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	345543	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

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E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		4/3/25

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

Electronically Signed | 03/27/2025

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to establish and maintain a comprehensive Emergency Preparedness (EP) plan. The EP plan did not include the process for EP collaboration, emergency officials contact information which included State licensing and Certification agency and office of the State Long Term Care Ombudsman, alternate means of communication, emergency Prep Training/testing Program, annual employee EP training and two emergency prep training and testing exercises. This had the potential to affect all residents and staff. The findings included: A review of the facility's supplied Emergency Preparedness (EP) plan revealed the Administrator had reviewed the material in December 2024. The following areas were not present, updated, or revised: a. The facility's EP plan did not include the process for EP collaboration with local, tribal, regional, state, and Federal EP officials to maintain an integrated response during a disaster or emergency. b. The facility's EP plan did not include any of the emergency officials' complete contact information with phone numbers and addresses.	E 001	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. E001 1. Corrective action for resident(s) affected by the alleged deficient practice: The facility Administrator contacted local, regional state and federal Emergency Preparedness officials is on 04/03/2025 to discuss integrated responses to emergencies. The Emergency Preparedness plan was updated by Administrator on 04/02/2025 to include complete contact information with phone numbers and addresses. The Administrator added alternate means of communication in the Emergency Preparedness on 04/02/2025. The Administrator added on 04/02/2025 the emergency preparation training/testing program for the facility which will be reviewed and updated annually. The Administrator conducted on 03/28/2025 annual employee Emergency	

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E 001	Continued From page 2 c. Alternate means of communication. d. The facility's EP plan did not include an emergency preparation training/testing program for the facility which should have been reviewed and updated at least annually. e. The facility's EP plan did not include annual employee EP training for existing staff and individuals providing services for emergency preparedness. f. The facility's EP plan did not include two emergency preparation training and testing exercises that involved annual full-scale community-based exercise or a full-scale facility-based exercise clinically- relevant to emergency scenarios with analysis of facility's response to all drills, tabletop exercises, and emergency events. An interview was conducted on 3/6/25 at 1:13 PM with the Administrator. The Administrator reported he had reviewed the current EP plan in December of 2024. The Administrator verified the facility had not participated in collaboration or communication with local, tribal, regional, state, and Federal EP officials prior to his employment in October of 2024 nor after his start as Administrator. The Administrator confirmed emergency officials' contact information did not include addresses or phone numbers. The Administrator stated he completed one Table-Top training since his start as Administrator in October of 2024. The Administrator verified the facility's EP plan did not include annual training for employees and a full-scale exercise that was community-based or facility based in 2024. The Administrator stated he would be the person responsible for updating EP plan information.	E 001	Preparedness training for existing staff and individuals providing services for emergency preparedness. The Administrator added to the plan on 03/27/2025 one emergency preparation training and testing exercises that involved annual full-scale community-based exercise or a full-scale facility-based exercise clinically- relevant to emergency scenarios with analysis of facility's response to all drills, tabletop exercises, and emergency events. Table top exercise on 03/27/2025 with Department Leaders of burst water pipe and flooding to hallway/resident rooms. An Active Shooter community exercise is scheduled for 4/03/2025 with the Davie County Sheriff□s Office for facility staff. A table top exercise was conducted 1/31/2025 regarding facility power outage with facility staff. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. The Regional Director of Operations trained the Administrator on the need for an updated EP plan to include: process for Emergency Preparedness collaboration with local, tribal, regional, state, and Federal Emergency Preparedness officials to maintain an integrated response during a disaster or emergency; emergency officials' complete contact information with phone numbers and addresses; Alternate means	

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E 001	Continued From page 3	E 001	of communication; emergency preparation training/testing program for the facility which should have been reviewed and updated at least annually; annual employee Emergency Preparedness training for existing staff and individuals providing services for emergency preparedness; two emergency preparation training and testing exercises that involved annual full-scale community-based exercise or a full-scale facility based exercise clinically- relevant to emergency scenarios with analysis of facility's response to all drills, tabletop exercises, and emergency events. The Administrator trained the Maintenance Director on 03/28/2025 on: process for Emergency Preparedness collaboration with local, tribal, regional, state, and Federal Emergency Preparedness officials to maintain an integrated response during a disaster or emergency; emergency officials' complete contact information with phone numbers and addresses; Alternate means of communication; emergency preparation training/testing program for the facility which should have been reviewed and updated at least annually; annual employee Emergency Preparedness training for existing staff and individuals providing services for emergency preparedness; two emergency preparation training and testing exercises that involved annual full-scale community-based exercise or a full-scale facility based exercise clinically- relevant to emergency scenarios with analysis of facility's response to all drills, tabletop	

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E 001	Continued From page 4	E 001	exercises, and emergency events. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The Regional Director of Operations will monitor the Emergency Preparedness program monthly for 3 months to ensure that the plan includes: process for Emergency Preparedness collaboration with local, tribal, regional, state, and Federal Emergency Preparedness officials to maintain an integrated response during a disaster or emergency; emergency officials' complete contact information with phone numbers and addresses; Alternate means of communication; emergency preparation training/testing program for the facility which should have been reviewed and updated at least annually; annual employee Emergency Preparedness training for existing staff and individuals providing services for emergency preparedness; two emergency preparation training and testing exercises that involved annual full-scale community-based exercise or a full-response to all drills, tabletop exercises, and emergency events. This information will be brought to monthly Quality Assurance for continued compliance. On 03/27/2025, the Regional Director of Operations re-educated the Administrator on the need for annual review of the Emergency Management Program and the components of the program. The	

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E 001	Continued From page 5	E 001	Administrator began educating the facility Department Leaders; Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Business Office, Social Services Director, Activities Director, Dietary Director, Maintenance Director, MDS Coordinator, Health Admissions Director, Rehab Director, and Environmental Services Director on 03/28/2025 regarding the Emergency Management Program. Education included overview of the program, purpose and scope, risk assessment, risk mitigation, communication plan, staffing during an emergency, staffing during evacuation, evacuation locations, coordination with response partners, education and training, activation of the emergency management plan, structure and leadership, and policy and procedure. An all-facility staff meeting was conducted on 03/28/2025 to review the Emergency Management Program as stated above. This information has been integrated into the standard orientation training for Department Leaders and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 04/03/25, any Department Leader who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:	

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E 001	Continued From page 6	E 001	Quality assurance monitoring will be completed by the Regional Director of Operations or designee using the E001 Quality Assurance Tool; Emergency Preparedness. This monitoring consists of observing the missing elements of the Emergency Preparedness. Monitoring will be completed weekly x 3 weeks and monthly x 2 months. Reports will be presented to the monthly Quality Assurance committee by the Regional Director of Operations or designee to ensure corrective action is initiated as appropriate. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, and Regional Director of Operations (as needed). Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 04/03/2025	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/03/25 through 03/06/25. Event ID# IT8N11. The following intakes were investigated NC00214544 and NC00215978. 9 of the 9 complaint allegations did not result in deficiency	F 000		
F 565	Resident/Family Group and Response	F 565		4/1/25

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F 565 SS=D	Continued From page 7 CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on review of Resident Council meeting	F 565	To remain in compliance with all federal	

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F 565	Continued From page 8 minutes, and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated concerns by residents of noise at night during Resident Council meetings for 3 of 10 months reviewed (January 2024, February 2024 and October 2024). The findings included: The Resident Council meeting minutes were reviewed for January 2024. Under the heading "New Business", minutes noted residents' complaints of noise in the hallway at around 4:00 AM and a plan by the Activities Director to notify the Director of Nursing (DON) about the issue. In the February 2024 meeting minutes, under the heading "Old Business", there was no documented follow up for the January 2024 noise complaint. The February 2024 minutes, under the heading "New Business" made note that the noise at night was persisting and a plan was made to speak with the DON about the issue. Meeting minutes for March 2024 revealed no documented follow up on the noise complaints from February 2024 under the heading of "Old Business". "New Business" showed no documentation of new noise complaints. The April 2024 meeting minutes revealed no documented follow up on noise complaints under the heading of "Old Business" for past noise complaints from February 2024. "New Business" showed no documentation of new noise complaints. Meeting minutes reviewed for May 2024 revealed	F 565	and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 565 1. Corrective action for resident(s) affected by the alleged deficient practice: A corrective action was obtained for resident council concern for noise at night and documented in the November resident Council meeting. Follow-up of noise at night was competed by Director of Nursing who spoke with night shift staff. A Communication form for facility response to Resident Council concerns was implemented January 2025. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 03/27/2025, the Administrator began identification of follow-up needed for resident council concerns. This audit consisted of a 100% look back of resident council minutes for January 2025 and February 2025. March Resident Council is scheduled for 3/31/2025. January□s audit had 5 concerns presented at the council meeting; 5 documented responses recorded. February□s audit	

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F 565	Continued From page 9 no documented follow up on noise complaints under the heading of "Old Business" for past noise complaints from February 2024. "New Business" showed no documentation of new noise complaints. The June 2024 meeting minutes showed no documented follow up on noise complaints under the heading of "Old Business" for past noise complaints from February 2024. "New Business" showed no documentation of new noise complaints. There was no Resident Council meeting in July 2024 per the Activities Director. Meeting minutes reviewed for August 2024 revealed no documented follow up on noise complaints under the heading of "Old Business" for past noise complaints from February 2024. "New Business" showed no documentation of new noise complaints. There were no September 2024 meeting minutes provided following two requests. Review of October 2024 Resident Council meeting minutes revealed no documented follow up on noise complaints under the heading of "Old Business" for past noise complaints from February 2024. "New Business" showed a resident complaint of having been woken up in the middle of the night from noise and staff talking loudly. There was no plan documented for resolution of the new noise complaint in the October 2024 minutes, however the Administrator and the DON were noted as being in attendance at the meeting.	F 565	had 6 concerns noted from Resident Council; 5 of 6 had documented responses. Documented response for the missing February meeting concern was obtained 03/28/2025. Audit for January 2024 had 0 documented follow-up of concerns, February 2024 had 0 documented follow-up of concerns, March 2024 had 0 documented follow-up of concerns, April 2024 had 0 documented follow-up of concerns, May 2024 had 0 documented follow-up of concerns, June 2024 had 0 documented follow-up of concerns, no meeting for July 2024, August 2024 had 0 documented follow-up of concerns, no meeting for September 2024, October 2024 had 0 documented follow-up of concerns, November 2024 had documented follow-up of noise at night concern, December 2024 had notation of noise being resolved. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/25/2025, the Activities/Social Work Liberty Corporate Consultant educated the Activities Director on Resident Council Policy and Procedure, documentation of Resident Council Minutes, and use of the Communication Form for recording response to concerns. On 03/27/2025 Administrator educated the Leadership team on responding to the Communication Form and reviewed resident Council Policy and Procedure, and Resident Council Minutes. In attendance were Director of Nursing,	

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F 565	Continued From page 10	F 565		

The November 2024 meeting minutes revealed under "Old Business" that the DON had spoken with staff about the noise at night. There were no new noise complaints under "New Business". The DON was noted as in attendance at the meeting.

The December 2024 meeting minutes showed under "Old Business" a repetition of the noise complaint from October 2024. "New Business" noted the repetition that the DON had spoken to staff about the noise and that the issue was "resolved". The DON was noted as in attendance at the meeting.

In a Resident Council meeting on 03/05/25 at 11:08 AM, six members of the Resident Council who attended meetings regularly (Resident #93, Resident #50, Resident # 76, Resident #11, Resident #77 and Resident #84), reported that they knew how to complete an individual grievance form and that they knew where the forms were located. All Residents present reported that they were not aware of separate forms to be filled out regarding concerns that were brought forward at their Resident Council meetings with staff. When the surveyor inquired about whether there was any noise at night, all residents present stated that there was sometimes noise at night but that they understood that this happened sometimes and that they knew there were shift changes at night.

In an interview with the Activities Director on 03/05/25 at 09:50 AM the Activities Director reported that she documented resident concerns from the meetings in the Resident Council meeting minutes. She stated follow up from Resident Council concerns were then

Assistant Director of Nursing, MDS Coordinator, Therapy Manager, Activities Director, Health Information Manager, Dietary Manager, Admissions Director, Human Resources Manager, Staff Development Coordinator, and the Maintenance Director.
This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 04/01/25, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:

Quality assurance monitoring will be completed by the Director of Nurses or designee using the F565 Quality Assurance Tool; Resident Council Communication Form Completion. This monitoring consists of auditing monthly Resident Council Minutes and Communication Form responses. Monitoring will be monthly x 4 months. Reports will be presented to the monthly Quality Assurance committee by the Administrator or designee to ensure corrective action is initiated as appropriate. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health

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F 565	Continued From page 11 documented in subsequent months' meeting minutes as "Old Business" and then noted as resolved or not resolved. The Activities Director reported that she did not document resident concerns brought forward at Resident Council meetings separately as a resident grievance or group concern. She reported that she shared all concerns with the Administrator, the DON and whatever person would be responsible for the resolution. On 03/06/25 at 2:47 PM, during a follow up interview with Activities Director, she reported resident/group concerns were documented in Resident Council meeting minutes, then she would go to the person responsible for resolution and discuss with that person how to resolve a given complaint/concern. She reported that all concerns were shared with the Administrator or DON every month. The Activities Director confirmed all resolution efforts were conducted verbally. She said once a resolution of a complaint was reached, this was documented in the next months' meeting minutes as "resolved". The Activities Director confirmed residents were not given any kind of written notation of resolution of concerns. The Activities Director confirmed any follow-up with residents was conducted verbally. In an interview with the Director of Nursing (DON) on 03/06/25 at 3:32 PM, the DON confirmed that any concerns brought forward at the Resident Council meeting were followed up on at next month's Resident Council meeting. The DON confirmed that any follow up was done verbally with the person responsible for resolution. She explained that any concerns from Resident Council meetings were brought forward to facility staff at staff meetings. The DON confirmed that	F 565	Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 04/01/2025	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 12	F 565		

she had spoken to staff about the residents' complaints of noise at night. The DON also confirmed there was no written documentation of concerns brought forward apart from the meeting minutes, and no written follow-up documentation was provided to the resident council.

On 03/05/25 at 10:03 AM, an interview was conducted with the Administrator, the Social Worker (SW) and the Activities Director. The Administrator stated that the facility's practice was to document any resident concerns brought forward at Resident Council meetings on the meeting minutes and that follow-up was documented on subsequent months' meeting minutes as either resolved or not resolved. The Administrator said that the Activities Director reported concerns to the Administrator, the DON and whatever person was responsible for the resolution. The Activities Director reported that facility leadership conducted these efforts verbally, there was no written documentation. She said leadership spoke with the person who they believed would best be able to resolve the issue. That person then took their own steps to do so. The Administrator confirmed that there was no other documentation of resident group concerns attached or documented with Resident Council minutes. The SW reported that she was instructed by her corporate team to keep all resident grievances separate from Resident Council meeting minutes. The Administrator confirmed he was aware of the noise complaints, and he reported that facility staff were addressed about noise at staff meetings and that noise issue was resolved.

In a follow-up interview with the Administrator on 03/06/25 at 3:46 PM, he confirmed that resident

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	345543	A. BUILDING _____ B. WING _____	C 03/06/2025

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F 565	Continued From page 13 concerns mentioned at Resident Council meetings were documented on the meeting minutes including any planned follow-up actions. He said facility leadership was responsible for coordinating resolution of concerns. He verbalized that follow up was then documented on the next month's meeting minutes. The Administrator confirmed any resident or group concerns were then verbally brought to the attention of the person responsible for the resolution and that documentation was in the next months' meeting minutes as "resolved" or "not resolved". The Administrator confirmed resolution efforts were conducted verbally and that there was no written follow-up provided to residents. He voiced that if a concern was not resolved in the next month, that he would then share a new proposed plan to the Resident Council. He reported that he was made aware of issues and/or concerns brought forward at Resident Council meetings. The Administrator confirmed any new resolution plans were also conducted verbally and that there was no written process for staff to follow.	F 565		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network,	F 575		4/1/25

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F 575	Continued From page 14 home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit for 4 of 4 days of the recertification survey. The findings included: On 3/3/2025 at 11:18 AM, an observation of the facility (inclusive of all hallways) revealed no postings of name or contact information for the following: the local department of social services, the State Long Term Care Ombudsman or the resident advocacy group. On 3/4/2025 at 9:50 AM, an observation of the facility (inclusive of all hallways) revealed no	F 575	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 575 1. Corrective action for resident(s) affected by the alleged deficient practice: On 03/26/2025 a corrective action was completed by the facility of posting a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups including; State Survey Agency, State licensure office, adult protective services, where state law provides jurisdiction in long term care facilities, the Office of the State Long Term Care Ombudsman Program, the protection and advocacy	

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F 575	Continued From page 15 postings of name or contact information for the following: the local department of social services, the State Long Term Care Ombudsman or the resident advocacy group. An observation of the facility (inclusive of all hallways) on 03/05/25 at 2:56 PM, revealed there were no postings of name or contact information for the following: the local department of social services, the State Long Term Care Ombudsman or the advocacy group. During a walking tour of the facility and interview on 3/6/25 at 3:46 PM with the Administrator, there were no postings of name or contact information for the local department of social services, the State Long Term Care Ombudsman or the advocacy group. The Administrator reported it was the Administrator's responsibility to ensure that postings of name and contact information for the local department of social services, the State Long Term Care Ombudsman and advocacy group were present. The Administrator confirmed that all residents and their representatives should be informed of all available resources and that the postings be in a location easily visible and accessible if any resident or their representative should need them.	F 575	network, home, and community based service programs, and the Medicaid Fraud Control Unit. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 03/26/2025, the Administrator began identification of the missing required posting information. This audit consisted of a 100% audit of all locations in the building where this type of information is displayed; 100 hallway and 400 hallway. Audit was completed on 3/26/2025. Results included that facility was missing information for the following required postings: local Department of Social Services, the state Long Term Care Ombudsman, and the resident advocacy group. Corrective action was taken by obtaining information and posting in the 100 hallway and the 400 hallway areas. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/27/2025, the Administrator began educating the facility Department Leaders; Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Business Office, Social Services Director, Activities Director, Dietary Director, Maintenance Director, MDS Coordinator, Health Admissions Director, Rehab Director, and Environmental Services	

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F 575	Continued From page 16	F 575	Director of the importance of maintaining all required postings. This information has been integrated into the standard orientation training for Department Leaders and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 04/01/25, any Department Leader who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Quality assurance monitoring will be completed by the Administrator or designee using the F575 Quality Assurance Tool. This monitoring consists of observing both areas for all required postings. Monitoring will be completed weekly x 3 weeks and monthly x 2 months. Reports will be presented to the monthly Quality Assurance committee by the Administrator or designee to ensure corrective action is initiated as appropriate. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.	

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F 575	Continued From page 17	F 575		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F 578	Date of Compliance: 04/01/2025	4/1/25

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F 578	Continued From page 18 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to have a signed Medical Orders for Scope of Treatment (MOST) form for 1 of 7 residents reviewed for advance directives (Resident #55). The findings included: Resident #55 was admitted to the facility on 12/07/2022 with diagnoses that included diabetes mellitus, congestive heart failure and hypertensive heart disease. A review of the quarterly Minimum Data Set (MDS) dated 01/23/2025 revealed Resident #55 was cognitively intact. A review of the active care plan dated 12/22/2022 revealed that Resident #55 had goals and interventions for Do Not Resuscitate (DNR). A review of the medical record revealed an order from the Nurse Practitioner (NP) dated 07/11/2024 for Do Not Resuscitate (DNR): Intubation if only temporary; Hospitalization if needed; IV (intravenous) fluids if needed; Antibiotics if needed; Feeding tube if only temporary. A review of the Nurse Practitioner (NP) note dated 07/11/2024 revealed that the NP had	F 578	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 578 1. Corrective action for resident(s) affected by the alleged deficient practice: On 03/24/2025 a corrective action was obtained for Resident #55 when the advance directives were reviewed, resident signature obtained, and care plan updated to reflect code status per physician order. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents with Advance Directives/MOST have the potential to be affected by the alleged deficient practice. On 03/24/2025, the Director of Nurses (DON) began identification of residents that were potentially impacted by this	

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F 578	Continued From page 19 reviewed advance directives with Resident #55 and had confirmed Resident #55's wishes to remain a DNR. The MOST form completed on 07/11/2024 was found in the advance directive's binder at the nurse's station but had not been signed by Resident #55 or her representative. An interview on 03/04/2025 at 9:33 AM with Resident # 55 revealed she had discussed her wishes regarding advanced directives with her representative and thought someone from the facility had discussed this with her as well. She did not recall ever signing a document regarding advanced directives. An interview on 03/04/2025 at 3:54 PM with Social Worker #1 revealed the nurse usually handled the completion of the MOST form and obtained the required signatures. Social Worker #1 indicated she reviewed the resident's wishes as part of the care conference but did not complete the forms if any changes were identified. She did not know why the MOST form was not signed by Resident #55. An interview on 03/04/2025 at 04:01 PM with the Physician revealed the NP had reviewed Resident #55's wishes regarding advance directives on 07/11/2024. The physician did not know why the MOST form was never signed by Resident #55 and thought this was a nursing responsibility to obtain the signature. An interview on 03/06/2025 at 10:21 AM with the Director of Nursing (DON) indicated it was the responsibility of social services to obtain the resident's or representative's signature required on the MOST form. An interview on 03/06/2025 at 4:39 PM with the	F 578	practice. This audit consisted of a 100% audit of current residents advance directives/MOST to ensure that the advance directive/MOST was reflective of resident preference, signature obtained, orders, and care plans. This audit was completed on 03/24/2025. Results included: 54 out of 104 residents had advance directives/MOST forms reflective of their preference, orders, and care plans. Of the 54 advance directives 9 had a consent signature on the MOST form. Corrective action taken by obtaining a signature on the remaining unsigned MOST forms and this was completed on 3/31/2025. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/23/2025, the DON and Staff Development Coordinator began reeducating Licensed Nurses, Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s) including agency licensed nurses on advance directives. (See Education) ¿ Policy and procedures for advance directives This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 3/31/2025 any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.	

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F 578	Continued From page 20 Administrator revealed he was not sure why the MOST form was not signed by Resident #55. An interview on 03/06/2025 at 4:48 PM with the Medical Records Specialist indicated she assumed the responsibility for the monthly MOST form audit two months ago. The last audit was 02/15/2025. She stated the MOST form should have been signed by Resident #55 and the previous person who audited should have noted the form was missing the signature as Resident #55 had been at the facility for a long time.	F 578	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Quality assurance monitoring will be completed by the Director of Nurses or designee using the F587 Quality Assurance Tool. This monitoring consists of monitoring 5 random residents advance directives to ensure compliance and that the advance directive was reflective of resident preference, orders, care plans, and has a consent signature. Monitoring will be completed weekly x 3 weeks and monthly x 2 months. Reports will be presented to the monthly Quality Assurance committee by the DON or designee to ensure corrective action is initiated as appropriate. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 04/01/2025	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		4/1/25

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F 584	Continued From page 21 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with a resident and staff, the facility failed to provide an	F 584	To remain in compliance with all federal and state regulations the facility has taken	

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F 584	Continued From page 22 adequate supply of bath linens for 3 of 6 halls (Halls 100, 500, and 600) observed for a homelike environment. The findings included: Observations of linen carts on 3/3/25 between 11:40 AM and 11:50 AM on halls 100, 500 and 600 revealed no washcloths or towels on the linen carts. No linen carts were available for observation on halls 200, 300 or 400. An interview conducted with Resident #90 was completed on 3/3/25 at 11:29 AM. Resident #90 was cognitively intact according to Minimum Data Set (MDS) dated 12/04/24. Resident #90 stated she was told she could not get a bath at this time because there were no washcloths available. An interview with Nurse Aide (NA) #1 was completed on 3/3/25 at 11:35 AM. NA #1 stated there were no washcloths available for showers and baths and baths would be on hold until washcloths were available. NA #1 also stated there were no washcloths available on Sunday 3/2/25 when she worked and there had been a shortage of washcloths since she started in January of 2025. On 3/6/25 at 9:33 AM Nurse #1 (worked on the 100 and 200 halls) stated she worked on 3/3/25 and the washcloths were out for a "short period of time" until the laundry was able to provide more washcloths. Nurse #1 reported she found 5 washcloths on 3/3/25 that she provided to 3 residents that wanted a shower while waiting for laundry to provide more washcloths. An interview was conducted on 3/6/2025 at 10:20	F 584	or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 584 1. Corrective action for resident(s) affected by the alleged deficient practice: On 03/26/2025 and 3/28/2025 a corrective action was completed by purchasing additional washcloths to increase par level for resident care. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 03/26/2025, the Administrator began identification of the number of additional washcloths needed to provide resident care. Audit on morning of March 26, 2025 at 10:00 AM par level was adequate for washcloths in the laundry area. Washcloths for early morning care were already in use on the floor. No verbalizations from nursing staff regarding lack of washcloths. 3. Measures /Systemic changes to prevent reoccurrence alleged deficient practice: On 03/28/2025, the Administrator	

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F 584	Continued From page 23 AM with NA #2. NA #2 stated on Monday 3/3/2025 at 7:15 AM there were no washcloths or towels. NA #2 reported she had to use washcloths and towels from another hall and waited for laundry to provide more. An interview was conducted on 3/6/25 at 10:25 AM with NA #3 (worked on the 400, 500, and 600 halls). NA #3 reported it had been difficult to locate a washcloth for the past month. During the tour of the laundry room with the Administrator on 3/6/25 at 9:45 AM, it was observed that shelves labeled washcloths and towels were empty. At 9:49 AM on 3/6/25 an interview with the Housekeeping Supervisor was completed. The Housekeeping Supervisor stated when she arrived at 7:00 AM on 3/3/25 there were not enough washcloths. The Housekeeping Supervisor reported she provided clean washcloths to all the halls at 8:00 AM on 3/3/25. The Housekeeping Supervisor stated she continued to supply the halls with washcloths in 15-minute increments on 3/3/25 for the rest of the day. The Housekeeping Supervisor stated if the hall linen carts did not have washcloths or towels, the staff would sometimes stash the washcloths and towels away or use them up. The Housekeeping Supervisor also stated she purchased 54 washcloths on 3/3/25, 72 washcloths on 3/6/25 and was expecting a shipment on 3/10/2025 of 300 washcloths that she ordered 2 weeks ago. The Housekeeping Supervisor confirmed the shelves labeled washcloths and towels observed in the clean linen entrance of the laundry room was the only storage area for clean washcloths and towels.	F 584	educated the Housekeeping Supervisor of the appropriate par level for washcloths. Housekeeping Supervisor began educating Laundry department of the amount of washcloths that need to be available for adequate resident care on 3/28/2025. Regular monthly purchases of washcloths will be implemented to sustain adequate par level. Through monitoring if additional purchases are needed prior to monthly order Housekeeping Supervisor will purchase at a local department store such as Walmart. This information has been integrated into the standard orientation training for the Housekeeping Supervisor and laundry employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 3/31/25, any laundry employee who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Quality assurance monitoring will be completed by the Administrator or designee using the F584 Quality Assurance Tool; Washcloth Audit. This monitoring consists of observing number of wash cloths available for resident care. Monitoring will be completed weekly x 3 weeks and monthly x 2 months. Reports will be presented to the monthly Quality	

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	345543	A. BUILDING _____ B. WING _____	C 03/06/2025

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F 584	Continued From page 24 An interview with the Director of Nursing (DON) was completed on 3/6/25 at 11:00 AM. The DON stated housekeeping nor staff reported a shortage of washcloths on Monday 3/3/25. The DON reported she was aware that housekeeping placed an order for 300 washcloths about a week ago because washcloths were running low and informed the staff. An interview was conducted with the Administrator on 3/6/25 at 09:42 AM. The Administrator stated he was not aware of the washcloth shortage. The Administrator reported all laundry was completed in the facility during first and second shifts and there was no staff in laundry during third shift. The Administrator stated there should be enough washcloths available each day to provide resident care.	F 584	Assurance committee by the Administrator or designee to ensure corrective action is initiated as appropriate. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 04/01/2025	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, staff and Medical Director interviews, the facility failed to provide humidified oxygen (oxygen that has been moistened with water vapor) as ordered by the physician for 1 of 1 resident reviewed for respiratory care (Resident	F 695	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged	4/1/25

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F 695	Continued From page 25 #20) The findings included: Resident #20 was admitted to facility on 12/20/19 with diagnoses that included chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure and dependence on supplemental oxygen. Resident #20's physician orders dated 11/15/24 revealed oxygen at 4 liters per minute by nasal cannula continuously for chronic obstructive pulmonary disease Resident #20's care plan dated 12/30/24 noted a focus area for chronic obstructive pulmonary disease and interventions including the use of continuous oxygen and BIPAP (a bi-level positive airway pressure machine used to aid breathing) every night with oxygen bleed-in and water (which produces humidification of the inhaled oxygen). The quarterly Minimum Data Set (MDS) dated 12/31/24 noted Resident #20 was cognitively intact and coded for oxygen. Resident #20's physician orders dated 2/4/25 revealed BIPAP 15/5 centimeters of water with oxygen at 2 liters per minute bleed-in with a large full-face mask every night for obstructive sleep apnea. The Medication Administration Record (MAR) dated 3/2/25 revealed documentation that Resident #20 received humidified oxygen therapy for the night of 3/2/25. On 03/03/25 at 12:01 PM, Resident #20 was	F 695	deficiencies cited have been or will be corrected by the dates indicated. F695 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/4/2025 a corrective action was obtained for Resident #20 when oxygen humidification was not provided as ordered. On 3/4/2025 nurse #6 immediately replaced oxygen humidification for resident #20. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All current residents with oxygen therapy have the potential to be affected by the alleged deficient practice. On 3/5/2025, the Director of Nurses (DON)/ staff development clinician (SDC)/ Treatment nurse began identification of residents that were potentially impacted by this practice. Visual inspection completed on 3/5/2025 of all current residents with oxygen humidification and 0 of 24 resident found to have humidification not empty. No additional corrective action needed at that time. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/5/2025, the SDC/DON began reeducating Licensed Nurses, Registered	

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F 695	Continued From page 26 observed to be on 4 liters of oxygen by nasal canula via oxygen concentrator with a water canister for humidified oxygen. The canister was observed empty and attached to the oxygen concentrator. The MAR dated 3/3/25 revealed documentation that Resident #20 received humidified oxygen therapy for the night of 3/3/25. On 03/04/25 at 08:08 AM, the water canister on Resident #20's oxygen concentrator remained empty. On 03/04/25 at 03:01 PM, the water canister on Resident #20's oxygen concentrator remained empty. In an interview with Resident #20 on 03/04/25 at 3:03 PM, he stated that his nose was not dry without the use of the humidification. He stated that he had not had any nose bleeds and that his nose was not hurting at that time. During the interview, Resident #20 was wearing his oxygen cannula and the flow regulator on the oxygen concentrator was set to 4 liters per minute. Nursing Assistant (NA) #5 was interviewed on 3/4/25 at 3:11 PM. The NA reported she assisted if the nasal cannula was off or not in place and turned the concentrator on if it was off. NA #5 reported she did not do anything else related to the concentrator or oxygen. During an interview with Medication Aide (MA) #1 on 3/4/25 at 3:20 PM, she reported that she checked the concentrator if it was beeping. Med Aide #1 stated she would change out the water canister if it was empty. She also reported the	F 695	Nurses (RN□s) and Licensed Practical Nurses (LPN□s)/Medication Aides on oxygen administration education. (See Education) " policy and procedures related Oxygen administration with use of humidification " Education on changing of humidification when empty for resident receiving oxygen therapy This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 3/30/2025, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance monitoring will be completed by the Director of Nurses or designee using the F695 Quality Assurance Tool. This monitoring consists of monitoring 3 random residents who are currently receiving oxygen therapy to ensure that humidification present on oxygen concentrators to ensure humidification in use. Monitoring will be completed weekly x 3 weeks and monthly x 2 months on various days and various shifts. Reports will be presented to the	

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F 695	Continued From page 27 machine would beep when water was getting low, but she was not allowed to assess Resident #20's oxygen level. On 03/04/25 at 04:04 PM Nurse #6 was interviewed and reported Resident #20 liked to wear his oxygen connected to his BIPAP and was currently on 4 liters by nasal cannula. Nurse #6 reported the concentrator machine would sound an alarm when the water was getting low and self-muted when water canister was full. Nurse #6 reported that staff checked for water in the canister every time the BIPAP was applied. Upon observation with Nurse #6 on 3/4/25 at 4:10 PM of Resident #20's oxygen concentrator, the water canister was still empty. Nurse #6 noticed this and proceeded to remove the empty canister and stated that "the canister should have water in it" and reiterated that canisters were to be monitored and replaced as needed when empty. Nurse #6 proceeded to obtain new/full canister. The Director of Nursing (DON) was interviewed on 3/4/25 at 4:35 PM and reported oxygen concentrator settings should be correct, water canisters should be full for humidification and canisters should be assessed every shift and as needed. The DON reported nurses refilled water canisters from the supply cabinet. On 03/05/25 at 03:12 PM the Medical Director was interviewed by telephone. The Medical Director stated, "not good when the humidifying bottle is empty for several days." She also stated Resident #20 needed humidified oxygen during the day and while using the BIPAP machine at night. The Medical Director said she thought that the humidification mentioned in the BIPAP order	F 695	monthly QA committee by the DON or designee to ensure corrective action is initiated as appropriate. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 4/1/2025	

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F 695	Continued From page 28 was sufficient for Resident #20's daytime oxygen as well. She reported that there were no long-term effects from not having the humidification but there were short-term effects such as discomfort. On 03/06/25 at 5:00PM The Administrator reported nursing monitored all oxygen administration and concentrators.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		4/1/25

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F 761	Continued From page 29 by: Based on observations and staff interviews the facility failed to (1a.) date an open bottle of eyedrops and an open bottle of nasal spray with an open/discard by date for 1 of 4 medication carts (500 hall cart), (1b.) failed to dispose of a loose pill in 1 of 4 medication carts (100 hall cart) and (2.) and failed to secure medication left at 1 of 1 resident (Resident #19) bedside reviewed for medication storage. The findings included: 1a. An observation of the 500 hall medication cart was conducted with Nurse #3 on 03/05/25 at 4:40 PM. An open bottle of moxifloxacin (a medication used to treat eye infections) solution 0.5% was observed in a small plastic container with no open date. An open bottle of fluticasone (a medication used to treat allergies) nasal spray 50 microgram was observed in a small plastic container with no open date. Both bottles of medication were verified as open by Nurse #3. An interview with Nurse #3 on 03/05/25 at 4:42 PM revealed she didn't work often at the facility and did her best to keep up with what was on the medication cart. She indicated the open dates should have been documented when the medications were opened. b. An observation of the 100 hall medication cart was conducted with Nurse #4 on 03/05/25 at 3:50 PM. An unidentified white round pill was observed loose in the top right drawer of the medication cart. Nurse #4 revealed she didn't know how the pill got there as she checked the cart regularly and the pill shouldn't have been loose and unsecured in the medication cart.	F 761	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 761 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 3/5/2025 Nurse # 3 removed the open bottle of moxifloxacin for Resident # 43 from the medication cart and discarded it. The order for moxifloxacin for resident #43 was completed on 3/4/2025. On 3/5/25 Nurse #3 removed the open bottle of (fluticasone) nasal spray 50 mcg from the 500 hall medication cart and notified pharmacy for refill. On 3/5/2025 Nurse #4 discarded 1 loose unidentified white round pill observed in the top right drawer of 100 Hall medication cart. On 3/5/2025 Nurse #4 immediately discarded the 1 loose unidentified white round pull found on 100 hall medication cart. On 3/4/2025 Nurse #2 observed the antibiotic/pain relieving ointment on the bedside table of resident #19 and	

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F 761	Continued From page 30 On 03/06/25 at 2:16 PM an interview with the Director of Nursing (DON) revealed the third shift (11:00 PM to 7:00 AM) nurse conducted a weekly audit of all the medication carts. She indicated nurses should date medications when they were opened and discard according to expiration dates, and that pills should not be loose and unsecured in the medication carts. An interview with the Administrator on 03/06/25 at 2:25 PM revealed he expected nurses who opened medications to label them upon opening and that pills should not be loose and unsecured in the medication carts. 2. Resident #19 was admitted to the facility on 9/22/23 with diagnoses including late onset Alzheimer's disease and dementia. The quarterly Minimum Data Set (MDS) dated 2/13/25 noted Resident #19 had moderate cognitive impairment. On 03/03/25 at 12:14 PM Resident #19 was observed to have a tube of antibiotic/pain reliever ointment on her bedside table. Resident #19 stated "I put it on my forehead", but reported she did not remember why she was using it. When asked, she said she did not remember where she got the ointment. During an observation of Resident #19's room on 03/04/25 at 8:10 AM the tube of antibiotic/pain reliever ointment remained on her bedside table. During an interview with Nurse #1 on 3/4/25 at 2:06 PM, she reported that she was not aware of any medication on Resident #19's bedside table.	F 761	immediately removed the tube from resident #19□s bedside table. On 3/5/2025 Resident□s family member contacted by Director of Nursing (DON) about the antibiotic/pain relieving ointment and educated any medication at bedside must have a physician order and self administration evaluation completed by nursing. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 3/5/2025, the Director of Nurses (DON)/designee completed a facility wide check of all current resident rooms to ensure no other resident subjected by deficient practice of medications left at bedside. Findings included no other residents found to have medications left at bedside. On 3/26/2025 an initial audit completed for medication cart inspection to ensure medications were not expired and they were stored per pharmacy recommendations. This completed on 3/26/2025. The audit revealed: 3 eye drops and 2 nose sprays removed out of the 4 medication carts that had expired. These medications were removed by the DON and immediately discarded and replaced from OTC backup and pharmacy notified to replenish. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not	

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F 761	Continued From page 31 On 03/04/25 at 3:08 PM the tube of antibiotic/pain reliever ointment was observed still on Resident #19's bedside table. Resident #19 again reported she put the ointment on her forehead "about three times a day, it itches sometimes". Upon observation of Resident #19's bedside table with Nurse #2 on 3/4/25 at 4:27 PM, Nurse #2 observed the antibiotic/pain relieving ointment on the bedside table and removed the tube and took it to the nurse's station. Nurse #2 reported that it should not have been on the resident's bedside table. On 03/05/25 at 2:19 PM the Director of Nursing (DON) reported that a physician's order was required to have any medication at a resident's bedside. In a telephone interview with the Medical Director on 3/5/25 at 3:12 PM, she reported that Resident #19's family member probably brought the medicated ointment. The Medical Director stated she was surprised the staff had not seen the medicated ointment before it was brought to their attention. She also stated she would have expected the staff to see the medicated ointment and remove it from Resident #19's room. In an interview with the Administrator on 3/5/25 at 5:15 PM. The Administrator confirmed that residents and family were educated to not bring in medications from home and leave them at resident's bedside.	F 761	reoccur: Education: On 3/5/25 the Staff Development Clinician/DON/ began educating all licensed nurses (RN□s and Licensed Practical Nurses, full time, part time, PRN staff, and medication aides on Drug Storage and Biologicals. This education includes: Medications are stored safely and securely. All unidentified medications are to be discarded immediately when found. Pay attention to medication expiration dates (ex. Fluticasone date when opened and discard when applicable to comply with manufactures instructions). Medications cannot be left at bedside. Any medications found at resident□s bedside will be removed immediately. The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 3/31/2025. 4. Monitoring Procedure to ensure that the plan of correction is effective and that	

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F 761	Continued From page 32	F 761	specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee will begin monitoring compliance on utilizing the QA tool: Medication/ Treatment Cart Inspection beginning 3/27/2025 weekly x 3 weeks then monthly x 2 months to ensure that medications are labeled when opened and no loose pills. The DON/designee will monitor 5 random resident rooms beginning 3/27/2025 weekly x3 weeks then monthly for 2 months to ensure there are no medications left at bedside. The DON or designee will monitor for compliance the proper way to store medications and remove expired medications. Reports will be presented to the monthly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Compliance Date: 4/1/2025	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		4/1/25

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F 812	Continued From page 33 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to discard expired nutritional supplement drinks that were past the use by date in 2 of 2 nourishment rooms (300 Hall and 500 Hall Nourishment rooms). The findings included: An observation was made on 03/05/2025 at 2:33 PM of the nourishment room on the 300 Hall. The observation revealed that there were 17 individual nutritional supplement drink cartons with a use by date of 02/01/2025 available for use located on a lower shelf in the nourishment room. An observation was made on 03/05/2025 at 2:44 PM of the nourishment room on the 500 Hall. The observation revealed that there were 121	F 812	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 3/05/2025. Based on nourishment room observations on 3/05/2025, it was noted the facility had failed to discard expired supplements from 2 of 2 nourishment rooms. On 3/05/2025 expired supplements thrown	

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F 812	Continued From page 34 individual nutritional supplement drinks with a use by date of 02/01/2025 available for use located on a lower shelf in the nourishment room. An interview and tour of the nourishment room on the 300 Hall on 03/05/2025 at 3:00 PM with the Dietary Manager revealed she was responsible for stocking snacks and the fortified nutritional shakes. She stated Central Supply was responsible for stocking the nutritional supplement drinks and should have pulled the out of date items. An interview and tour of the nourishment rooms on 300 Hall and 500 Hall on 03/05/2025 at 3:05 PM with Central Supply revealed that she checked the nourishment rooms once a week for expired items. She checked both rooms last week and did not know why the out of date nutritional supplement drinks had not been removed. An interview on 03/06/2025 at 4:32 PM with the Administrator and the Dietary Manager revealed they were unsure why the expired nutritional supplement drinks had not been removed from stock. The Dietary Manager stated that Central Supply should have pulled the out of date nutritional supplement drinks. The Administrator indicated all food/drink items should have been removed from stock as soon as they expired.	F 812	out. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 3/05/2025 Central Supply completed a walk-through of the nourishment rooms to ensure nourishments rooms met standards to store, prepare, and serve sanitary supplements. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Education: In-service education was provided to Central Supply and Housekeeping Supervisor on 3/24/2025. Topics included: " First In First Out with supplements " Inventory to be completed and reviewed prior to ordering. " Supplement orders to be updated and reviewed prior to ordering. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the	

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F 812	Continued From page 35	F 812	plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Central Supply or Housekeeping Supervisor will monitor procedures for proper supplement storage weekly x 3 weeks then monthly x 2 months using the Nourishment Room Inspection Tool which will observe that all supplements are labeled, dated, within proper dates, and stored properly. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of Compliance:4/1/2025	
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	F 883		4/1/25

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F 883	Continued From page 36	F 883		

annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(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

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F 883	Continued From page 37 (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 document education was provided in the medical record regarding the benefits and potential side effects of the influenza and pneumonia vaccines prior to the administration of vaccines. This occurred for 4 of 5 residents (Resident #98, Resident #77, Resident #262, and Resident #27) reviewed for vaccines. The findings included: a. Resident #98 was admitted to the facility on 04/04/24. The resident's immunization record was reviewed and revealed that staff answered "no" under the education provided tab for influenza vaccine administered by Nurse #7 on 10/03/24 and for pneumonia vaccine administered by Nurse #7 on 10/18/24. The immunization record review also revealed that nothing was documented under the education notes section on the immunization record for these doses. b. Resident #77 was admitted to the facility on 03/22/22. The resident's immunization record was reviewed and revealed staff answered "no" under the education tab for influenza vaccine administered by Nurse #7 on 10/07/24, and pneumonia vaccine administered by Nurse #7 on 10/21/24. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for these doses.	F 883	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F883 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The Facility did not follow processes as outlined in the policies and procedures to ensure that documentation of education was provided in the medical record regarding the benefits and potential side effects of the influenza and pneumonia vaccines prior to administration of vaccine. Residents # 98. Resident #77, Resident #262, Resident #27 were assessed for the eligibility of and offered the pneumococcal and influenza vaccines and resident□s immunization record revealed that staff answered no under the education provided tab for influenza vaccine and pneumonia vaccine administration.	

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F 883	Continued From page 38 c. Resident #262 was admitted to the facility on 02/11/25. The resident's immunization record was reviewed and revealed staff answered "no" under the education tab for influenza vaccine administered by Nurse #7 on 02/12/25, and pneumonia vaccine administered by Nurse #7 on 02/15/25. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for these doses. d. Resident #27 was admitted to the facility on 10/01/21. The resident's immunization record was reviewed and revealed the education area was answered "no" under the education tab for influenza vaccine administered by Nurse #7 on 10/03/24. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for these doses. An interview with the Infection Preventionist (IP) on 03/06/25 at 1:40 PM revealed that the floor nurse would administer the vaccines per the Medication Administration Record (MAR). She stated there should be education provided prior to administration of vaccines by the nurse administering the vaccine. The IP stated she and the Director of Nursing track which staff and residents received vaccines. An interview with Director of Nursing on 03/06/25 at 2:40 PM revealed she kept a record of the vaccines administered on the Vaccine Information Flowsheet. She stated the education should be provided to the resident or resident's representative prior to the vaccine being administered. The Director of Nursing stated the expectation was for the nurse that provided the	F 883	1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #98 was assessed and offered the influenza vaccine and administration documented on 10/03/2024 and pneumonia vaccine on 10/18/2024. MD was informed. Resident representative educated on 3/27/2025 for influenza and pneumonia vaccine. Resident #262 was assessed and offered the influenza vaccine and administration for influenza vaccine on 2/12/2025 and pneumonia vaccine on 2/15/2025. No corrective action due to resident discharged from facility 3/17/2025. Resident #77 was assessed and offered the pneumococcal and influenza vaccine. Influenza was administered 01/07/2024 and pneumonia on 10/21/2024. MD was informed. Resident educated on influenza and pneumonia vaccine on 3/27/2025. Resident #27 assessed and offered the influenza vaccine on 10/3/2024. MD was informed. Resident educated on influenza vaccine on 3/27/2025. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All current residents have the potential to be affected by the alleged deficient practice.	

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F 883	Continued From page 39 education to document in the medical record that education had been provided on the immunization record. An interview with the Administrator on 03/06/25 at 5:05 PM revealed he expected the resident and/or the resident's legal representative to be provided with education regarding the benefits and potential side effects prior to offering vaccines. He stated the expectation of consistency and the procedures for providing vaccine education was not carried out.	F 883	On 3/27/2025 corrective action was initiated. The Director of Nurses/Unit Managers/Minimum data nurse completed a 100% Initial audit of all current residents from 3/1/2025-3/27/2025 who were offered pneumonia/influenza vaccine upon admission and provided education revealed 3 out of the 9 residents did not receive education prior to refusal of influenza/pneumonia vaccine. Influenza/Pneumococcal Education was provided to the identified residents or responsible party on 3/27/2025 and medical record has been updated to show documentation of the influenza and pneumococcal education. Despite education the residents continued to refuse the pneumonia/influenza vaccinations. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Education: The Director of Nurses educated all RN□s and LPN□s on the influenza and pneumococcal policy and procedures including: Explain risk and benefits of receiving the vaccine to the resident and /or responsible party and document education in resident□s medical record. On 3/21/2025 the Director of Nurses/Nurse Management team began	

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education of all RN□s and LPN□s full time, part time and as needed nurses on the Pneumococcal and Influenza administration. The in-service will be completed by 3/31/2025 at which time all nurses must be in-serviced prior to working. The Director of Nurses will ensure that that any of the above identified staff who does not complete the in-service training by 3/31/2025 will not be allowed to work until the training is completed. The in-service will be incorporated into the new employee facility orientation.

Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:

The Director of Nurses/Unit Managers will monitor the immunization process for pneumococcal and influenza vaccines by observing 5 residents utilizing the Immunization Audit Tool during the Daily Clinical Meeting Monday through Friday for compliance of the facility policy. This audit will be completed weekly for a period of 3 weeks and then monthly for a period of 2 months. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. The Clinical Team will review in the Quality Assurance Meeting weekly until resolved. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality

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F 883	Continued From page 41	F 883	Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nurses, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/1/2025	
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;	F 887		4/1/25

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F 887	Continued From page 42 (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 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 document education was provided in the medical record regarding the benefits and potential side effects of the COVID-19 vaccines prior to administration of the vaccines. This occurred for 5 of 5 residents reviewed for immunizations (Resident #43, Resident #98, Resident #77, Resident #262, and Resident #27). The findings included:	F 887	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F887	

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F 887	Continued From page 43 a. Resident #43 was admitted to the facility on 07/10/19. The Resident's immunization record was reviewed and revealed that staff answered "no" under the education provided tab for COVID-19 vaccine administered by Nurse #7 on 11/06/24. The immunization record review also revealed that nothing was documented under the education notes section on the immunization record for this dose. b. Resident #98 was admitted to the facility on 04/04/24. The resident's immunization record was reviewed and revealed that staff answered "no" under the education provided tab for the COVID-19 vaccine administered by Nurse #7 on 05/25/24. The immunization record review also revealed that nothing was documented under the education notes section on the immunization record for this dose. c. Resident #77 was admitted to the facility on 03/22/22. The resident's immunization record was reviewed and revealed staff answered "no" under the education tab for the COVID-19 vaccine administered by Nurse #7 on 10/21/24. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for this dose. d. Resident #262 was admitted to the facility on 02/11/25. The resident's immunization record was reviewed and revealed staff answered "no" under the education tab for the COVID-19 vaccine administered by Nurse #7 on 02/12/25. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for this dose.	F 887	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The Facility did not follow processes as outlined in the policies and procedures to ensure that documentation of education was provided in the medical record regarding the benefits and potential side effects of the COVID-19 vaccine prior to administration of vaccine. Residents # 43, Resident #98, Resident #262, Resident #77, and Resident #27 were assessed for the eligibility of and offered COVID-19 vaccine and revealed that staff answered no under the documentation for education provided tab for the COVID-19 vaccines. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #98 was assessed and offered the COVID-19 vaccine by nurse #7 on 5/25/2024. MD was informed. Resident provided education on 3/27/2025 using the vaccine information statement updated version 1/31/2025. Education was documented in point click care under the immunization tab. Resident #43 was assessed and offered the COVID-19 vaccine by nurse #7 on 11/6/2024. MD was informed. Resident provided education on 3/27/2025 using the vaccine information statement	

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F 887	Continued From page 44 e. Resident #27 was admitted to the facility on 10/01/21. The resident's immunization record was reviewed and revealed the education area was answered "no" under the education tab for the COVID-19 vaccine administered by Nurse #7 on 10/25/24. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for this dose. An interview with the Infection Preventionist (IP) on 03/06/25 at 1:40 PM revealed that the floor nurse would administer the vaccines per the Medication Administration Record (MAR). She stated there should be education provided prior to administration of the vaccine by the nurse administering the vaccine. An interview with the Director of Nursing on 03/06/25 at 2:40 PM revealed she kept a record of the vaccine administered on the Vaccine Information Flowsheet. She stated the education should be provided to the residents or the resident's representative prior to the vaccine being administered. The Director of Nursing stated the expectation was for the nurse that provided the education to document in the medical record that education had been provided on the immunization record. An interview with the Administrator on 03/06/25 at 5:05 PM revealed he expected the resident and/or the resident's legal representative to be provided with education regarding the benefits and potential side effects prior to offering vaccines. He stated the expectation of consistency and the procedures for providing vaccine education was not carried out.	F 887	updated version 1/31/2025. Education was documented in point click care under the immunization tab. Resident #77 was assessed and offered the COVID-19 vaccine by nurse #7 on 10/21/2024. MD was informed. Resident provided education on 3/27/2025 using the vaccine information statement updated version 1/31/2025. Education was documented in point click care under the immunization tab. Resident #262 assessed and offered the COVID-19 vaccine on 2/12/2025 No corrective action due to resident discharged from facility 3/17/2025. Resident #27 assessed and offer the COVID-19 vaccine by nurse on #7 on 10/25/2024. MD was informed. Resident provided education on 3/27/2025 using the vaccine information statement updated version 1/31/2025. Education was documented in point click care under the immunization tab. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents who have not been assessed and offered the COVID-19 vaccine for the 2024/2025 season have the potential to be affected by the alleged deficient practice. All residents who have not been	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

(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
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assessed and offered education including the vaccine information sheet prior to administration have the potential to be affected by the alleged deficient practice.

On 3/27/2025 a corrective action was initiated. The Director of Nurses/Unit Managers/Minimum data nurse completed a 100% Initial audit of all current residents from 3/1/2025-3/27/2025 who were offered COVID-19 vaccine upon admission and provided education revealed 2 out of the 9 residents did not have education documented in PCC prior to refusal of COVID-19. Education was provided to the identified residents on 3/27/2025 and medical record has been updated to show documentation of education. Despite education the resident continued to refuse the COVID-19 vaccine.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

Education:

The Director of Nurses and the Nurse Management team were re-educated on the immunization policy to include COVID-19 documentation process for education.

Documentation of the vaccination education in the resident□s immunization record in PCC.

On 3/21/2025 the Director of

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F 887	Continued From page 46	F 887	Nurses/Nurse Management team began education of all RN□s and LPN□s full time, part time and as needed nurses on the COVID-19 administration to include documentation of education in the medical record in point click care under the immunization tab. The in-service will be completed by 3/31/2025 at which time all nurses must be in-serviced prior to working. The Director of Nurses will ensure that that any of the above-mentioned staff who do not complete the in-service training by 3/31/2025 will not be allowed to work until the training is completed. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nurses/Unit Managers will monitor the immunization process for COVID-19 vaccines by observing 5 residents utilizing the Immunization Audit Tool during the Daily Clinical Meeting Monday through Friday for compliance of the facility policy. This audit will be completed weekly for a period of 3 weeks and then monthly for a period of 2 months. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. The Clinical Team will review in the Quality Assurance Meeting weekly	

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F 887	Continued From page 47	F 887	until resolved. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nurses, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/1/2025	