the Staff Development Coordinator found that 14 residents are up to date. 11 residents had consented and 10 received the vaccine on August 30, 2024, and 1 resident received the vaccine on September 4, 2024. 4 residents are not eligible to receive it, and 7 residents had declined, and 10 residents do not have consents/declines in their medical record. The Staff Development Coordinator will reach out to	

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F 883	Continued From page 10 under the section entitled check vaccines consented to be given. The vaccine consent signature section indicated verbal consent was provided by Resident #18's family during a video conference and was dated 7/18/24. Review of Resident #18's medical record revealed there was no documentation that a pneumococcal vaccine had been administered. There was no prior pneumococcal immunization history documented in Resident #18's medical record. Review of the standing orders attached to Resident #18's August 2024 physician orders revealed there was a standing order that read: May give pneumococcal vaccine on admission according to acceptable standards of clinical practice or unless medically contraindicated. An interview was conducted on 8/21/24 at 3:53 PM with Resident #18. She said she remembered the pneumococcal vaccine being offered to her and the consent form being completed. She said she had probably received a Pneumonia Vaccine in the past but that she did not recall when. Resident #18 said she had wanted the "newest" pneumococcal vaccine and that she was waiting on the facility to give it. An interview with the Director of Nursing (DON) was conducted on 8/22/24 at 10:52 AM. The DON said there was no record that a pneumonia vaccine had been administered to Resident #18 while at the facility. The DON said the facility did not have any past pneumonia vaccine history for Resident #18. The DON explained she expected the pneumococcal vaccine to be offered to residents on admission and a consent/	F 883	the resident/resident representative to offer the vaccine and get the consent/decline, and have it placed in the electronic medical record and provide the vaccine if consent is received. The Director of Nursing developed a protocol to be used in the admission conference or the next working day for consents or declines of all required offerings of vaccines. This was completed and implemented on August 1, 2024. The Staff Development Coordinator/Infection Preventionist received training by the Director of Nursing on August 28, 2024 on the facility's procedure for obtaining consents/declines and administration of required vaccines. The Staff Development Coordinator/designee will be responsible for getting consents/declines, putting the physician order for the vaccine on the Medication Administration Record for the nurse to administer and the follow up to ensure the vaccine was given and that it was documented in the Electronic Medical Record. The Resident Care Coordinator/designee will audit immunizations weekly x4 then monthly x2 for new admissions to ensure that that consents/declines are completed, immunizations are put on the Medication Administration Record, and that the immunizations were given and	

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F 883	Continued From page 11 declination form to be completed. The DON stated the Infection Preventionist (IP) was responsible for obtaining immunization history of residents, offering immunizations, and completing the immunization consent/ declination form with residents/ families on admission and annually. The DON explained once consent for the pneumococcal vaccine was obtained, she expected the vaccine to be given to the resident ideally by the next day. The DON stated she thought the IP had been "bogged down" with other things and had not communicated well. She explained that the IP had made changes to the immunization process that she had thought would be okay. The DON said the IP had not discussed or communicated the changes with her and that the pneumococcal vaccine being administered for Resident #18 had been missed. The IP was currently on leave and unavailable for interview. An interview was conducted with the Administrator on 8/22/24 at 12:37 PM. The Administrator said the pneumococcal vaccine should be offered to residents on admission. The Administrator said if Resident #18 had wanted the pneumococcal vaccine that the vaccine should had been administered to her. She said there was an issue with the process that Resident #18's pneumococcal vaccine being given had been missed.	F 883	documented appropriately. Audit results will be reported at the monthly Quality Assurance Performance Improvement committee by the Resident Care Coordinator/designee. The Quality Assurance Performance Improvement Committee will assess and modify the action plan as needed to ensure continued compliance. The completion date is September 19, 2024	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:	F 887		9/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345078	A. BUILDING _____ B. WING _____	C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND FARMS	200 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711

(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 887	Continued From page 12 (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical	F 887		

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F 887	Continued From page 13 contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to offer and provide a COVID-19 vaccine to 1 of 5 residents reviewed for COVID-19 immunizations (Resident #42). The findings included: Resident #42 was admitted to the facility on 7/15/24. The admission Minimum Data Set Assessment (MDS) dated 7/22/24 revealed Resident #42 had moderate cognitive impairment. Review of Resident #42's medical record revealed he had last received a COVID-19 vaccine prior to admission on 6/16/22. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #42. An interview was conducted on 8/21/24 at 3:40 PM with Resident #42. He stated that the facility had not discussed or offered the COVID-19	F 887	The facility was unable to provide the vaccine to Resident 42 due to the resident being discharged from the facility on August 23, 2024. An audit of residents in the facility was performed by Staff Development Coordinator on August 29, 2024 to ensure that Covid vaccines were offered, consents/declines obtained and the vaccine was administered when clinically indicated. In the audit, the Staff Development Coordinator found that 13 residents were up to date with the 2023-2024 formula mRNA COVID-19 vaccines. 16 residents declined and 17 residents are out of date with the vaccine. The updated COVID-19 vaccine (2024-2025 mRNA) will be offered as per CDC and/or FDA guidelines and education will be provided to the residents/resident representative. The Staff Development Coordinator/designee	

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F 887	Continued From page 14 vaccine with him since his admission to the facility. Resident #42 said that it had been more than a year since he had last received a COVID-19 vaccine. He said he had not received the newest recommended COVID-19 vaccine. Resident #42 said that if he was able to get the COVID-19 vaccine at the facility he wanted to receive it. An interview was conducted with the Director of Nursing (DON) on 8/22/24 at 10:52 AM. The DON said there was no record of where the COVID-19 vaccine had been offered to Resident #42. The DON explained she expected the COVID-19 vaccine to be offered to residents on admission and a consent/ declination form to be completed. The DON stated the Infection Preventionist (IP) was responsible for obtaining immunization history of residents, offering immunizations, and completing the immunization consent/ declination form with residents/ families on admission and annually. The DON explained once consent for the COVID-19 vaccine was obtained, the facility would coordinate with the pharmacy for the vaccine to be administered. The DON stated she thought the IP had been "bogged down" with other things and had not communicated well. She explained that the IP had made changes to the immunization process that she had thought would be okay. The DON said the IP had not discussed or communicated the changes with her and that the COVID-19 vaccine being offered to Resident #42 had been missed. The IP was on leave during the survey and unavailable for interview. An interview was conducted with the Administrator on 8/22/24 at 12:37 PM. The	F 887	will reach out to the resident/resident representative to offer the vaccine and get the consent/decline and have it placed in the electronic medical record, obtain a physician order for the vaccine, and schedule with the pharmacy to provide and administer the vaccine. The Director of Nursing developed a protocol to be used in the admission conference or the next working day for consents or declines of all required offerings of vaccines. This was completed and implemented on August 1, 2024. The Staff Development Coordinator/Infection Preventionist received training by the Director of Nursing on August 28, 2024 on the facility's procedure for obtaining consents/declines and administration of required vaccines. The Staff Development Coordinator/designee will be responsible for getting consents/declines and having it placed in the electronic medical record, obtain a physician order for the vaccine, and schedule with the pharmacy to provide and administer the vaccine and then follow up timely to ensure the vaccine was given and that it was documented in the Electronic Medical Record. The Resident Care Coordinator/designee will audit immunizations weekly x4 then monthly x2 for new admissions to ensure	

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F 887	Continued From page 15 Administrator said the COVID-19 vaccine should be offered to residents on admission. The Administrator said if Resident #42 had wanted a COVID-19 vaccine then the vaccine should had been administered to him.	F 887	that that consents/declines are completed, immunizations are put on the Medication Administration Record, and that the immunizations were given and documented appropriately. Audit results will be reported at the monthly Quality Assurance Performance Improvement committee by the Resident Care Coordinator/designee. The Quality Assurance Performance Improvement Committee will assess and modify the action plan as needed to ensure continued compliance. The completion date is September 19, 2024.	