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	345386	A. BUILDING _____ B. WING _____	04/23/2025

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WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

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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		5/22/25

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

Electronically Signed | 05/16/2025

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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 EP Program patient population, names and contact information for staff, resident's physicians, other long-term care (LTC) facilities, and volunteers, emergency officials contact information, emergency prep training program, and integrated health systems. This had the potential to affect all 8 residents and staff. The findings included: A review of the facility's supplied Emergency Preparedness (EP) plan revealed the Emergency Management Manager had reviewed the material in February 2025. The following areas were not present, updated, or revised: a. The facility's EP plan did not include EP program patient population. b. The facility's EP plan did not include names and contact information for staff, resident physicians, other LTC facilities, and volunteers. c. The facility's EP plan did not include emergency officials contact information including Federal, State, tribal, regional, or local emergency preparedness staff.	E 001	Emergency Management (EM) has conducted a full crosswalk of all Long-Term Care (LTC) Emergency Preparedness (EP) requirements for the SNF and is addressing all areas. Completed 5/14/25 1) This crosswalk consists of reviewing all policies and procedures to ensure they match expectations from both a regulatory perspective as well as meeting the needs of the SNF population. 2) Establishes a unified command when integrating into the hospitals overarching Incident Command System (ICS). 3) A standalone Emergency Management Binder has been built specific to the SNF and will remain present within the unit continuously with staff education on intent and usage. 4) Education for SNF staff regarding the Emergency Management Binder will be completed via written and inservice education by 5/21/25. Education ensured staff knowledge of binder location, intent, and purpose. 5) Target compliance date 5/22/25 Patient Population Action: Emergency Management and SNF leadership have developed a summary of	

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E 001	Continued From page 2 d. The facility's EP plan did not include emergency prep training including initial training in emergency preparedness policies and procedures for all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. e. The facility's EP plan did not include integrated health systems During an interview with the Emergency Management Manager on 4/23/25 at 11:45am he reported he had reviewed the current EP plan in February 2025. The Emergency Management Manager verified the facility had not addressed patient/client population, including, but not limited to, persons at-risk; the type of services the LTC facility could provide in an emergency; and continuity of operations, including delegations of authority and succession plans prior to his employment in October of 2024 nor after his start as Emergency Management Manager. The Emergency Management Manager confirmed the facility's EP plan did not include names and contact information for staff, resident's physicians, other LTC facilities, and volunteers. The Emergency Management Manager confirmed the facility's EP plan did not include emergency officials contact information including Federal, State, tribal, regional, or local emergency preparedness staff. The Emergency Management Manager verified the facility's EP plan did not include emergency prep training including initial training in emergency preparedness policies and procedures for all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. The Emergency	E 001	its resident population to determine specific needs during an activation of the Emergency Operations Plan (EOP). This consists of clinical and other support needs and associating each within the risk categories identified through our Hazard Vulnerability Assessment (HVA) This measure has been completed as of May 8, 2025. An annual review will be done for ongoing compliance. Communication (List of Staff, Physicians, other LTC facilities, Volunteers) Action: SNF leadership has provided Emergency Management with a list of all staff and physicians assigned to the unit including mobile phone numbers (note: volunteers do not operate at this location). Likewise, Emergency Management has developed a list of nearby LTC facilities and included within the Emergency Management Binder. To enhance our response framework, this communication directory has been added to our Emergency Notification System (ENS) allowing for mass messaging to members of the SNF during an emergency activation. This directory will be updated by EM annually or more frequently as changes are identified. This measure has been completed as of May 8, 2025. Emergency Officials Contact Information Action: Emergency Management has developed a comprehensive list of local, regional, State, and Federal contact information and included within the EM Binder. This includes redundant points-of-contact for agencies including,	

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E 001	Continued From page 3 Management Manager confirmed that the facility's EP plan did not include integrated health systems. The Emergency Management Manager stated he would be the person responsible for updating the EP plan information. The Emergency Management Manager stated that he was unaware that the skilled facility within the hospital system had it's own requirements of information that should be included in the emergency preparedness plan but going forward he would certainly include the information. During an interview with Nursing Assistant (NA) # 1 on 4/23/25 at 1:51pm she reported that EP manual was probably in the Minimum Data Set office. NA #1 reported that if there were an emergency she would first contact the nursing supervisor and then notify security. During an interview with Nurse # 3 on 4/23/25 at 1:53pm she reported she was not sure where the EP manual was but assumed it was probably in the nursing office. Nurse #3 pointed out the EP plan/diagram posted on the wall in hallway. Nurse #3 stated if there was an emergency she would first contact the staff in the office who are in charge and if it were a weekend she would call the nursing supervisor. During an interview with the Doctor of Nursing Practice (DNP) on 4/23/25 at 2:14pm she reported never seeing the EP checklist and was not aware of the information or training that was required for the facility unit. The DNP reported she understood what needed to change.	E 001	but not limited to: Wilkes County Emergency Medical Services (EMS), Wilkes County EM, Wilkes County Health Department, North Carolina Emergency Management (24-Hour Watch Center), NC EM Western Branch Office, NC Department of Public Safety, Division of Health Services Regulation (DHSR), NC Office of EMS (OEMS), Federal Emergency Management Agency (FEMA) (24-Hour Watch Center), FEMA Region 4 including State Administrator contact, amongst other support agencies. This measure has been completed as of May 9, 2025. Training Program Action: Atrium Health Wake Forest Baptist (AHWFB) requires that all employees upon orientation (new hire) and on a continuous basis (annually) to complete Annual Required Learning (ARL) modules which include a portion specific to emergency response policies and procedures. These training courses are updated yearly based on HVA results and include a testing component that all teammates, volunteers, and contractors must successfully pass to demonstrate competency. This measure has been completed as of May 9, 2025. An annual review will be done for ongoing compliance. Integrated Health System Action: Emergency Management maintains an Emergency Management Plan (EMP) that aligns the Emergency Program from a market perspective	

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E 001	Continued From page 4	E 001	(Wake Market/Winston-Salem) as well as integration from an enterprise approach (Atrium Health/Advocate). This Integrated EMP has been active since 2023 and establishes a response framework to include both acute care and non-acute care settings, including LTC, Ambulatory, and other service lines. A copy of the EMP has been included within the EM Binder and is available for review as necessary. This measure, including submission within the EM binder, has been completed as of May 8, 2025. An annual review will be done for ongoing compliance.	
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted from 4/21/25 through 4/23/25. Event ID# UH8N11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for the use of oxygen for 1 of 8 residents (Resident #109) whose MDS assessments were reviewed. The findings included: Resident #109 was admitted to the facility on 4/3/2025 with diagnosis that included chronic obstructive pulmonary disease (COPD).	F 641	Corrective Action for Affected Resident: The affected resident oxygen order (resident 109) was immediately reviewed. Oxygen therapy was initiated as ordered on 4/19/25. MDS coordinator immediately reviewed the MDS and found oxygen had not been placed during the MDS observation period. Identification of Other Residents at Risk: A screen of all residents was completed on	5/22/25

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F 641	Continued From page 5 A review of the admission Minimum Data Set (MDS) dated 4/12/2025 revealed Resident #109 was cognitively intact. The MDS indicated diagnosis of COPD and was not coded for oxygen use. A review of Resident #109's orders revealed oxygen care orders: - (4/8/25) Nasal Cannula 1 liter per minute, keep oxygen saturation greater than 92% - (4/8/25) Pulse oximetry, continuous, maintain oxygen saturations greater than 94% An interview with the MDS Coordinator on 4/23/25 at 10:43 AM revealed respiratory orders should be addressed on admission by including them in assessments and care plans. MDS Coordinator did not say why the oxygen was not coded.	F 641	all residents on 4/23/25 to assess oxygen therapy orders and correct initiation with no discrepancies found. Systemic Changes to Prevent Recurrence: New Order Process revised to include: 1. Mandatory nursing review of all oxygen therapy orders for correct implementation effective by 5/21/25 2. Initial review conducted by Staff nurse to be followed by Charge Nurse or designee within 24hrs effective by 5/21/25. Nursing Staff re-education including: 1. Importance of timely review and correct implementation of all oxygen therapy orders 2. Correct Documentation of Oxygen therapy in the Medical Record and plan of care 3. Including Oxygen therapy status in communications such as shift handoff. 4. Educational components have been incorporated into new staff orientation plan 5. Nursing Education will be completed by 5/21/25. Monitoring and Quality Assurance Charge Nurse or a designee too: 1. As of 5/21/25, review every new Resident O2 order for correct implementation and documentation daily. 2. As of 5/21/25 100% review of all new oxygen therapy orders and MDS Coding will be conducted for the next 60 days with random reviews thereafter to ensure	

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F 641	Continued From page 6	F 641	compliance. 3. Results will be reviewed monthly by both nurse manager and charge nurses and at each QAA meeting. 4. Any trends or recurrent issues will prompt immediate re-education and process review. Target Full Compliance Date: 5/22/25	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655		5/22/25

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F 655	Continued From page 7 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to develop a baseline care plan that addressed a resident's oxygen and respiratory care for 2 of 3 residents reviewed for baseline care plans (Resident #109 and Resident #110). The findings included: 1. Resident #109 was admitted to the facility on 4/3/2025 and readmitted on 4/8/25 with a diagnosis that included chronic obstructive pulmonary disease (COPD). A review of the admission Minimum Data Set (MDS) dated 4/12/2025 revealed Resident #109 was cognitively intact. The MDS also indicated diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and was not coded for oxygen. A review of Resident #109's active care plan dated 4/8/2025 revealed there were no goals or	F 655	Corrective Action for Affected Residents: 1. The residents oxygen and respiratory care needs were immediately assessed by the RN on 4/22/25. 2. A baseline care plan was created and implemented to address oxygen therapy and respiratory care by the RN on 4/22/25. For Resident 109 care plan additions included Chronic Disease Management and Alternate Respiratory Status. For Resident 110 an Altered Respiratory Status care plan was added. Identification of Other Residents at Risk: A screen of all residents was completed by the RN on 4/22/25 to assess oxygen and respiratory care plan needs with no discrepancies found. Systemic Changes to Prevent Recurrence:	

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F 655	Continued From page 8 interventions regarding oxygen or respiratory care included in the baseline care plan. An interview with Nurse #1 on 04/22/25 at 01:22 PM stated orders and care plans were reviewed by the nurse each shift. Nurse #1 confirmed Resident #109 was receiving oxygen and respiratory status was assessed. Nurse #1 stated that respiratory care was not added to the care plan when Resident #109 was readmitted to the unit. Nurse #1 reported oxygen and oxygen monitoring was ordered on readmission. A review of Resident #109's orders revealed oxygen care orders: - (4/8/25) Nasal Cannula 1 liter per minute, keep oxygen saturation greater than 92% - (4/8/25) Pulse oximetry, continuous, maintain oxygen saturations greater than 94% An interview with the MDS Coordinator on 4/23/25 at 10:43 AM revealed respiratory orders should be added to the care plan and resolved on discharged. The MDS Coordinator reported the nurse should address respiratory care in the care plan on admission and any time after if not addressed on admission. An interview with the Nurse Manager on 4/23/25 at 1:47 PM revealed that each nurse was expected to review orders and the care plan for oxygen needs and to communicate any changes during the shift change report. The Nurse Manager stated that nurses should add respiratory care to the care plan upon admission. She also stated that nurses should have addressed respiratory care in the care plan for Resident #109 when reviewing the care plan during the shift.	F 655	Baseline Care plan Implementation Process revised to include within 48hrs of admission or with any new oxygen or respiratory care needs: 1. Mandatory Staff RN review of all identified patients with oxygen and respiratory care needs for timely baseline care plan implementation effective 5/21/25 2. A daily review by Charge Nurse or designee within 24hrs effective 5/21/25. Nursing Staff re-education includes: 1. Importance of timely implementation within 48hrs of admission, or upon a change in a residents respiratory status an individualized baseline care plan 2. Nursing Education will be completed by 5/21/25. 3. Nursing Education will be incorporated into a new staff orientation plan. Monitoring and Quality Assurance (How often and who) Charge Nurse or a designee too: 1. As of 5/21/25, conduct 100% review of residents with identified Oxygen or respiratory care needs for correct baseline care plan initiation. 2. As of 5/21/25 conduct 100% review of all new admissions or residents with condition change with oxygen or respiratory care needs for correct baseline care plan initiation for the next 60 days with random reviews thereafter to ensure ongoing compliance. 3. Results will be reviewed monthly by both nurse manager and charge nurses	

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F 655	Continued From page 9 2. Resident #110 was admitted to the facility on 9/3/2021 and readmitted on 4/14/2025 with diagnosis that included respiratory failure. A review of Resident #110's quarterly Minimum Data Set (MDS) dated 2/28/2025 indicated diagnosis of chronic respiratory failure with hypoxia and was coded for oxygen use. The MDS also revealed Resident #110 was cognitively intact. A review of Resident #110's active care plan dated 4/8/2025 revealed there were no goals or interventions regarding oxygen or respiratory care included in the baseline care plan. An interview with Nurse #1 on /22/25 at 01:22 PM stated orders and care plans were reviewed by the nurse each shift. Nurse #1 confirmed Resident #110 was receiving oxygen and respiratory status was assessed. Nurse #1 stated that respiratory care was not added to the care plan when Resident #110 was readmitted to the unit. Nurse #1 reported oxygen and oxygen monitoring was ordered on readmission. A review of Resident #110's oxygen care orders revealed: -(4/14/25) Oxygen Therapy nasal cannula, rate 3 liters per minute, keep oxygen saturation level greater than 90%. -(4/14/25) Initiate Adult Respiratory Chronic-Stable Bilevel Positive Airway Pressure/ Continuous Positive Airway Pressure (BIPAP/CPAP) Protocol (Adult Non-invasive Ventilation) continuously. An interview with the MDS Coordinator on	F 655	and at each QAA meeting. 4. Any trends or recurrent issues will prompt immediate re-education and process review. Target Full Compliance Date: 5/22/25	

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F 655	Continued From page 10 4/23/25 at 10:43 AM revealed respiratory orders should be added to the care plan and resolved on discharged. The MDS Coordinator reported the nurse should address respiratory care in the care plan on admission and any time after if not addressed on admission. An interview with the Nurse Manager on 04/23/25 at 1:47 PM revealed that each nurse was expected to review orders and the care plan for oxygen needs and to communicate any changes during the shift change report. The Nurse Manager stated that nurses should add respiratory care to the care plan upon admission. She also stated that nurses should have addressed respiratory care in the care plan for Resident #110 when reviewing the care plan during the shift.	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow physician orders for 1 of 1 resident (Resident #209) reviewed for professional standards of practice. The findings included: Resident #209 was admitted to the facility on 4/18/2025 with a diagnosis that included Diabetes, and bilateral leg swelling.	F 658	Corrective Action for Affected Resident: 1. The resident was assessed for proper positioning of the affected lower extremity and offloading boot applied by the RN on 4/22/25. 2. SNF staff performed routine rounding on 4/22/25 and ongoing to evaluate appropriate offloading of affected lower extremity.	5/22/25

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F 658	Continued From page 11 A review of the Admission Statement submitted by Nurse #1 on 4/18/2025 revealed Resident #209 was alert, disoriented to place, time, person, and event, speech was clear, and cognition level was appropriate for attention/concentration. At the time of review no behaviors had been identified. A review of the physician orders dated 4/18/25 revealed a treatment for no-sting barrier film to the right heel, heel floating boot placed on resident, and float heels always. A review of the Baseline Care Plan dated 04/18/2025 revealed a problem as skin integrity. The goal listed was that skin integrity would improve with the interventions of providing skin care and provide pressure relieving interventions. An observation and interview on 4/21/2025 at 1:11 PM revealed Resident #209 was up in a recliner with both feet elevated with no heel floating boot and Resident #209's heels were not floating. Resident #209 stated he was admitted because his legs were swollen. He stated he was doing exercises with Physical Therapy/Occupational Therapy (PT/OT) to get rid of the fluid in his legs. Observation at 4/21/25 at 3:15 PM revealed Resident #209 was in bed with a heel floating boot on his right foot. There was no heal floating boot under the sink at the time of the observation. Resident #209 stated he had a heel floating boot that morning while in bed. Resident #209 stated when he got up in the chair staff removed his heel floating boot so he could get some traction. Resident #209 stated they leave the heal floating	F 658	Identification of Other Residents at Risk: A screen of all residents was completed on 4/22/25 by Staff RN to assess compliance of ordered pressure relieving interventions or devices with no non-compliance found. Systemic Changes to Prevent Recurrence: Nursing and Therapy Staff re-education includes: 1. Importance of adherence to provider order for pressure relieving interventions or devices 2. Proper monitoring throughout shift of continued compliance with ordered offloading 4. Proper communication of pressure relieving treatments or devices during handoff. 5. Nursing and Therapy Staff education will be completed by 5/21/25. 6. Nursing Education will be incorporated into new staff orientation plan. Monitoring and Quality Assurance Charge Nurse or a designee too: 1. As of 5/21/25 conduct daily 100% review of all residents with orders for pressure-relieving interventions or devices to ensure implementation and Compliance for the next 60 days. Reviews will be completed utilizing routine rounding. Then random reviews thereafter to ensure ongoing compliance. 2. Results will be reviewed monthly by both nurse manager and charge nurses and at each QAA meeting. 3. Any trends or recurrent issues will	

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F 658	Continued From page 12 boot off while he was in the chair. An observation and interview with the Occupational Therapist on 4/22/2025 at 10:41AM revealed Resident #209 lying in the bed with both legs laying flat on the bed without a heel floating boot on the right foot. Two pillows were observed to the right of Resident #209's legs. A dark purple circular area was observed on the resident's right heal. At the end of therapy Resident #209 was assisted into the recliner by the therapist with the stand to lift chair. She was observed floating the residents heals with two pillows under his legs but did not place the heel floating boot on Resident #209's right heel. The therapist stated she assisted him in the chair for the first time on 4/21/2025. An interview and observation with Nurse #1 on 4/22/2025 at 12:21 PM revealed she was the nurse that admitted Resident #209 on the 4/18/2025. She stated he had dry areas to his right leg that looked like scratches and abrasions and a light gray area on his right heel. Nurse #1 read the treatment orders out loud during the interview. Orders for no sting barrier film to the right heel daily, heal floating boot placed on patient, and float heals at all times. She stated she received a new heal floating boot for him this morning around 10:30am because the other one was dirty, but she did not have time to apply it yet. Nurse #1 and the surveyor walked to Resident #209's room. The resident was sitting in the recliner with both heels resting on the leg rest without his heels being floated. Nurse #1 placed the heel floating boot on the right foot. Nurse #1 was observed not to float Resident #209's heels. An interview with the Minimum Data Set Nurse	F 658	prompt immediate re-education and process review. Target Full Compliance Date: 5/22/25	

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F 658	Continued From page 13 (MDS)/Nurse Supervisor on 4/22/25 at 12:33pm revealed that a new heel floating boot had come in for him today because the old one was soiled. The MDS/Nurse Supervisor was made aware that Resident #209 had been observed without the heel floating boot or feet being floated on pillows. The MDS/Nurse Spervisor stated if a heel floating boot was not available, she would expect the heels to be floated. An interview with Nurse #6 on 4/22/2025 at 1:03 PM revealed she had removed the pillows under Resident #209's legs during lunch. She stated she removed pillows so she could place his lunch tray on the overbed table over the resident's lap. She stated she thought she had put the pillows back under Resident #209's legs but must have forgotten. Nurse #6 stated if the heel floating boot was not available for the resident she would float his heels with pillows. An interview with the Physician's Assistant (PA) at 04/22/25 at 2:03 PM revealed he had not assessed Resident #209 this morning. The PA was notified that Resident #209 was observed without a heel floating boot on his right foot and without his heels being floated. He stated he would expect staff to follow the orders for the heel floating boot and heels to be floated.	F 658		
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	F 695		5/22/25

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F 695	Continued From page 14 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 observations, record review, and staff interviews, the facility failed to post cautionary and safety signage outside resident rooms that indicated the use of oxygen and failed to follow Physicians orders related to oxygen use for 2 of 2 residents reviewed for respiratory care (Resident #109, and Resident #110). The findings included: A. Resident #109 was admitted to the facility on 4/3/2025 with diagnosis that included chronic obstructive pulmonary disease (COPD). A review of the admission Minimum Data Set (MDS) dated 4/12/2025 revealed Resident #109 was cognitively intact. The MDS indicated diagnosis of COPD and was not coded for oxygen use. A review of Resident #109's active care plan dated 4/8/2025 revealed there were no goals or interventions regarding oxygen or respiratory care included in the baseline care plan. Resident #109's April 2025 oxygen assessment flowsheet for nursing revealed all nursing staff documented oxygen flow rate was 2 liters per minute and completed a spot check for oxygen level. A review of Resident #109's orders revealed oxygen care orders: - (4/8/25) Nasal Cannula 1 liter per minute, keep oxygen saturation greater than 92%	F 695	Corrective Action for Affected Residents: On 4/21/25 an immediate signage was posted on the affected residents' doors, residents 109 and 110 with clear visibility by public traffic indicating Oxygen in Use. The affected resident oxygen order (resident 109) was immediately reviewed. Oxygen therapy was initiated as ordered on 4/19/25. MDS coordinator immediately reviewed the MDS and found oxygen had not been placed during the MDS observation period. Detailed plan of correction for oxygen discrepancy is outlined in F641. Identification of Other Residents at Risk: A screen of all resident doors was completed on 4/21/25 by the staff RN to assess oxygen signage needs with no further discrepancies found. Systemic Changes to Prevent Recurrence: In addition to Oxygen in Use signage displayed over entry to facility, additional Oxygen in Use signage has been obtained for display on all entry room doors for impacted residents. Nursing Staff re-education includes: 1. On 4/21/25 verbal communication regarding the posting of the Oxygen in use sign on impacted residents entry room doors was completed with onsite	

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F 695	Continued From page 15 - (4/8/25) Pulse oximetry, continuous, maintain oxygen saturations greater than 94% An observation on 04/21/25 at 11:01 AM revealed Resident #109 sitting in his wheelchair with oxygen being administered via nasal cannula via wall oxygen concentrator at 2 liters. There was no caution or safety signage posted outside of Resident #109's room indicating supplemental oxygen was in use. An observation on 04/22/25 at 9:25 AM revealed Resident #109 sleeping in bed with oxygen being administered via nasal cannula via wall oxygen concentrator 2 liters. There was no caution or safety signage posted outside of Resident #109's room indicating supplemental oxygen was in use. B. Resident #110 was originally admitted to the facility on 9/3/2021 and readmitted on 4/14/2025 with diagnosis that included respiratory failure. A review of the quarterly Minimum Data Set (MDS) dated 2/28/2025 indicated diagnosis of chronic respiratory failure with hypoxia and was coded for oxygen use. A review of Resident #110's oxygen care orders revealed: -(4/14/25) Oxygen Therapy nasal cannula, rate 3 liters per minute, keep oxygen saturation level greater than 90%. -(4/14/25) Initiate Adult Respiratory Chronic-Stable Bilevel Positive Airway Pressure/ Continuous Positive Airway Pressure (BIPAP/CPAP) Protocol (Adult Non-invasive Ventilation) continuously. An observation on 4/21/25 at 12:39 PM revealed	F 695	nursing staff. 2. Further education regarding the Oxygen in Use signage on resident room entry doors with all nursing staff will be completed by 5/21/25. 3. Nursing Education will be incorporated into new staff orientation plan. Monitoring and Quality Assurance Charge Nurse or a designee too: 1. As of 5/21/25 conduct 100% daily review of all resident doorways with oxygen in use to ensure appropriate signage for the next 60 days with random reviews thereafter to ensure ongoing compliance. 2. Results will be reviewed monthly by both nurse manager and charge nurses and at each QAA meeting. 3. Any trends or recurrent issues will prompt immediate re-education and process review. Target Full Compliance Date: 5/22/25	

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F 695	Continued From page 16	F 695		

Resident #110 awake with head of bed elevated with oxygen being administered via nasal cannula via wall oxygen concentrator. There was no caution or safety signage posted outside of Resident #110's room indicating supplemental oxygen in use. Resident did not allow a close enough observation to view liters of oxygen

An observation on 4/23/25 at 2:51 PM revealed Resident #110 asleep with oxygen being administered via BIPAP via wall oxygen concentrator. There was no caution or safety signage posted outside of Resident #109's room indicating supplemental oxygen was in use.

An observation of signs above double doors to the entrance of the skilled nursing unit on 4/21/25 at 11:00 AM and 4/23/25 at 8:30 AM, stated "No Smoking Oxygen in Use."

An interview with Nurse #1 on 4/22/25 at 01:22 PM stated she did not know if oxygen caution signs were on the resident's door, and was not aware oxygen caution sign should be posted on resident doors. Nurse #1 reported oxygen use was communicated verbally to other staff if residents had oxygen, and orders were reviewed by the nurse each shift. Nurse #1 also stated a respiratory assessment was completed by each nurse for each shift.

An interview with Nurse #2 on 4/22/25 at 1:30 PM stated there was an oxygen cautionary sign over the entrance doors to the unit that stated, "No Smoking Oxygen in Use." Nurse #2 reported that she had worked for the facility for seven years and used to place oxygen caution signs on resident doors. Nurse #2 stated, "Lately staff have not placed signs on resident doors." Nurse

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F 695	Continued From page 17 #2 stated oxygen orders were communicated in staff-to-staff reports during each shift change. Nurse #2 stated that oxygen levels and care were communicated during nurse-to-nurse shift report. An interview with the Nurse Manager on 4/23/25 at 1:47 PM reported oxygen caution signs were located above the double doors to the entrance of the unit and on residents' doors. Nurse Manager stated that oxygen signs should be placed when an order was implemented. Nurse Manager revealed a respiratory assessment was completed and charted in the electronic health record. The assessment included an assessment of oxygen administration level. She reported that each nurse would review orders and a care plan for oxygen needs and communicate any changes during shift change report. If there was a discrepancy in what the nurse assessed and the actual order, the nurse would call the provider or send a secure chat to clarify an order. The Nurse Manger reported the nurses missed clarifying the order for Resident #109.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		5/22/25

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F 756	Continued From page 18 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and Consultant Pharmacist interviews, the Consultant Pharmacist failed to communicate to the facility the need to limit the use of a psychotropic drug (drug that affects the mental state) ordered as needed to 14 days for 1 of 5 residents reviewed for unnecessary medications (Resident #2). The findings included: Resident #2 was admitted to the facility on 12/11/24 with a diagnosis of anxiety disorder.	F 756	Corrective Actions: 1. Immediate action on 4/23/2025 Advanced Practice Provider did face to face evaluation of patient to determine medication (Ativan) was still needed (complete 4/23/2025). 2. Immediate action Education was provided on 4/23 to provider by Clinical Informacist associated with improperly entered prn Ativan order. Education centered on proper way to enter medication stop date (end date field) and	

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F 756	Continued From page 19 The physician order dated 12/11/24 read, Ativan (antianxiety) 0.5 milligrams (mg) by mouth twice daily as needed for anxiety with a start date of 12/12/2024 for a duration of 14 days (12/26/24). Review of January 2025 MAR revealed Resident #2 received Ativan 0.5 mg by mouth each night from 01/01/25 through 01/31/25. The Pharmacy Consultant's drug regimen review dated 1/13/25 included no recommendations for a stop date for Ativan 0.5 mg and there was no clinically significant medication issues identified. Review of February 2025 MAR revealed Resident #2 received Ativan 0.5 mg by mouth each night from 2/1/25 through 2/28/25. The Pharmacy Consultant's drug regimen review dated 2/14/25 included no recommendations for a stop date for Ativan 0.5 mg and there was no clinically significant medication issues identified. Review of March 2025 MAR revealed Resident #2 received Ativan 0.5 mg by mouth each night from 3/1/25 through 3/31/25. The Pharmacy Consultant's drug regimen review dated 3/12/25 included no recommendations for a stop date for Ativan 0.5 mg and there was no clinically significant medication issues identified. The Quarterly Minimum Data Set (MDS) dated 3/18/25 revealed Resident #2 was cognitively intact. The MDS documented Resident #2 received antianxiety medication 7 out of 7 days during the assessment period.	F 756	not to place this information in the prn field (comment field). (complete 4/23/2025). 3. Education was provided by Pharmacy Director for all pharmacist on SNF pharmacy regulations (centered on prn 14-day stop of psychotropic and antipsychotic medications) by email on 5/9 and in-person 5/14). The in-person review with pharmacist at WMC was on 5/14 at 2 pm (complete 4/23/2025). 4. Education for providers by the Pharmacy Director is scheduled for 5/21 to enhance education and knowledge around pharmacy recommendations and state pharmacy requirements for nursing home patients (focus on prn 14 day stop of psychotropic and antipsychotic medications), (scheduled for 5/21/2025). 5. As of 5/12/25 currently working on a process to receive daily automated reports for psychotropic and antipsychotic medications. (Initiation phase started). Preventing Future Occurrences: 1. Education provided by Pharmacy Director to providers and pharmacists (complete by 5/21), and will be incorporated into orientation of new Pharmacist. 2. Pharmacy will monitor for any drug regiment irregularities through our current process of patient initial order reviews, a 7 day review on new SNF patients and our monthly 30 day review at WMC on all patients. Pharmacy will provide written documentation of any irregularities in Encompass (electronic medical record) and through secure chat (Encompass	

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F 756	Continued From page 20 During an interview with the Pharmacy Consultant on 4/23/25 at 2:00 PM, she stated that as needed psychotropics should have a stop date. The Pharmacy Consultant reported she reviewed Resident #2's chart and realized the original order had been entered incorrectly which would not have triggered the "safeguards". She reports this was not realized until it was called to her attention during this survey. She reported that she was aware that all as needed psychotropics should have a stop date and be reviewed every 14-21 days. She stated this particular order stop date was missed because the "for 14 days" was entered in a comment section that was not part of the actual order and was not caught during the January 2025, February 2025, and March 2025 monthly pharmacy reviews. Therefore, when the order flowed over to the MAR it showed as an order without a stop date.	F 756	communication tool) to provider. All urgent medication changes will be escalated to a direct provider call and final escalation to SNF program leaders. 3. Monitoring results will be reported through the SNF QAA Committee 4. Target Compliance date 5/22/25	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		5/22/25

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F 758	Continued From page 21 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, Consultant Pharmacist, and Nurse Practitioner interviews, the facility failed to correctly enter an as needed psychotropic (drug that affects the mental state) medication order to include the 14 day stop date for 1 of 5 residents reviewed for unnecessary medications (Resident #2).	F 758	Corrective Actions: 1. Immediate action on 4/23/2025 Advanced Practice Provider did face to face evaluation of patient to determine medication (Ativan) was still needed (complete 4/23/2025). 2. Immediate action Education was	

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F 758	Continued From page 22 The findings included: Resident #2 was admitted to the facility on 12/11/24 with a diagnosis of anxiety disorder. The physician order dated 12/11/24 reviewed for Resident #2 revealed an order for Ativan (antianxiety) 0.5 milligrams (mg) by mouth twice daily as needed for anxiety with a start date of 12/12/2024 for a duration of 14 days (12/26/24). Review of the December 2024 Medication Administration Record (MAR) revealed Resident #2 received Ativan 0.5 mg by mouth each night from 12/11/24 through 12/27/24. He did not receive it on 12/29/24. He did receive it on 12/30/24 and 12/31/24. Review of January 2025 MAR revealed Resident #2 received Ativan 0.5 mg by mouth each night from 01/01/25 through 01/31/25. Review of February 2025 MAR revealed Resident #2 received Ativan 0.5 mg by mouth each night from 2/1/25 through 2/28/25. Review of March 2025 MAR revealed Resident #2 received Ativan 0.5 mg by mouth each night from 3/1/25 through 3/31/25. The Quarterly Minimum Data Set (MDS) dated 3/18/25 revealed Resident #2 was cognitively intact. The MDS documented Resident #2 received antianxiety medication 7 out of 7 days during the assessment period. Review of April 2025 MAR revealed Resident #2 received Ativan 0.5 mg by mouth each night from	F 758	provided on 4/23 to provider by Clinical Informacist associated with improperly entered prn Ativan order. Education centered on proper way to enter medication stop date (end date field) and not to place this information in the prn field (comment field). (complete 4/23/2025). 3. Education was provided by Pharmacy Director for all pharmacist on SNF pharmacy regulations (centered on prn 14-day stop of psychotropic and antipsychotic medications) by email on 5/9 and in-person 5/14). The in-person review with pharmacist at WMC was on 5/14 at 2 pm (complete 4/23/2025). 4. Education for providers by the Pharmacy Director is scheduled for 5/21 to enhance education and knowledge around pharmacy recommendations and state pharmacy requirements for nursing home patients (focus on prn 14 day stop of psychotropic and antipsychotic medications), (scheduled for 5/21/2025). 5. As of 5/12/25 currently working on a process to receive daily automated reports for psychotropic and antipsychotic medications. (Initiation phase started). Preventing Future Occurrences: 1. Education provided by Pharmacy Director to providers and pharmacists (complete by 5/21, and will be incorporated into orientation of new Pharmacist. 2. Pharmacy will monitor for any drug regiment irregularities through our current process of patient initial order reviews, a 7 day review on new SNF patients and our	

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F 758	Continued From page 23 4/1/25 through 4/23/25. During an interview with Nurse #4 on 4/23/25 at 1:10 PM, she stated that when orders were put into their system, active orders would transfer over, and she believed those orders to be correct and what the provider wanted the resident to receive. Nurse #4 verbalized she could view "for 14 days" on the order and reported she thought it was a continuous order. An interview with the Unit Nurse Manager on 4/23/25 at 1:20 PM revealed that the order for Ativan should have had a stop date. She reported that she felt the order was entered incorrectly by the hospitalist on admission with no stop date. She reported the "for 14 days" with a start date of 12/12/24 should have been noticed and questioned. During an interview with the Nurse Practitioner on 4/23/25 at 1:45 PM, she stated the order for Ativan 0.5 mg twice daily as needed for anxiety for 14 days had been entered by one of the hospitalist. The hospitalist had entered the "for 14 days" in the comment section and had not included the end date. The Nurse Practitioner explained by notating the 14 days in the comment section this caused none of the safeguards or alerts in the system to activate and no one paid attention to the duration of the Ativan. She reported "it just slipped through the cracks". The Hospitalist that entered the Ativan order on 12/11/24 was not available for interview on 4/23/25 at 1:15 PM During an interview with the Pharmacy Consultant on 4/23/25 at 2:00 PM, she stated that as needed	F 758	monthly 30 day review at WMC on all patients. Pharmacy will provide written documentation of any irregularities in Encompass (electronic medical record) and through secure chat (Encompass communication tool) to provider. All urgent medication changes will be escalated to a direct provider call and final escalation to SNF program leaders. 3. Monitoring results will be reported through the SNF QAA Committee. 4. Target Compliance date 5/22/25	

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F 758	Continued From page 24 psychotropics should have a stop date. The Pharmacy Consultant reported she reviewed Resident #2's chart and realized the original order had been entered incorrectly which would not have triggered the "safeguards". She reported that she was aware that all as needed psychotropics should have a stop date and be reviewed every 14-21 days.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (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 observations and staff interviews, the facility failed to: (1) remove expired items from 1 of 1 reach in cooler; (2) provide an open/ use by date for food available for use in 1 of 1 walk in refrigerators and 2 of 2 walk in freezers; (3) maintain dishware that was stacked wet and	F 812	a. The policies Food Safety Product Labelling and Dating Guidelines revision date 12/06/2022 and PQA (Product Quality Assurance) Food Product Shelf Life Guidelines revision date 1/28/22 were reviewed. Beginning 4/25/25, the	5/16/25

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F 812	Continued From page 25 available for use; and (4) keep dishes free from dried debris available for use. This deficient practice had the potential to affect eight (8) of eight (8) residents. The findings included: a. On 4/21/25 at 11:45 AM with the Kitchen Supervisor, one half gallon of whole milk was observed with an expiration date of 04/18/25 and was available for use in the reach in cooler. b. Observation of the kitchen occurred on 4/21/25 at 11:45 AM with the Kitchen Supervisor. The reach in cooler had food open to air and no use by date which included broccoli, shredded chicken and sausage and gravy. The walk-in refrigerator had the following food with no open or use-by date: one package of American cheese, one package of pepper jack cheese, half of a 5-pound (lb.) bag of carrots, and one 5 lb. container of pimento spread. The walk-in freezer #1 and walk-in freezer #2 had food with no open or use-by date which included one package of cheddar cheese wrapped in plastic clear cling wrap, one bag of uncooked potato wedges, and one bag of uncooked omelets. c. Observation of the kitchen occurred on 4/21/25 at 11:45 AM with the Kitchen Supervisor. Ready-for-use dishware was put away and stacked wet. At the meal preparation station, 4 out of 8 plastic dome lids were stacked wet and available for use, 8 out of 15 trays were stacked wet, and 4 out of 8 bowls were stacked wet. d. Observation of the kitchen occurred on 4/21/25 at 11:45 AM with the Kitchen Supervisor. Ready-for-use dishware in the meal preparation	F 812	supervisors and the manager have immediately begun making rounds daily to monitor all items available for use ensuring dating guidelines are followed. Additionally, this monitoring will include confirming that open dates and use by dates are visible on the products. For immediate compliance, a manual process of labeling with an open date and a use by date has been initiated on 4/25/25. To ensure ongoing compliance the manager has ordered an electronic labeling system. This new electronic labeling system will include an open date and a use by date. The new system will be available for use within 90 days barring any shipping interruptions. The manual process will continue until the electronic system is available. All dietary staff received education regarding the policy and process of proper dating on 4/24/25. Education will be provided in orientation of new staff. Compliance began on 4/25/25. Daily monitoring by the supervisor or manager will continue for 60 days. After 60 days, random monitoring by the supervisor or manager will be done. Monitoring results will be reported to the SNF QAA committee b. The policy Food Safety Product Labelling and Dating Guidelines revision date 12/06/2022 was reviewed. Beginning 4/25/25, the supervisors and the manager have immediately begun making rounds daily to monitor all items available for use ensuring dating guidelines are followed. Additionally, this monitoring will include confirming that	

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F 812	Continued From page 26 area and in the plate warmer contained dried food debris. 2 out of 6 plates with dry debris were available for use on the meal preparation station and 8 out of 15 plates with dry debris were available for use on the plate warmer. An interview with the Kitchen Supervisor on 04/21/2025 at 11:45 AM revealed staff should remove dirty plates prior to use. The Kitchen Supervisor explained dishware should be thoroughly dried prior to use. Staff should not stack or use wet dishware. The Kitchen Supervisor continued to explain that all staff were responsible for properly storing, labeling, dating, and disposing of expired items in the kitchen area.	F 812	open dates and use by dates are visible on the products. For immediate compliance, a manual process of labeling with an open date and a use by date has been initiated. To ensure ongoing compliance the manager has ordered an electronic labeling system. This new electronic labeling system will include an open date and a use by date. The new system will be available for use within 90 days barring any shipping interruptions. The manual process will continue until the electronic system is available. All dietary staff received education regarding the policy and process of proper dating on 4/24/25. Education will be provided in orientation of new staff. Compliance began on 4/25/25. Daily monitoring by the supervisor or manager will continue for 60 days. After 60 days, random monitoring by the supervisor or manager will be done. Monitoring results will be reported to the SNF QAA committee. c. The policy Food Safety Management System revision date 10-01-2024 was reviewed. On 4/24/25, the manager began reeducation on the importance of clean and dry dishes available for use in the kitchen using the Food Safety Management System guidelines. Also on 4/24/25, additional education was provided using the Ecolab Dish machine procedures guidelines. Education will be provided in orientation of new staff. Compliance began on 4/25/25. The supervisor monitors and inspects all service ware daily to ensure it is clean and dry before being stored away or being	

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F 812	Continued From page 27	F 812	placed into use for patients. The daily monitoring by the supervisor or manager will continue for 60 days. After 60 days, random monitoring by the supervisor or manager will be done. Monitoring results will be reported to the SNF QAA committee. d. The policy Food Safety Management System revision date 10-01-2024 was reviewed. On 4/24/25, the manager began reeducation on the importance of clean and dry dishes available for use in the kitchen using the Food Safety Management System guidelines. Also on 4/24/25, additional education was provided using the Ecolab Dish machine procedures guidelines. Education will be provided in orientation of new staff .Compliance began on 4/25/25. The supervisor monitors and inspects all service ware daily to ensure it is clean and dry before being stored away or being placed into use for patients. The daily monitoring by the supervisor or manager will continue for 60 days. After 60 days, random monitoring by the supervisor or manager will be done. Monitoring results will be reported to the SNF QAA committee.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the	F 814	On 4/21/25 the identified items were	5/16/25

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F 814	Continued From page 28 facility failed to keep the area around the garbage compactor free of accumulated trash and debris for 1 of 1 garbage compactor observed. The findings included: An observation was completed on of the garbage compactor area on 4/21/2025 at 12:40 PM. The observation revealed the following items outside of the garbage compactor: 1 medium black plastic bag of trash, multiple blue latex gloves, 1 tin can, 2 dented hazard cones, 1 empty syringe, 1 small container of unidentified food. A large gray bag of trash and large brown box was sitting on the loading dock where the garbage compactor was located. An interview with the Kitchen Supervisor on 4/21/2025 at 1:00 PM revealed the garbage compactor was used by the whole hospital. The Kitchen Supervisor was not aware that the garbage area was the responsibility of Kitchen Services. An interview with the Nutritional Service Manager on 4/22/2025 at 11:40 AM revealed she was unaware that the garbage area was the responsibility of Kitchen Services. An interview with the Nurse Manager was completed on 4/23/2025 at 3:00 PM revealed she was unaware that the garbage area was the responsibility of Kitchen Services.	F 814	removed for appropriate disposal. As of April 25th 2025 a process was begun to monitor the back dock and trash area 3 times daily by a staff member from dietary, environmental services, or engineering. Verbal education was completed by Dietary Supervisor to all staff in these departments by 4/24/25. Education will be provided during orientation for new staff. Compliance achieved as of 4/25/25. We will continue this process for the next 60 days, after that we will monitor the area for cleanliness once in the morning and once in the evening, as well as when any teammate visits the area for trash disposal.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		5/22/25

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F 880	Continued From page 29	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 30 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement an infection surveillance plan for monitoring and tracking infections in the facility. This practice had the potential to affect 8 of 8 residents in the facility. Findings included: The facility's "Infection Prevention and Control Surveillance" policy dated 2/1/25 documented the Infection Preventionist (IP) conducts surveillance of all infections among residents and partners including tracking and analysis of outbreaks of infections.	F 880	A review of processes for Infection Prevention and Control was conducted with the Infection Team on 4/23/25. Effective 5/21/25, WMC SNF will follow the CDC NHSN Long-Term Facility Component Manual for Tracking Healthcare-Associated Infections (HAIs) in Long-Term Care Facilities, dated January 2023. Per this document acceptable methods for performing outcome surveillance will be followed specifically comprehensive and targeted. As outlined per this best practice guidance, several factors will be	

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F 880	Continued From page 31 Record review indicated Resident #2 receiving antibiotics for osteomyelitis and Resident #4 receiving antibiotics for a wound infection. The Infection Preventionist (IP) nurse was interviewed on 4/23/25 at 9:15 AM. The IP nurse discussed tracking and analyzing infections in the skilled nursing unit by using an approved tracking form. She explained the form was computerized, so she did not have a paper copy for review. IP provided computerized information for five infections that were regularly tracked, Central Line associated bloodstream infection, catheter associated urinary tract infections, methicillin-resistant staphylococcus, Clostridium difficile(C-Diff), Surgical Site Infection. This data showed only one infection on the unit in the last year. She reported that the system does not track flu, pneumonia, covid-19 or non-catheter associated infections. This system tracked both hospital and nursing home infections, however, IP was able to pull only information for the nursing home. The Unit Nurse Manager was interviewed on 4/23/25 at 10:30 AM. The Unit Nurse Manager explained the IP nurse was responsible for infection surveillance/tracking and she knew there had been at least one case of covid-19, 2 weeks ago, as well as other infections on the unit. She reported covid-19 was not treated on the unit and was transferred out to the hospital. She stated she expected the IP nurse to perform infection surveillance/tracking on all the residents who were present with an infection.	F 880	considered when determining which method to implement, such as staff time, available resources, the frequency of events being monitored and the IPC program surveillance goals. An annual risk assessment is performed to evaluate and provide guidance on priority focus areas for the facility. Surveillance, monitoring and tracking of infections for the facility will be achieved through multiple means of targeted data collection as stated per the NHSN Long-Term Facility Component Manual for Tracking Healthcare-Associated Infection in Long-Term Care Facilities. The Infection Control nurse and SNF nursing staff will receive education on infection surveillance plan for monitoring and tracking infections in the facility by 5/21/25 with a compliance completion date of 5/22/25 . The Infection Prevention Plan Policy (WMC) dated April 16, 2025, on pages 4-5 and page 16 addresses the targeted infection surveillance that will be performed along with the surveillance plan utilizing the following Surveillance Reports GI Panel Report High Priority Reportable Conditions Reportable Other Conditions Teammate Exposures ICON Covid Surveillance Influenza Report COVID/Influenza Death Report Isolation List Infection List CAUTI Lab ID CLABSI Lab ID Blood culture C. Diff	

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F 880	Continued From page 32	F 880	MRSA SSI (Colo, HPRO, KPRO)	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the	F 883		5/22/25

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F 883	Continued From page 33 benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document education was provided in the medical record regarding the benefits and potential side effects of the influenza and pneumonia vaccines. This occurred for 3 of 5 residents (Resident #210, Resident #110, and Resident #159) reviewed for vaccines. The findings included: a. Resident #210 was admitted to the facility on 04/17/25. The admission Minimum Data Set assessment dated 4/17/25 showed the resident to be cognitively intact. The resident's immunization record was reviewed	F 883	Corrective Action for Affected Residents: For Affected Residents identified on 4/23/25 vaccine education was provided indicating the benefits and potential side effects of the COVID-19, Influenza, and Pneumococcal vaccines. Identification of Other Residents at Risk: Beginning 4/30/25 COVID-19, Influenza (when in season), and Pneumococcal vaccine education is provided to every resident, and document in the medical record. Systemic Changes to Prevent Recurrence: Education regarding the benefits and potential side effects of the COVID-19,	

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	345386	A. BUILDING _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 34 and revealed that flu vaccine was current, but the resident was due the pneumonia vaccine and Resident #210 had declined the pneumonia vaccine. The immunization record review also revealed that nothing was documented under the education notes section on the immunization record. Interview with Resident #210 on 4/22/25 at 2:45 PM revealed she declined any additional pneumonia vaccine, and she reported her flu vaccine was up to date. She reported she did not remember being educated on the risk of her not receiving them. b. Resident #110 was admitted to the facility on 4/14/25. The admission Minimum Data Set assessment dated 4/21/25 showed the resident to be cognitively intact The resident's immunization record was reviewed and revealed the resident refused the pneumonia and flu vaccine. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record. Resident #110 declined to be interviewed on 4/21/25 at 11:00 AM. c. Resident #159 was admitted to the facility on 4/12/25. The admission Minimum Data Set assessment dated 4/19/25 showed the resident to be moderately cognitively impaired.	F 883	Influenza (when in season), and Pneumococcal vaccine is provided to every resident to the facility and appropriate documentation is completed. Nursing Staff Education includes: 1. Education regarding the benefits and potential side effects of the COVID-19, Influenza (when in season), and Pneumococcal vaccine is provided to every resident upon admission to the facility regardless of acceptance of vaccine. 2. Appropriate documentation by SNF RN or LPN in the Medical Record of provision of vaccine education 3. Nursing Education will be incorporated into new staff orientation plan. 4. Education to be completed by 5/21/25. Monitoring and Quality Assurance Charge Nurse or a designee too: 1. As of 5/21/25 conduct 100% review of all new admissions for provision of COVID-19, Influenza (when in season), and Pneumococcal vaccine education, and documentation of the provision of education in the Medical Record for the next 60 days with random reviews thereafter to ensure ongoing compliance. 2. Results will be reviewed monthly by both nurse manager and charge nurses and at each QAA meeting. 3. Any trends or recurrent issues will prompt immediate re-education and process review. Target Full Compliance Date: 5/22/25	

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F 883	Continued From page 35	F 883	See attachments for directed POC	

The resident's immunization record was reviewed and revealed he had refused flu and pneumonia vaccine. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record.

Interview with Resident #159 on 4/22/25 at 3:00 PM revealed he refused the flu and pneumonia vaccine. He reported he also did not remember getting any education regarding the vaccines

An interview with the Infection Preventionist (IP) on 4/23/25 at 10:40 AM 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 and documented in the "education section" of the resident's chart. If the resident declined education should be provided as to the risk of not being vaccinated. IP reports she did not know why this had not been done.

An interview with the Unit Nurse Manager on 4/23/25 at 12:30 PM revealed that education should be provided to the residents or the resident's representative prior to the vaccine being administered. She 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. If the resident declined the vaccine, it should be noted in their chart along with education for risk of not being vaccinated. Unit Nurse Manager reports she did not know why this had not been done.

An interview with Nurse Navigator on 4/22/25 at 2:00 PM indicated that immunizations were

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F 883	Continued From page 36 entered by a "data entry person". Vaccines were offered to the resident and if the resident agrees to have the vaccine an order was created and sent to the Medication Administration Record. If the resident declines the vaccines the process stopped with the declination.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a	F 887		5/22/25

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F 887	Continued From page 37 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, resident, and staff interviews, the facility failed to document that education was provided in the medical record regarding the benefits and potential side effects of the COVID-19 vaccines. This occurred for 4 of 5 residents reviewed for immunizations (Resident #210, Resident #110, Resident #159, Resident #4). The findings included: a. Resident #210 was admitted to the facility on	F 887	Corrective Action for Affected Residents: For Affected Residents identified on 4/23/25 vaccine education was provided indicating the benefits and potential side effects of the COVID-19, Influenza, and Pneumococcal vaccines. Identification of Other Residents at Risk: Beginning 4/30/25 COVID-19, Influenza (when in season), and Pneumococcal vaccine education is provided to every resident, and document in the medical	

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F 887	Continued From page 38 4/17/25. The admission Minimum Data Set assessment dated 4/17/25 showed the resident to be cognitively intact. The Resident's immunization record was reviewed and revealed that the resident had declined the covid vaccine. The immunization record review also revealed that nothing was documented under the education notes section on the immunization record for this vaccine. An interview with Resident #210 was conducted on 4/22/25 at 2:45 PM and revealed she declined any additional covid vaccines and she did not remember being educated on the risk of her not receiving them. b. Resident #110 was admitted to the facility on 4/14/25. The admission Minimum Data Set assessment dated 4/21/25 showed the resident to be cognitively intact The resident's immunization record was reviewed and revealed that the resident declined the covid vaccine. The immunization record review also revealed that nothing was documented under the education notes section on the immunization record for this vaccine. Resident #110 declined an interview on 4/21/25 at 11:00 AM. c. Resident #159 was admitted to the facility on	F 887	record. Systemic Changes to Prevent Recurrence: Education regarding the benefits and potential side effects of the COVID-19, Influenza (when in season), and Pneumococcal vaccine is provided to every resident to the facility and appropriate documentation is completed. Nursing Staff Education includes: 1. Education regarding the benefits and potential side effects of the COVID-19, Influenza (when in season), and Pneumococcal vaccine is provided to every resident upon admission to the facility regardless of acceptance of vaccine. 2. Appropriate documentation by SNF RN or LPN in the Medical Record of provision of vaccine education 3. Nursing Education will be incorporated into new staff orientation plan. 4. Education to be completed by 5/21/25. Monitoring and Quality Assurance Charge Nurse or a designee too: 1. As of 5/21/25 conduct 100% review of all new admissions for provision of COVID-19, Influenza (when in season), and Pneumococcal vaccine education, and documentation of the provision of education in the Medical Record for the next 60 days with random reviews thereafter to ensure ongoing compliance. 2. Results will be reviewed monthly by	

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F 887	Continued From page 39 4/12/25. The admission Minimum Data Set assessment dated 4/19/25 showed the resident to be moderately cognitively impaired. The resident's immunization record was reviewed and revealed the resident agreed to the covid vaccine. Review of the immunization record revealed nothing was documented under the education note section on the immunization record for this vaccine. An interview with Resident #159 conducted on 4/22/25 at 3:00 PM revealed he agreed to have the covid vaccine. He reported he did not remember getting any education regarding the vaccine. d. Resident #4 was admitted to the facility on 3/3/25. The admission Minimum Data Set assessment dated 3/10/25 showed the resident to be cognitively impaired. The resident's immunization record was reviewed and revealed the resident refused the covid vaccine. Review of the immunization record also revealed nothing was documented under the education notes section on the immunization record for this vaccine. An interview with Resident #4 was conducted on 4/22/25 at 3:15 PM and indicated he declined any further covid vaccinations and he did not remember getting any education regarding the vaccination.	F 887	both nurse manager and charge nurses and at each QAA meeting. 3. Any trends or recurrent issues will prompt immediate re-education and process review. Target Full Compliance Date: 5/22/25	

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F 887	Continued From page 40	F 887		

An interview with the Infection Preventionist (IP) on 4/23/25 at 10:40 AM revealed 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 and documented in the "education section" of the resident's chart. If the resident declined the vaccine, education should be provided as to the risk of not being vaccinated. She reports she is unsure why education was not documented.

An interview with Nurse Navigator on 4/22/25 at 2:00 PM indicated that immunizations were entered by a "data entry person". Vaccines were offered to the resident and if the resident agreed to have the vaccine an order was created and sent to the Medication Administration Record. If the resident declined the vaccines the process stopped with the declination.

An interview with the Unit Nurse Manager on 4/23/25 at 12:30 PM revealed that education should be provided to the residents or the resident's representative prior to the vaccine being administered. She 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. If the resident declined the vaccine, it should be noted in their chart along with education for risk of not being vaccinated. She reported she was unsure why education was not documented.