STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345566	A. BUILDING ______ B. WING ______	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 06/27/22 through 06/30/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #EWWX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/27/22 through 6/30/22. Three (3) of the 21 complaint allegations were substantiated resulting in deficiencies. Intakes: NC00188318, NC0088315, NC0088744, NC00183960, NC00190410, and NC00190480. Event ID# EWWX11.	F 000		
F 565 SS=D	Resident/Family Group and Response 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.	F 565		7/28/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/25/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(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 record review, resident and staff interviews the facility failed to resolve and communicate the facility's efforts to address residents repeated concerns voiced during three of three Resident Council meetings for three consecutive months reviewed for Resident Council. (April 2022, May 2022, and June 2022).

The Resident Council Meeting Minutes from April 25, 2022, May 25th, 2022, June 22, 2022, were reviewed.
The review revealed the following concerns were voiced during the monthly Resident Council meetings and the facility's response:

Review of the Resident Council Meeting Minutes from April 25, 2022, reported concerns related to:

A. Food served to residents is cold.
B. Residents receiving too many mixed vegetables and too much barbeque sauce on food.
C. Housekeeping is not cleaning rooms that

F 565

This plan of correction constitutes a written Allegation of Compliance with federal and state requirements. Preparation and submission of this Allegation of Compliance does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
The Recreational Director (RD) coordinated a Resident Council meeting with the permission & invitation of the Resident Council president & members on July 6, 2022, with the Administrator, Social Worker (SW), Director of Nursing

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well.
D. Housekeeping is only mopping bathrooms one time a week.
E. Hallways need to be vacuumed more often.
F. Beds are not being made every day.
G. Residents are not receiving showers when they are scheduled.
H. When Nurses give out medications, they do not introduce themselves.
I. Nurse Aides are not always nice.

There was no documented response the concerns were acted upon by the facility.

Review of the Resident Council Meeting Minutes from May 25, 2022, reported concerns related to:

A. Nurse Aides are not working, they are watching television, or they are on their cell phones and not making rounds.
B. Residents would like the nurses to tell them what medication they are on before taking it.
C. Nurse Aides use curse words and have a bad attitude.
D. Some Nurse Aides do not change the residents and don't wear badges, so we do not know who they are.
E. Residents would like menus to be given out so they can choose their meal.

There was no documented response the concerns were acted upon by the facility.

Review of the Resident Council Meeting Minutes from June 22,2022, reported concerns related to:

A. Not enough nursing staff.
B. Some Nurse Aides are rude
C. Nurse Aides do not make beds regularly.

F 565

Services (DHS), Dietary Manager (DM) & Environmental Services Director (EVS) to address all concerns noted on April 25, May 25 and June 22, 2022, meetings. The minutes of meeting was documented by the RD and all concerns were written on a grievance form and processed per the center□s Grievance policy. Documented response related to each concern as acted upon by the facility is available on the Resident Council Meeting Binder.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice :

100% audit of all residents on any concerns was initiated on July 8 ,2022 and will continue for completion on or before July 28,2022. All findings will follow the facility Grievance Policy to address and resolve any concern received and noted.

Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur:

Effective July 8th, 2022, any Resident Council Meeting concern will be written on formal complaint / grievance form. RD will forward each concern to the responsible Department Head and will be processed based on the company□s Grievance Policy. Any closed grievance will be signed completed by the responsible department head and will be submitted to the Administrator for review. The Resident

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F 565	Continued From page 3 D. Nurse Aides are not announcing themselves when taking care of residents. E. Nurses do not let resident know what medication they are taking. F. Briefs are not very good because they are too thin. G. Residents stated they are tired of sandwiches. H. Food is sometimes cold. I. The combination of food is not good, and the food could be better at the evening meal. There was no documented response the concerns were acted upon by the facility. An interview was conducted on 6/29/22 at 3:13 PM with the Activities Director (AD) who facilitates the resident council meetings. The AD stated that after the Resident Council meetings she will read off the grievances the following morning at the facilities stand up meeting. All departments attend the stand-up meeting and would write down the grievance. The AD stated she had not gotten any response back from the previous meetings since April 2022 and explained they have an interim Director of Nursing and our Administrator who is the grievance official started in May 2022. An interview was completed with the Vice President of Clinical Services (VPCS) and the interim Director of Nursing on 6/30/2022 at 3:20 PM. The VPCS who stated that it would be their expectation that grievances from Resident Council are turned around with a written response within 72 hours and that there is a written response that is documented and presented to the Resident Council.	F 565	Council Meeting minutes of meeting will be reviewed and signed by the Council president, RD, and Administrator after each monthly Resident Council Meeting . Administrator in-serviced RD on this process on 7/25/22. Department heads and Managers in-serviced on Grievance P&P by CCC on 7/5/22. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will review with RD old and new business of each Resident Council Meeting minutes and ensure that old business have all been addressed and closed accordingly . RD will report compliance monthly to QAPI x 3 months Include dates when corrective action will be completed: Date of compliance will be on or before July 28, 2022.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		7/28/22

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F 578	Continued From page 4 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. (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.	F 578		

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F 578	Continued From page 5 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 reviews and staff interviews the facility failed to obtain an order for Do Not Resuscitate (DNR) for 1 of 1 resident (Resident #16) reviewed for advanced directives. The findings included: Resident #16 was admitted to the facility on 4/22/22 with diagnoses which included: Hemiplegia and hemiparesis following a stroke, dysphagia (difficulty swallowing), rheumatoid arthritis, generalized weakness, lack of coordination, dementia, severe protein-calorie malnutrition, heart failure, peripheral vascular disease, pulmonary fibrosis, depression, chronic pain syndrome, age-related physical debility, and anorexia. A review of Resident #16's medical record conducted on 6/27/22 revealed no physician's order to establish the resident's code status to identify if the resident was a Full Code (cardiopulmonary resuscitation (CPR) to be initiated if the heart stopped beating) or a Do Not Resuscitate (DNR). The care plan for Resident #16 was reviewed on 6/17/22 and the resident had a care plan problem area under the category of advanced directives to allow a natural death, DNR. The problem area had a start date of 4/22/22. Further review of Resident #16's medical record revealed there were indications the resident was	F 578	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #16 Do Not Resuscitate (DNR) order was obtained on June 30, 2022. Address how the facility will identify other residents having the potential to be affected by the same deficient practice : A 100% audit of current residents Do Not Resuscitate (DNR) orders was initiated on June 13, 2022 by the Case Mix Director(CMD) /Minimum Data Set (MDS) Nurse with an ongoing audit by the DHS (Director of Nursing Services) /CCC (Clinical Competency Coordinator) to ensure 100% compliance. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: Admitting Nurse will ensure that every admission will have a Do Not Resuscitate (DNR) order in place upon admission. The Registered Nurse Unit Manager will check that this is completed using the Admission Checklist for every new admission or re-admission. The CCC (Clinical Competency Coordinator)	

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a DNR as indicated on the resident's face sheet. Included in the resident's medical record was a Medical Orders for Scope of Treatment (MOST) form which documented the resident as a DNR, and a Stop sign document indicating the resident was a DNR. Both documents were dated 4/26/22.

An interview and record review were conducted on 6/30/22 at 11:08 AM with the Minimum Data Set (MDS) nurse. She said residents who are a DNR are supposed to have a physician's order and have the Stop sign document. She reviewed Resident #16's medical record and stated the resident did not have an order for her to be an DNR, but she should have one because the resident was a DNR. She said the care plan problem for the resident having been a DNR was entered into the record based on the hospital discharge summary, the stop sign document, and when the social worker had a care plan meeting, the resident's and family's wishes were verified during the care plan meeting for the resident to be a DNR. She stated either during or shortly after the care plan meeting, the Social Worker had entered the care plan problem for the resident to be a DNR. She explained it was the nurse who put a new resident's admission orders into the system would be the nurse who was responsible for getting the DNR order, or the Director of Nursing.

An interview was conducted on 6/30/22 at 3:54 PM with the Vice President of Clinical Services (VPCS). She stated she expected for the facility nursing staff to obtain advanced directives orders for each resident, along with the other necessary paperwork, such as the MOST form and the stop sign form for a resident who was a DNR.

F 578

in-serviced the nurses on 7-11-22 on this process. The Administrator in-serviced the Social Worker 1:1 on this process on 7/25/22. The Clinical Competency Coordinator (CCC) will in-service all current nursing staff and all new nursing staff upon hire during orientation, and anyone not receiving the in-service due to FMLA or vacation will be educated prior to next shift.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The Director of Health Services / Clinical Competency Coordinator will double check each admission within 24 hours to ensure that the Do Not Resuscitate order is in place. The Social Worker will maintain a running audit of the Do Not Resuscitate orders and will be reviewed/ updated during the clinical meeting weekly. Compliance will be reported by the Social Worker to the Quality Assurance Process Improvement committee monthly x 3

Include dates when corrective action will be completed:
July 28, 2022

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F 578	Continued From page 7 An interview was not conducted with the nurse who put in the admission orders. The Social Worker was unavailable for interview.	F 578		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on hospital record review, facility record review, family, and staff interviews, the facility failed to assess, document, and treat skin tears, resulting in the resident receiving antibiotic treatment, for one of three sampled residents (Resident #59) reviewed for wound care. Findings included: Review of a hospital wound note for Resident #59 revealed a hospital wound nurse assessed the resident's wounds on 4/11/22 at 3:30 PM. The nurse documented the resident had a large skin tear to right knee with an open area measuring 8 centimeters (cm) up and 3 cm up, with a skin flap back over the wound which extended toward the outside of the knee by 4 cm. The skin flap was documented as having been non-viable, meaning the skin tissue in the skin flap was dead skin	F 684	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Per Resident Sample list, Resident #59 is patient referred under this citation . Resident #59 has been discharged and is not a current resident at this time. Address how the facility will identify other residents having the potential to be affected by the same deficient practice : A 100% skin audit has been initiated as of July 13 , 2022 by the Wound Nurse and will be completed on or before July 28, 2022. Any identified skin issues will be assessed, documented, and treated as	7/28/22

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F 684

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tissue and would not adhere to the wound. Further review revealed the resident had a skin tear to the right shoulder which measured 8 cm up and 4 cm across. The tissue was beefy red and was bleeding slightly.

Review of the hospital discharge orders dated 4/14/22 revealed no orders for wound care for the skin tears.

Resident #59 was admitted to the facility on 4/14/22 and was discharged on 4/16/22. The resident's admission diagnoses included heart failure, diabetes, history of falls, difficulty walking, unsteadiness on feet, and peripheral venous insufficiency (poor blood flow the arms/legs).

A nursing progress note by Nurse #2 dated 4/14/22 and timed 3:38 PM documented Resident #59 arrived via facility transport in a wheelchair. The resident's right leg was documented as having been swollen and wrapped and there was no bleeding observed. The note further documented a "complete assessment" was completed.

There was no documentation regarding skin tears on an admission assessment.

There were no admission orders for wound care for the skin tears.

Nurse Practitioner (NP) #2 saw Resident #59 on 4/15/22 and documented in her progress note the resident was at the facility for short term rehabilitation due to deconditioning. Under Review of Systems (ROS) the NP documented the resident's skin was positive for bruising and generalized soreness status post fall. The

F 684

ordered/ needed.

Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur:

Every new admission will have a head-to-toe skin assessment completed by the admitting nurse &/or Wound Nurse upon admission. The RN manager will ensure that this is completed and checked off on the admission checklist. Any existing wounds with dressing will be assessed , documented and treatment completed as ordered. Any other identified skin issue will be assessed, documented and treatment completed as ordered per Medical Doctor (MD) order. Any treatment will be noted by the nurse on the TAR (Treatment Administration Record). Clinical Competency Coordinator (CCC) in-serviced nursing staff on skin assessment upon admission; treatment orders & documentation on 7/11/22. The Clinical Competency Coordinator (CCC) will in-service all current nursing staff and all new nursing staff upon hire during orientation , and staff not receiving the in-service due to FMLA or vacation will be educated prior to next scheduled shift.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Director of Nursing Services or the Clinical Competency will double check

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F 684	Continued From page 9 resident was documented as having aching pain to the right upper extremity. For the physical exam, the NP documented for cardiovascular-the resident had trace edema (swelling) to both upper extremities and both lower extremities; skin-very fragile skin, right upper extremity skin tear-stable, scattered bruising of the right upper extremity. There was no mention of the wound to the right knee, measurements of the wounds, assessments/descriptions of the wounds, and orders for treatments to the wounds to wounds on the right upper extremity, or the right knee. A review of Resident #59's medical record, including the Treatment Administration Record (TAR), revealed no documentation, regarding assessment of the wounds to the right upper extremity (shoulder) or the right knee, no physician's orders for wound care or treatment to the right upper extremity (shoulder) or the right knee and no documentation regarding treatment applied or wound care provided for the wounds to the right upper extremity (shoulder) or the right knee. During a phone interview conducted on 6/30/33 at 10:07 AM with Resident #59's family member he stated when he went to the facility to see Resident #59 on 4/16/22 she still had dressings on her right arm/shoulder and right knee which were dated 4/14/22, the date of her admission. He explained he was not only concerned about the dressings having not been changed in 2 days, but also the resident's right arm and hand appeared swollen and red. Through discussion with Nurse #2 he was made aware the resident had an infection and a new order was recently received for the resident to receive an antibiotic. Due to the concerns about the dressings, and	F 684	that skin assessment has been completed using the admission checklist on all new admission or re-admission . Wound nurse will report skin audits to the Clinical Committee weekly . All patients with wounds or skin issues will be reviewed during weekly clinical meeting & referred to Wound MD as needed. Skin Audit / current wounds and compliance on assessment, documentation and treatment order and administration will be reported by the Wound Nurse to Director of Health Services (DHS) . The Director of Health Services (DHS) will report compliance to QAPI committee monthly x 3 Include dates when corrective action will be completed: July 28, 2022	

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concerns about the resident's possible decline in condition, he explained he requested the resident be sent to the Emergency Room for further evaluation. He said when the staff at the hospital attempted to remove the dressings to the resident's right shoulder and right knee, the dressing had to be soaked to release the dressing from the wound because the dressings had become stuck to the wound.

Review of a resident progress note dated 4/16/22 and timed 2:45 PM revealed Nurse #2 documented Resident #59's family had come to the facility and expressed concern regarding the resident's leg. The nurse documented she informed the resident's family member about an antibiotic ordered for the resident's leg. The nurse documented the resident's son requested the resident be sent to the emergency room for further evaluation.

A phone interview was conducted with Nurse #2 on 6/30/22 at 9:48 AM. She stated she remembered Resident #59's family coming to the facility on 4/16/22 and had expressed concern about bandages being dated 4/14/22, the date the resident was admitted, and not having been changed since the resident's admission. She said she explained to him the wound nurse had orders of how to change the dressings, and the dressings should have been changed daily. She said the dressings were due to be changed and she had offered to change the dressings when he discovered they had not been changed. She stated the resident's family declined to have the dressings changed at the facility and chose to have the resident sent out to the hospital. She said when the resident's family was at the facility on 4/16/22 she could only remember looking at

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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 684	Continued From page 11 the dressing, which was dated 4/14/22, on the resident's leg, she did not remember looking at any other dressings or wounds the resident may have had, and she wasn't familiar with the resident's wounds. Review of Resident #59's Medication Administration Record (MAR) for the period of 4/14/22 through 4/16/22 revealed no antibiotic medications which were started on 4/16/22. Review of Resident #59's hospital record revealed an assessment dated 4/16/22 which noted the wound to the Right Upper Extremity (RUE)/shoulder was consistent with a skin tear, there was malodorous (an unpleasant odor, a possible sign of infection), purulent (containing pus, which is one sign of a possible infection), warmth (another sign of a possible infection), redness (another sign of possible infection), and the wound bled with the removal of the dressing. The wound to the right knee was found to have been malodorous, had purulent drainage, with surrounding swelling, and warmth. The resident was diagnosed with cellulitis (infection of a wound or skin tissue) and an infected skin tear. Review of Resident #59's History and Physical, dated 4/16/22, from the hospital documented it was reported the resident's dressings to her knee and shoulder were not changed at the facility and had not been changed since she was discharged from the hospital on 4/14/22. The resident had developed right lower extremity swelling and right upper extremity swelling, and wounds to the right knee and right shoulder had developed purulent discharge. The resident was placed on intravenous antibiotics of vancomycin and piperacillin/tazobactam for the wound infections.	F 684		

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F 684	Continued From page 12	F 684		

An interview and record review were conducted on 6/30/22 with the Vice President of Clinical Services (VPCS). She reviewed Resident #59's medical record and noted orders for cream to the gluteal (buttock) crease, hydrocortisone cream to a rash, and an antifungal cream to a rash, but there were no other orders for wound care in the Treatment Administration Record (TAR), physician's orders, or in the progress notes from the nursing staff or physician/physician extender notes. She further reviewed the medical record and stated she was not able to find a skin assessment, body assessment, wound assessment, admission assessment or other documentation which would have documented the resident's wounds, wound assessments, or treatments to the wounds. She explained the facility had standing orders for wound care, but she could not find in the medical record where standing orders had been activated for the resident's wound care. She stated she did observe where Nurse #2 documented the resident's right leg was swollen and wrapped on 4/14/22, the date of her admission.

During a second interview with the VPCS conducted on 6/30/22 at 3:54 PM she stated she had continued to review Resident #59's medical record and was unable to discover further information regarding wounds or wound care for the resident. She said it was her expectation for a head-to-toe assessment to be completed of a resident at the time of admission, and if there were wounds which required an intervention, the nurse would utilize the facility standing orders for wound care, contact the physician for orders for the wound care, and apply the ordered treatment. She explained once that was completed, she

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F 684	Continued From page 13 expected the wound nurse and other nursing staff to monitor the wound(s), and to apply the wound treatments as ordered. The wound nurse was not available for interview. Attempts to interview the NP were unsuccessful.	F 684		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		7/28/22

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F 732	Continued From page 14 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to retain regulatory posted daily nurse staffing sheets for 4 days out of the 7-day period reviewed (6/2/22, 6/3/22, 6/4/22, and 6/5/22). Findings included: There were no regulatory posted daily nurse staffing sheet available to review for 6/2/22. There were no regulatory posted daily nurse staffing sheet available to review for 6/3/22. There were no regulatory posted daily nurse staffing sheet available to review for 6/4/22. There were no regulatory posted daily nurse staffing sheet available to review for 6/5/22. An interview was conducted in conjunction with a record review on 6/30/22 at 11:34 AM with the scheduler. She said she was in charge of posting, receiving, storing, and maintaining the regulatory posted daily nurse staffing sheets. While she was reviewing the sheets for the period of 6/1/22 through 6/7/22 she said she had the sheets for 6/1/22, 6/6/22, and 6/7/22. She further stated she was unable to locate and did not have	F 732	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Staffing Coordinator was unable to locate Regulatory Daily Nurse Staffing posting for June 2, 3, 4 & 5. Address how the facility will identify other residents having the potential to be affected by the same deficient practice : Audit of the Daily Nurse Staffing sheets was conducted by the Staffing Coordinator and noted all other dates were accounted for as July 6, 2022 Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: Staffing Coordinator will complete the Regulatory Daily Nurse Staffing, post daily and file a copy in the staffing binder. An electronic copy and copy submitted to the Director of Health Services (DHS) daily will serve as a back-up copy to be readily	

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F 732	Continued From page 15 the sheets for 6/2/22, 6/3/22, 6/4/22, and 6/5/22. She explained she did not know what had happened to the sheets for those dates and she was unable to locate all of the sheets for the requested period. She stated she kept the sheets in a book where she kept track of them, and also kept track of the daily staffing schedule forms which she was able to produce for the period of 6/1/22 through 6/7/22. An interview was conducted on 6/30/22 at 3:54 PM with the Vice President of Clinical Services. She stated she expected the regulatory daily posted nurse staffing sheets to be readily available upon demand.	F 732	available upon demand. Administrator in-serviced Staffing Coordinator on 7/24/22 on this process. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Staffing coordinator will report 5x/week compliance of posting and filing to Administrator during morning meeting and report compliance to Quality Assurance Process Improvement (QAPI) Monthly x 3 . Director of Health Services (DHS) and Administrator will randomly check posting and filing of the Regulatory Daily Nurse Staffing posting Include dates when corrective action will be completed: July 28, 2022	
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---	F 758		7/28/22

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F 758	Continued From page 16 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Nurse Practitioner interviews the facility failed to ensure 1 of 5 residents, Resident #40, reviewed for unnecessary medications received a dose reduction of an antipsychotic medication which	F 758	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 758	Continued From page 17 was ordered by the Psychological Services Nurse Practitioner. The Psychological Services Nurse Practitioner wrote an order for Resident #40's antipsychotic to be discontinued, but she received the medication for 7 days following the discontinuation order. Resident #40 was admitted to the facility on 8/23/2021 and her diagnoses included dementia with behaviors and anxiety. A Quarterly Minimum Data Set Assessment dated 5/17/2022 indicated Resident #40 was severely cognitively impaired and had received antipsychotics, antidepressants, and antianxiety medications in the previous 7 days. The Quarterly Minimum Data Set Assessment further indicated Resident #40 had not had behaviors. Review of Resident #40's Care Plan edited on 5/21/2022 revealed she had periods of agitation, wandering and combativeness; she had dementia with short term memory loss; and she received antipsychotic medications for management of dementia with behaviors, an antidepressant for appetite stimulation, and an antianxiety for anxiety. A Psychiatry Progress Note written by the Psychological Services Nurse Practitioner dated 6/20/2022 stated Resident #40 was currently taking an antipsychotic, Quetiapine, for behaviors associated with dementia and an antidepressant, Mirtazapine, to boost her appetite. The Progress Note further stated Resident #40 was also prescribed an antianxiety and an antidepressant and staff reported Resident #40 had calmed and her behaviors had improved. The Psychological Services Nurse Practitioner also indicated in her	F 758	A clarification order was obtained on Resident #40 on July 19, 2022, related to current antipsychotic medication. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 100% audit of all residents on antipsychotic medication was completed by the Social Worker on July 7, 2022. This audit includes ensuring correct order for all patients currently on any antipsychotic regimen . Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur: Antipsychotic Gradual dose reduction 100% audit has been completed by the Social Worker on July 7, 2022 . An ongoing review and update of the audit will be conducted by the Social Worker with each patient on any new or new dosing of any antipsychotic order. This updated audit is reported and reviewed during the clinical meeting weekly to include double checking that the correct & current antipsychotic order is in place. The Administrator in-serviced the Social Worker and Clinical Competency Coordinator on 7-25-22. The Director of Health Services will review new or new dosing of any psychotropic orders, notes and recommendations and communicate these changes to the	

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F 758	Continued From page 18 progress note she was discontinuing the antipsychotic and would monitor for behaviors.	F 758	nursing team. The new or new dosing of psychotropic orders will also be reviewed during daily clinical meetings. The Clinical Competency Coordinator (CCC) will in-service all current nursing staff and all new nursing staff upon hire during orientation, anyone not receiving the education due to FMLA or vacation will be educated before next scheduled shift, on ensuring Psychotropic medication orders are accurate and nurses continue to monitor and document residents' behaviors while communicating any changes to the Medical Providers. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Social Worker will report compliance to the Quality Assurance Process Improvement Committee monthly x 3 Include dates when corrective action will be completed: July 28, 2022	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		7/28/22

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

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F 883 Continued From page 20

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 staff interviews and record reviews, the facility failed to offer the pneumococcal vaccine and include documentation in the resident's medical record of education or vaccination status for the pneumococcal vaccination for two of five residents reviewed for the pneumococcal vaccinations (Resident #29 and Resident #16).

The findings included:

Review of the policy titled Pneumococcal Vaccinations, which had a revision date of 12/10/21, read in part; All patients/residents who reside in this healthcare center are to receive the pneumococcal vaccine(s) within the current Centers for Disease Control and Prevention (CDC) guidelines unless contraindicated by their physician or refused by the patient/resident or patient/resident's family. If the patient/resident is cognitively impaired as evidenced by scoring on the Minimum Data Set (MDS), the responsible party will be contacted, and their wishes will be followed in this matter. Under Procedure, 1) The admission process will include determining whether the patient/resident has received the pneumococcal vaccine in the past. If no reliable date of previous vaccination ca be obtained, the patient/resident should be considered eligible for vaccination. 2) A Vaccination information Statement will be provided to inform the patient/resident/family member of the side

F 883

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Resident #29 has a consent and education documentation signed and dated on April 27, 2022, in the medical record.

Resident #16 has a consent and education signed and dated on April 19, 2022, in the medical record.

Resident #29 and #16 will be administered their pneumonia dose as ordered.

Resident #10 has an education and completed declination form signed and dated on September 03, 2021, in the medical record. Therefore, Resident #10 did not receive the vaccination.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice :

100% compliance audit of Pneumonia vaccination education , consent and administration or declination was initiated

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effects, benefits, and risks of the vaccine. This education will be documented on the interdisciplinary teaching record. 3) Permission or refusal to receive the vaccine within the CDC guidelines will be obtained on admission using the pneumococcal vaccine consent/refusal for. A separate consent for each type of vaccine is required.

1. Resident #29 was admitted to the facility on 4/28/22.

Review of the Minimum Data Set (MDS) revealed an admission comprehensive assessment for Resident #29 with an Assessment Reference Date (ARD) of 5/4/22. Further review revealed the resident was coded as having had moderately impaired cognition. The MDS indicated the pneumococcal vaccine was up to date.

A review of Resident #29's medical record revealed there was no documentation to indicate whether the resident received the pneumococcal vaccine, refused the pneumococcal vaccine, or was provided education regarding the pneumococcal vaccine.

During an interview conducted on 6/30/22 at 11:16 AM with the Vice President of Clinical Services (VPCS) she stated she was unable to locate the consent form for Resident #29 which would document the resident chose to receive the pneumococcal vaccine, declined the pneumococcal vaccine, or was provided education regarding the pneumococcal vaccine.

An interview was conducted on 6/30/22 at 3:54 PM with the VPCS. During the interview she said the pneumonia vaccine

F 883

and will be completed on or before July 28, 2022, by CCC the (Clinical Competency Coordinator) and DHS (Director of Nursing Services) on all residents.

Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur:

Pneumonia vaccination education , consent or declination will be completed upon admission by the admitting nurse or Admission Coordinator . Director of Health Services / Clinical Competency Coordinator will ensure administration of vaccine and documentation on the Medication Administration Record (MAR) will be completed in a timely manner. Registered Nurse Manager will check the completion of the admission vaccination on each admission or re-admission. The Director of Health Services /Clinical Competency Coordinator will double check within 24 hours compliance using the admission checklist, Medication Administration Record, and vaccination record as tools. The administrator in-serviced the Clinical Competency Coordinator on 7-25-22. The Clinical Competency Coordinator (CCC) will in-service all current nursing staff and all new nursing staff upon hire during orientation , and staff not receiving the in-service due to FMLA or vacation will be educated prior to next scheduled shift.

Indicate how the facility plans to monitor

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F 883	Continued From page 22 consent/education/decline forms needed to be in the resident's medical record. She further stated the pneumonia vaccine needed to be kept in stock and offered to residents or the resident's family when the resident is admission, along with education regarding the vaccine. She said it then needed to be documented in the resident ' s medical records they received education regarding the vaccine, if the resident or family member chose to have or not have the vaccine, and date the vaccine was administered. 2. Resident #16 was admitted to the facility on 4/22/22. Review of the Minimum Data Set (MDS) revealed an admission comprehensive assessment for Resident #16 with an Assessment Reference Date (ARD) of 4/28/22. Further review revealed the pneumonia vaccine was not administered. The reason listed for the pneumonia vaccine not being administered was coded as not offered. A review of Resident #16's medical record revealed there was no documentation to indicate whether the resident received the pneumococcal vaccine, refused the pneumococcal vaccine, or was provided education regarding the pneumococcal vaccine. During an interview conducted on 6/30/22 at 11:16 AM with the VPCS she stated she was unable to locate the consent form for Resident #16 which would document the resident chose to receive the pneumococcal vaccine, declined the pneumococcal vaccine, or was provided education regarding the pneumococcal vaccine. An interview was conducted on 6/30/22 at 3:54	F 883	its performance to make sure that solutions are sustained: Clinical Competency Coordinator (CCC) will keep a running audit of Pneumonia vaccine compliance and update as needed. Clinical Competency Coordinator (CCC) will report audit and compliance to the Director of Health Services during the weekly clinical meeting. The Clinical Competency Coordinator / Director of Health Services will report compliance audit to the Quality Assurance Process Improvement Committee monthly x 3. Include dates when corrective action will be completed: July 28, 2022	

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	345566	A. BUILDING ______ B. WING ______	C 06/30/2022

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F 883	Continued From page 23 PM with the VPCS. During the interview she said the pneumonia vaccine consent/education/decline forms needed to be in the resident's medical record. She further stated the pneumonia vaccine needed to be kept in stock and offered to residents or the resident's family when the resident is admission, along with education regarding the vaccine. She said it then needed to be documented in the resident's medical records they received education regarding the vaccine, if the resident or family member chose to have or not have the vaccine, and date the vaccine was administered.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (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	F 887		7/28/22

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F 887	Continued From page 24 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 or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (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:	F 887		

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F 887 Continued From page 25

Based on record review and staff interview, the facility failed to ensure an unvaccinated resident was offered the vaccine for COVID-19 and failed to maintain a resident's record of refusal for the vaccine for COVID-19 two of five residents reviewed for vaccination (Resident #29 and Resident #10).

The findings include:

Review of the policy titled COVID-19 Vaccination Clinics, which was most recently revised on 4/1/22, revealed in part, all partners (staff members), residents, and patients who have no medical contraindications to the vaccine will be offered the COVID-19 vaccine per Centers for Disease Control and Prevention (CDC) recommendations to encourage and promote the benefits associated with the vaccinations against COVID-19. Further review revealed the facility, agency, or office shall provide pertinent information about the significant risks and benefits of vaccines to partners, residents, patients and/or family members. If the residents/patient was cognitively impaired as evidence by scoring on the resident's Minimum Data Set (MDS)/patient Outcome and Assessment Information Set (OASIS), the authorized responsible party will be contacted, and his/her wishes will be followed in this matter. Under Scope, the policy applied to all partners, residents, and patients of the facility. Under Procedure; 1) The patient or legal representative will sign the COVID-19 Vaccine Consent/Refusal Form indicating their wishes to receive or decline the vaccination. 2) All new admissions will be reviewed for consent or declination of vaccine to ensure previous doses of the vaccine have been documented and new/next doses can be

F 887

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Education and consent for second dose of Covid-19 will be obtained by Clinical Competency Coordinator / Director of Health Services on Resident #29 and vaccine will be administered thereafter.

Covid-19 education and additional information on benefits of immunization will be provide prior to declination form completion Resident #10 by the Clinical Competency Coordinator /Director of Health Services .

Address how the facility will identify other residents having the potential to be affected by the same deficient practice :

A 100% Covid-19 vaccination audit on education, consent and any declination with additional information will be completed by the Clinical Competency Coordinator /Director of Health Services on all current residents. Correction will be implemented as needed for compliance .

Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur:

All new admission and re-admission will receive education , consent, or declination with additional information on Covid-19 vaccination . Registered Nurse Manager

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F 887	Continued From page 26 scheduled appropriately. 3) All residents declining the vaccine will be given additional information on the benefits of immunization and an opportunity to discuss their concerns and to ask questions before signing the declination form. Under Timing of Vaccination; 1) Current unvaccinated and newly admitted residents/patients (unvaccinated or required second dose) will be offered the COIVD-19 vaccine per CDC recommendation. For Emergency Use Authorization (EUA) for vaccine; 1) Pfizer, Incorporated, and BioNTech, Number of Shots: 2 shots, 3-8 weeks apart. For Documentation, 1) Each resident's and patient's immunization status will be determined prior to COVID-19 vaccine administration and documented in the resident and patient's medical record. 3) The resident or legal representative will sign the COVID-19 vaccine consent/refusal from indicating their wishes to received or decline the vaccination. 4) The resident or legal representative may refuse vaccination. Vaccination refusal and reasons why (e.g., allergic, contraindicated, etc.) should be documented in the patient's medical record. 1. Resident #29 was admitted to the facility on 4/28/22. Review of the Minimum Data Set (MDS) revealed an admission comprehensive assessment for Resident #29 with an Assessment Reference Date (ARD) of 5/4/22. Further review revealed the resident was coded as having had moderately impaired cognition. Review of the medical record for Resident #29 revealed an entry dated 4/29/22 where the resident was documented as having received the	F 887	will ensure that this is completed upon admission . The Director of Health Services and Clinical Competency Coordinator in-serviced the Registered Nurse Manager on 7-11-22. The Clinical Competency Coordinator will maintain an updated Covid-19 audit to ensure complete, accurate and readily accessible record for each patient . The Clinical Competency Coordinator will report , review and update Covid-19 audit during weekly clinical meeting . The Administrator in-serviced the Clinical Competency Coordinator on 7-25-22. The Clinical Competency Coordinator will complete in-servicing nursing staff by 7-28-22. The Clinical Competency Coordinator (CCC) will in-service all current nursing staff and all new nursing staff upon hire during orientation , staff not receiving the education due to FMLA or vacation will be educated prior to the next scheduled shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Clinical Competency Coordinator / Director of Health Services will report Covid-19 Vaccination compliance to the Quality Assurance Process Improvement Committee monthly x 3 Include dates when corrective action will be completed: July 28, 2022	

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F 887	Continued From page 27 first COVID-19 Pfizer-BioNTech vaccine on 12/20/21. Further review of the record revealed no evidence the resident had received the second dose of the COVID-19 vaccine, or subsequent boosters prior to entering the facility, or at the facility. The record review also did not reveal a consent form for the resident to receive or refuse further doses of the COVID-19 vaccine nor was there information regarding education provided to the resident's family regarding the COVID-19 vaccine. An interview was conducted with the Vice President of Clinical Services (VPCS) on 6/30/22 at 3:54 PM. She stated there had been some confusion when Resident #29 was initially admitted because it had been communicated the resident had received her initial COVID-19 vaccine during her hospitalization in April before she came to the facility, and the nursing staff had not pursued the resident receiving her second COVID-19 vaccine administration. She further explained once the confusion was clarified and it was clear, and verified, the resident had received her first dose of vaccine, and was due for her second vaccine, they followed up with the resident's family, and the resident's family did want her to receive the second dose of the COVID-19 vaccine, but they did not have the consent form completed. She explained another issue had been the vaccine provider preferred the facility have multiple residents who were ready to receive the vaccine when they come to the facility because they had to bring 10 doses of the vaccine, and whatever doses were not administered, had to be wasted. The VPSC stated they would get Resident #29 her second dose of the COVID-19 vaccine and would also explore the option of having her go to a local	F 887		

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F 887	Continued From page 28	F 887		

pharmacy or other vaccine if necessary.

2. Resident #10 was admitted to the facility on 9/3/21.

Review of the MDS revealed a quarterly assessment for Resident #10 with an ARD of 4/11/22. Further review revealed the resident was coded as having been cognitively intact.

Review of Resident #10's medical record revealed no documentation regarding the resident having received a COVID-19 vaccine series or having been provided education and declined the COVID-19 vaccine series.

During an interview conducted on 6/30/22 at 3:54 PM with the VPCS she stated Resident #10 had refused not only the COVID-19 vaccine, but all vaccines. She explained they had all of the COVID-19 vaccine refusals in a binder, but they were unable to locate the binder at the time of the survey. She stated it was her expectation for the facility to maintain complete, accurate, and readily accessible records regarding COVID-19 vaccine refusals.