STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE NURSING & REHAB	300 NORTH MAIN STREET RICH SQUARE, NC 27869

(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 and complaint investigation survey was conducted on 6/3/24 through 6/6/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #21MQ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/3/24 through 6/6/24. Event ID# 21MQ11 The following intake was investigated: NC00215991. 3 of the 3 complaint allegations did not result in deficiency.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		7/1/24

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

Electronically Signed | 06/28/2024

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F 623	Continued From page 1	F 623		

made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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F 623	Continued From page 2 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to provide written notice of transfer/discharge to the resident and to the ombudsman for the resident who was transferred from the facility to the hospital for 1 of	F 623	F Tag 623 Notice Requirements Before Transfer/Discharge A. How corrective action will be accomplished for residents(s) found to have been affected:	

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F 623	Continued From page 3 2 residents reviewed for hospitalization (Resident #29). Findings included: Resident #29 was admitted to the facility on 09/29/2020. Resident #29 was discharged from the facility and admitted to the hospital on 12/14/2023. Resident #29 returned to the facility on 12/17/2023. A review of Resident #29's electronic medical record (EMR) revealed no written notice of transfer/discharge for Resident #29 related to the hospitalization on 12/14/2023. The quarterly Minimum Data Set (MDS) assessment dated 5/21/2024 indicated Resident #29 was cognitively intact. On 6/6/2024 at 7:12 a.m. in an interview with Resident #29, she stated she had not received a written letter notifying her of the reason she was discharged from the facility to the hospital on 12/14/2023. On 6/6/2024 at 9:43 a.m. in an interview with the Clinical Nurse Consultant, she stated she was unable to locate a written notice of transfer/discharge for Resident #29 in the EMR related to Resident #29's transfer from the facility to the hospital on 12/14/2023. She explained in February 2024 she identified the facility was not issuing a written notice of transfer/discharge to the resident or resident representatives when residents were transferred/discharged from the facility. On 6/6/2024 at 10:00 a.m. in an interview with the	F 623	Resident #29 was admitted back to the facility and still resides here. B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: On June 20, 2024, the DON reviewed residents with immediate discharge/ transfer to hospital in last 7 days who had not received the written notification for reason of discharge to the hospital. No residents were identified. C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? To prevent this from happening again on June 21, 2024 the Administrator and Director of Nursing provided education to licensed nurses, social worker and business office manager on the discharge/ transfer letter policy. D. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained: Nursing Home Administrator/ Designee will audit residents discharged to the hospital 5 times per week for 12 weeks to ensure residents discharged to the hospital received written notification of reason for transfer to the hospital. Business office manager/ Social worker will send a copy of the state specific discharge letter to resident/ resident's responsible party as soon as practicable. The business office manager /social Worker will send a copy via email to ombudsman monthly. NHA/ designee will bring the results of the audits to the monthly Quality Assurance performance Indicator meeting for review	

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F 623	Continued From page 4 Social Worker, she explained she had not worked in long term care prior to July 2023 when she began employment with the facility. She stated in December 2023 she had not notified the ombudsman of residents' transfers and discharges from the facility, and the ombudsman was not notified of Resident #29's transfer/discharge on 12/14/2023. She explained she started sending monthly notifications, except for 30-day discharge notifications, to the ombudsman of all resident transfers and discharges in February 2024 upon learning of the required notification process. On 6/6/2024 at 10:23 a.m. in an interview with the Director of Nursing (who started at the facility on 11/29/2023), she stated in December 2023 the facility had not provided residents or resident representatives a written notice of transfer/discharge and was not able to explain why the facility had not provided the notification. She explained upon learning in February 2024 the facility needed to provide residents or resident representatives and the ombudsman with a written notice of transfer/discharge when residents transferred or discharged from the facility, the nursing staff were educated on the process. On 6/6/2024 at 10:10 a.m. in an interview with the Administrator, he said Resident #29 and the ombudsman did not receive written notification for the reason of Resident #29's transfer/discharge on 12/14/2023 because an issue with residents or resident representatives and the ombudsman not receiving the written notice of transfer/discharge was not identified until February 2024.	F 623	for 3 months, or longer as deemed necessary by the QAPI committee. Revisions will be made as needed.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr	F 625		7/1/24

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F 625	Continued From page 5 CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to provide the bed hold policy in writing at the time of transfer to 1 of 2 residents reviewed for discharged to the hospital (Resident #29). This practice had the potential to impact other residents.	F 625	F625 Notice of Bed Hold Policy Before/ Upon Transfer A. How corrective action will be accomplished for residents(s) found to have been affected: Resident #29 was readmitted to facility and currently still resides in the facility.	

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F 625	Continued From page 6 Findings included: Resident #29 was admitted to the facility on 09/29/2020. Resident #29 was discharged from the facility and admitted to the hospital on 12/14/2023. Nursing documentation on 12/14/2023 at 4:28 a.m. recorded Resident #29 requested to go to the hospital due to feeling weak. The physician and Resident #29's Representative were notified, and Resident #29 was sent to the hospital for an evaluation. There was no documentation in Resident #29's electronic medical record (EMR) that the bed hold policy was provided to Resident #29 on 12/14/2023 when she was transferred and admitted to the hospital. Resident #29 returned to the facility on 12/17/2023. The quarterly Minimum Data Set (MDS) assessment dated 5/21/2024 indicated Resident #29 was cognitively intact. On 6/6/2024 at 7:12 a.m. in an interview with Resident #29, she stated she did not recall receiving a bed hold policy from the facility on 12/14/2023 when she was transferred to the hospital. On 6/6/2024 at 9:43 a.m. in an interview with the Clinical Nurse Consultant, she stated she was unable to locate in Resident #29's EMR documentation Resident #29 was issued the bed hold policy on 12/14/2023 when transferred from the facility to the hospital. She explained in	F 625	B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: The facility Director of Nursing on June 20, 2024, reviewed residents with immediate discharge/ transfer to hospital in the last 7 days to identify anyone affected by this issue. No residents were identified as affected by this deficient practice. C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? To prevent this from happening again, the licensed nurses, social worker and business office manager were educated on the bed hold policy by the Administrator and Director of Nursing on June 21, 2024. D. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained: Nursing Home Administrator/ designee will audit immediate discharges 5 times per week for 12 weeks to ensure residents discharged to the hospital received the bed hold letter. Business office manager/ Social Worker will mail a copy the bed hold policy to the resident/ residents representative as soon as practicable after resident is discharged to the hospital. The LNHA/ designee will bring the results of the audits to be reviewed in monthly Quality Assurance Performance Indicators meeting for 3 months; or longer as deemed necessary by the QAPI committee.	

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F 625	Continued From page 7 February 2024 it was identified the facility was not issuing the bed hold policy to residents or resident representatives when residents were transferred from the facility. On 6/6/2024 at 10:23 a.m. in an interview with the Director of Nursing (who started at the facility on 11/29/2023), she stated in December 2023 the facility was not issuing residents or resident representatives the bed hold policy when transferred from the facility. She stated she was not able to explain why the facility was not issuing the bed hold policy. She explained when the facility was informed in February 2024 of the need to provide residents or resident representatives with the bed hold policy when transferred from the facility, the nursing staff were educated on issuing the bed hold policy when transferring residents out of the facility. On 6/6/2024 at 10:10 a.m. in an interview with the Administrator, he said Resident #29 was not issued the bed hold policy when transferred from the facility on 12/14/2024. He explained the facility was not aware there was an issue with residents or resident representatives not receiving the bed hold policy when transferring from the facility until February 2024.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve	F 637		7/1/24

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F 637	Continued From page 8 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to perform a Significant Change in Status Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for hospice care (Resident #38). Findings included: Resident #38 was admitted to the facility on 7/6/22 with diagnoses that included hypertension and dementia. Review of Resident #38's medical records revealed she was receiving hospice services prior to admission to the facility and continued to receive services upon admission. Review of a Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (NOMNC, form 10123) dated 12/21/23 revealed Resident #38's hospice services were ending on 12/23/23. Review of Resident #38's quarterly Minimum Data Set (MDS) assessment dated 12/20/23 revealed she received hospice services during the lookback period. Resident #38's quarterly MDS assessment dated 3/20/24 revealed she did not receive hospice services during the lookback period.	F 637	F Tag 637 A. Corrective action for resident(s) affected by the alleged deficient practice: The MDS coordinator completed a significant change on 06/06/2024 for resident #38. B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: the MDS coordinator completed a 100% audit on residents on 6/10/2024 to assure no other significant changes noted. No other issues noted. C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? the Regional Clinical Reimbursement Consultant provided re-education to the Minimum Data Set Coordinator (MDS) on 6/20/2024 regarding the need for a significant change in status in the MDS within 14 days of significant change being identified. D. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: the Regional MDS consultant/designee will audit 3 residents weekly for 12 weeks for any condition that requires a significant change assessment. The Licensed	

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F 637	Continued From page 9 Review of Resident 38's MDS assessments revealed a significant change assessment had not been completed when Resident #38 had been discharged from hospice services. During an interview conducted with the MDS Coordinator on 6/5/24 at 2:40 PM she stated during December she had just begun working in the facility and was not aware Resident #38's significant change assessment was not done during the transition. An interview was conducted with the Administrator on 6/6/24 at 11:10 AM who stated MDS assessments should be done within the required time frames. He further stated the MDS Coordinator was transitioning to the facility during December, and the failure to complete a significant change assessment when Resident #38 stopped receiving hospice services was an oversight.	F 637	Nursing Home Administrator/designee will bring results from the audit to be reviewed to the QAPI meeting for 3 months or longer if deemed necessary by the QAPI committee.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to obtain a physician order for the use of supplemental oxygen and	F 695	F Tag 695 Respiratory/Tracheostomy Care and Suctioning A. Corrective action for resident(s)	7/1/24

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F 695	Continued From page 10 apply signage indicating the use of oxygen outside the resident's room for 1 of 3 residents reviewed for oxygen use (Resident #152). The findings included: Resident #152 was re-admitted to the facility on 12/21/23 with diagnoses including congestive heart failure, and chronic respiratory failure. The care plan dated 3/27/24 indicated Resident #152 was using oxygen as indicated. Review of the quarterly Minimum Data Set (MDS) assessment dated 4/18/24 indicated Resident #152 was severely cognitively impaired and the use of oxygen. Nursing documentation dated 5/30/24 recorded Resident #152 on return to the facility 10:25 pm was on oxygen at 2 liters per minute via nasal cannula. Further nursing documentation dated 5/31/24 at 11:00 pm revealed Resident #152 receiving oxygen via nasal cannula at 2 liters per minute. There was no physician's order for the use of oxygen in Resident #152's medical record. On 6/4/24 at 3:13 pm, there was no signage outside Resident #152's room indicating the use of oxygen. Resident #152 was observed wearing oxygen via nasal cannula at 3 liters per minute. On 6/5/24 at 3:28 pm in an interview with Nurse #1, she explained she did not recognize there was no "Oxygen in use, no smoking" signage outside his door. She stated an "Oxygen in use,	F 695	affected by the alleged deficient practice: Physician was notified, and oxygen orders were immediately obtained for resident #152. Oxygen sign was also placed on the door. B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: The Director of Nursing completed a 100% audit on June7, 2024 of all residents receiving oxygen with no other residents affected. C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? ON June 7,2024 the Director of Nursing educated licensed nurses and medication aides on the policy and procedures of oxygen use and obtaining physician orders D. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained: The Director of Nursing/ unit manager, will review all new orders and admissions 5 times weekly for 12 weeks to ensure that residents requiring oxygen have current orders in place and oxygen sign outside of resident□s door. The Licensed Nursing Home Administrator/designee will bring results of the audits to be reviewed in QAPI meeting for 3 months or longer if deemed necessary by the QAPI committee.	

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F 695	Continued From page 11 no smoking" signage should have been placed outside Resident #152's door when he was admitted or when nursing staff recognized signage was not outside the door. On 6/4/24 at 3:34 pm in an interview with Nurse Unit Manager, she explained she did not recognize there was not a "Oxygen in use, no smoking" signage out Resident #152's door. She stated an "Oxygen in use, no smoking" signage should have been placed outside Resident #152's door when he was admitted or when nursing staff recognized signage was not outside the door. After reviewing Resident#152's orders, Nurse Unit Manager stated there was no order for the use of 2 liters per minute of oxygen for Resident #152 in the physician's orders. She explained any nurse could enter a physician order for the use of oxygen and stated she did not know why there was not an order in Resident #262's electronic medical record (EMR) for the use of oxygen. On 6/5/24 at 8:35 a.m. in an interview with the Director of Nursing, she stated nursing should have called the physician for Resident #152 when he returned from the hospital for an order for the use of oxygen. The nursing staff should have entered an order for the use of oxygen into the EMR for Resident #152. She indicated the nursing staff could administer up to 2 liters per minute of oxygen when residents were in distress but usually called the physician for an order when oxygen was needed. She explained the nursing staff was responsible to ensure an "Oxygen in use, no smoking" sign was outside Resident #152's door due to oxygen in use.	F 695		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		7/1/24

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	345356	A. BUILDING _____ B. WING _____	C 06/06/2024

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F 883	Continued From page 12	F 883		

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

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

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F 883	Continued From page 13 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 providing education of the influenza vaccine (2023-2024 season) and pneumococcal vaccine and the resident's or resident representative's refusal to receive the influenza vaccine (2023-2024 season) and pneumococcal vaccine for 2 of 6 residents reviewed for immunizations (Resident #41 and Resident #152). Findings included: 1. a. Resident #41 was admitted to the facility on 8/02/2023. The quarterly Minimum Data Set (MDS) assessment dated 3/7/2024 indicated Resident #41 was severely impaired cognitively. There was no documentation in the electronic medical record (EMR) Resident #41 had received the influenza vaccine (2023-2024 season).	F 883	F Tag 883 Influenza and Pneumococcal Immunizations A. How corrective action will be accomplished for residents(s) found to have been affected: The Director of Nursing offered residents #152 and #41 pneumococcal vaccination. Influenza vaccination was not offered due to being outside of flu season dates. On 6/20/2024 the DON offered and received consent from Residents representative for residents #152 and #41. The DON provided education for both Resident Representative. On 6/21/2024 The DON administered the Pneumococcal immunization to resident #152 and Resident #41. B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: The Director of	

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F 883	Continued From page 14 The EMR for Resident #41 reported no past history of Resident #41 receiving a pneumococcal vaccine. The facility was unable to provide written documentation Resident #41 or Resident #41's Representative had received education for the influenza vaccine (2023-2024 season) and pneumococcal vaccine to consent for administration or refusal of administration of the influenza vaccine (2023-2024 season) and the pneumococcal vaccine. b. Resident #152 was admitted to the facility on 5/19/2021. A review of Resident #152's electronic medical record (EMR) reported on 5/20/2021refusal for the influenza and pneumococcal vaccines. The quarterly Minimum Data Set (MDS) assessment dated 4/18/2024 indicated Resident #152 was severely impaired cognitively. There was no documentation in the EMR Resident #152 had received the influenza vaccine (2023-2024 season). The EMR for Resident #152 reported no past history of Resident #152 receiving a pneumococcal vaccine. The facility was unable to provide written documentation Resident #152 or Resident #152's Representative had received education for the influenza vaccine (2023-2024 season) and pneumococcal vaccine to consent for	F 883	Nursing/ designee completed 100% audit of influenza and pneumococcal vaccinations on June 21,2024 All new issues identified were addressed and completed by 7/1/2024. C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 06/20/2024, the Director of Nursing and the Nurse Management team were re-educated on The pneumococcal and Influenza immunization policy and procedures by the Clinical Nurse Consultant. D. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained: The Director of Nursing/designee will audit new admissions 5 times a week for 12 weeks. To ensure residents were provided education and offered the influenza (if during flu season) and pneumococcal vaccinations and any declination signed. The License Nursing Home Administrator/designee will bring results of the audits to be reviewed in Quality assurance performance improvement meeting for 3 months or longer if QAPI committee deems necessary.	

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F 883	Continued From page 15 administration or refusal of administration of the influenza vaccine (2023-2024 season) and pneumococcal vaccine. On 6/6/2024 at 1:01 p.m. in an interview with the Director of Nursing (who was also acting as the Infection Preventionist), she stated she started at the facility on 11/30/2023. She explained the annual influenza vaccine (2023-2024 season) was offered and administered to all residents or resident representatives prior to her employment at the facility. She stated in May 2024 she offered the pneumococcal vaccine to the all residents or resident representatives. She stated the facility obtained a written consent for a vaccine when a vaccine was to be administered and if Resident #41 and Resident #152 or their Representatives refused the vaccines, she did not have documentation. She explained when the residents or resident representatives were asked if they wanted to receive the influenza vaccine (2023-2024 season) and pneumococcal vaccine, the facility was not obtaining a written consent that stated education was provided on the vaccines, and the resident or resident representative refused the administration of the influenza vaccine (2023-2024 season) and pneumococcal vaccine.	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	F 887		7/1/24

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F 887	Continued From page 16	F 887		

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

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F 887	Continued From page 17 (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document providing education of the COVID (2023-2024 season) vaccine and the resident's or resident representative's refusal to receive the COVID (2023-2024 formula) vaccine for 2 of 6 residents reviewed for immunizations (Resident #41 and Resident #152). Findings included: 1. a. Resident #41 was admitted to the facility on 8/02/2023. The quarterly Minimum Data Set (MDS) assessment dated 3/7/2024 indicated Resident #41 was severely impaired cognitively. There was no documentation in the electronic medical record (EMR) Resident #41 had received education for the COVID (2023-2024 formula) vaccine. The facility was unable to provide written documentation Resident #41 or Resident #41's Representative had received education for the COVID (2023-2024 formula) vaccine to consent for administration or refusal of administration of the COVID (2023-2024 formula) vaccine.	F 887	F Tag 887 Covid 19 Immunization A. How corrective action will be accomplished for residents(s) found to have been affected: The Director of Nursing offered residents #152 and #41 the Covid vaccine. On 6/20/2024 the DON offered and received consent from Residents representative for residents #152 and #41. The DON provided education for both Resident Representative. On 6/25/2024 The DON administered the Covid 19 immunization to resident #152 and Resident #41. B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: the Director of Nursing/designee completed a 100% audit on Covid 19 vaccines on June 22,2024. All new issues identified were addressed and completed by 6/25/2024. C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 06/20/2024, the Director of Nursing and the Nurse Management team were re-educated on the Covid 19	

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F 887	Continued From page 18 b. Resident #152 was admitted to the facility on 5/19/2021. A review of Resident #152's electronic medical record (EMR) reported on 1/4/2023 refusal for the COVID vaccine. There was no documentation that Resident #152 or Resident #152's Representative was provided education to consent or refuse the COVID (2023-2024 formula) vaccine. There was no documentation in the EMR Resident #152 had received the COVID vaccine (2023-2024 formula). The quarterly Minimum Data Set (MDS) assessment dated 4/18/2024 indicated Resident #152 was severely impaired cognitively. The facility was unable to provide written documentation Resident #152 or Resident #152's Representative had received education for the COVID (2023-2024 formula) vaccine to consent for administration or refusal of administration of the COVID (2023-2024 formula) vaccine. On 6/6/2024 at 1:01 p.m. in an interview with the Director of Nursing (who was also acting as the Infection Preventionist), she stated she started at the facility on 11/30/2023. She explained the COVID (2023-2024 formula) vaccine was offered and administered to all residents or resident representatives prior to her employment at the facility. She explained when the residents or resident representatives were asked if they wanted to receive the COVID (2023-2024 formula) vaccine, the facility was not obtaining a	F 887	immunization policy and procedures by the Clinical Nurse Consultant. D. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained: The Director of Nursing/designee will audit new admissions 5 times a week for 12 weeks. To ensure residents were provided education and offered the the Co-vid 19 Immunization and any declination signed. The Nursing Home Administrator/designee will bring results of the audits to be reviewed in Quality assurance performance Indicator meeting for 3 months or longer if QAPI committee deems necessary.	

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F 887	Continued From page 19 written consent that stated education was provided on the vaccines, and the resident or resident representative refused the administration of the COVID (2023-2024 formula) vaccine.	F 887		