STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAPPHIRE RIDGE HEALTH AND REHABILITATION	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 was conducted on 03/03/25 through 03/07/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #NL4611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/03/25 through 03/07/25. Event ID # NL4611. The following intakes were investigated: NC00217076, NC00227673, NC00219094, NC00220653, NC00212145, NC00212695, NC00227882, NC00221830, and NC00215142. 3 of the 17 allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		4/1/25

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

Electronically Signed | 03/27/2025

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide a dignified dining experience for a dependent resident seated at a table in the main dining room waiting to be served and assisted with his lunch while watching other residents in the main dining room receive and eat their lunch for 1 of 2 residents reviewed for dignity (Resident #49). The reasonable person concept was applied to this deficiency as an individual might feel forgotten or experience frustration at not being able to eat while watching others receive and eat their meals. Findings included: Resident #49 was admitted to the facility on	F 550	The facility failed to provide a dignified dining experience for a dependent resident seated at a table in the main dining room waiting to be served and assisted with his lunch while watching other residents in the main dining room receive and eat their lunch for 1 of 2 residents reviewed for dignity (Resident #49). Resident #49 was served and assisted with tray by nurse aide at this same meal. Current facility residents who are dependent with eating meals in a communal setting are at risk of being affected by the deficient practice. The Administrator monitored 3 meals in the	

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F 550	Continued From page 2 11/20/24 with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting the left non-dominant side and vascular dementia. The admission Minimum Data Set (MDS) assessment dated 11/28/24 revealed Resident #49 had severe cognitive impairment. He had impairment on one side of both the upper and lower extremities and required substantial/maximal staff assistance with eating. Review of the scheduled meal time posted at the facility revealed lunch was to be served in the main dining room at 12:30 PM. A continuous observation of the lunch meal was conducted on 03/06/25 from 12:00 PM to 1:30 PM. At 12:00 PM, Resident #49 was observed sitting in his wheelchair at a table in the back of the main dining room. Resident #49 was alert and looking around, watching the activity in the dining room. When asked if he was hungry, Resident #49 replied, "yeah lawd" (term often used as an expression to heighten an emotion). At 12:30 PM, meal carts had not arrived to the main dining room. At 12:40 PM, the meal cart arrived in the main dining room and there were five staff present who immediately started passing out meal trays to residents seated at the tables in the front of the main dining room. At 12:55 PM, the residents who were able to eat independently had all received their meal tray and were eating their lunch while the residents in the back of the main dining room, who needed staff assistance including Resident #49, had not been served their meal. At 1:00 PM, another meal cart arrived in the main dining room and staff started	F 550	main dining room and the memory care unit dining room to identify other residents being affected and to ensure meals were served timely and residents were assisted with their meals in a timely manner. No other concerns noted. These audits were conducted during the week starting March 24,2025. The measures that have been put into place to ensure the deficient practice does not recur, are as follows: 1) Newly adjusted meal times were presented to the Resident Council on 3-25-25 by the administrator for their approval. 2) Current facility and agency nursing staff, dietary staff, and interdisciplinary team were educated by the Administrator or designee on scheduled mealtimes and ensuring residents obtain their meal trays in a timely manner and dependent residents are fed in a manner that preserves their dignity and reduces risks of resident of feeling frustrated or forgotten by 3/31/2025. Nursing staff will notify dietary at least 2 hours prior to the meal time if there are residents that desire to eat in the dining room that normally do not. This will alert dietary as to the location where the tray should be delivered. 3) Newly hired facility and agency nursing staff, dietary staff, and interdisciplinary team members and staff not educated by 3/31/2025 will be educated upon hire or prior to working their next scheduled shift. 4) New meal times will be posted at each nurses station as well as in the dining rooms by 3-31-25 by the dietary manager.	

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F 550	Continued From page 3 sitting down at other tables assisting dependent residents with their meal. Resident #49 looked over at the staff assisting residents with their meals with a look of confusion on his face and made a groaning sound. When asked if he was ok, Resident #49 stated "no" and when asked if he was hungry, he replied "yeah lawd." At 1:25 PM, staff brought Resident #49's meal tray to the table and began assisting Resident #49 with his meal. Resident #49 eagerly accepted sips of fluid and bites of food when offered by staff. Resident #49 waited approximately one hour from the scheduled mealtime to be served and assisted with his lunch. During an interview on 03/07/25 at 4:34 PM, the Administrator expressed it was a dignity issue when residents sat in the main dining room an hour or longer waiting to be served their meal or receive assistance with a meal. She explained staff assisted residents to the dining room a little earlier than the scheduled meal time because once the meal trays arrived on the hall, staff couldn't stop passing meal trays out to the residents eating in their rooms in order to bring other residents to the main dining room. The Administrator revealed she was aware of the issue with meals being served late and stated while she was not sure where or how the breakdown occurred she felt it could be more of a process issue rather than a staffing issue.	F 550	The Administrator or designee will monitor 3 meals a week for 4 weeks, 2 meals a week for 4 weeks, and 1 meal a week for 4 weeks to ensure meals are being served at designated times and residents are receiving their trays in a timely manner. 6) Issues identified during this audit will be reviewed with the Dietary Manager and the DON. The results of this audit will be presented to the Quality Assurance and Process Improvement) QAPI committee monthly by the administrator starting in the month of April 2025. The QAPI team may make adjustments to the plan if necessary to achieve compliance. Completion Date: 4/1/2025	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		4/1/25

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F 561	Continued From page 4 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to honor a resident's preference for twice weekly showers for 1 of 3 residents reviewed for choices (Resident #104). Findings included: Resident #104 was admitted to the facility on 02/24/25 with diagnoses including metabolic encephalopathy and heart failure. The admission Minimum Data Set (MDS)	F 561	The facility failed to honor a resident's preference for twice weekly showers for 1 of 3 residents reviewed for Resident #104. Corrective action for this resident was achieved on 3-7-25 when the Unit Manager (UM) placed the resident's room number correctly on the shower assignment sheet in the assignment book. The resident was given a shower as well on 3-7-25. Current facility residents are at risk of being affected by the deficient practice.	

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F 561	Continued From page 5 assessment dated 02/26/25 indicated Resident #104's cognition was moderately impaired, she had limited range of motion affecting one side of the upper extremity, and bathe/shower was not applicable and not attempted. A review of the shower assignment revealed Resident #104's showers were scheduled on Tuesday and Friday. There was no documented shower sheets to indicate a bed bath or shower was provided on 02/25/25 (Tuesday) or 02/28/25 (Friday). A shower sheet dated 03/04/25 revealed Resident #104 had received one shower since admission on 02/24/25. During an interview and observation on 03/03/25 at 2:36 PM Resident #104 revealed she had not received a shower since being admitted to the facility. Resident #104's hair and face appeared clean, and she had no body odors. The care plan initiated on 03/04/25 revealed Resident #104 required assistance from staff for activities of daily living related to weakness with the goal to be clean and well-groomed daily through the next review. Interventions included provide assistance with activities of daily living. During an interview on 03/07/25 at 8:37 AM the Unit Manager (UM) revealed bathing was documented by Nurse Aide (NA) staff included using a paper shower sheet that was kept in a binder at the nurse station. The UM revealed the shower sheets were kept in the binder for one month then placed in medical record storage. The UM confirmed Resident #104 showers were scheduled on Tuesday and Friday and the first one should have been given on 02/25/25. The UM was unable to provide a shower sheet for	F 561	The UM audited the remaining shower assignments to ensure there were no resident rooms omitted, and no other concerns were identified. This was completed on 3-10-25. The measures that have been put into place to ensure the deficient practice does not recur, are as follows: 1) providing education surrounding this deficient practice to all facility and agency nursing staff. This will be completed by 3-31-25 and the education will be provided by the Director of Nursing (DON) and/or UMs. Newly hired nursing staff will be educated during orientation by the UM. New agency staff will also receive this education by the UM upon their first day of work in this facility. Staff not educated by 3-31-25 will be educated upon return to work on their first shift back by the UM. 2) Questionnaires will be completed by the Shower Aide, Scheduler, or UM for each resident by speaking with the resident or their Responsible Party (RP) regarding their preference for frequency of bathing and their preferred method of bathing (shower or bed bath). These questionnaires will be completed by 3-31-25. 3) The results of these questionnaires will be placed in each unit's assignment book with the most current information by the UMs. This will be maintained by the UM starting 4-1-25. 4) The UM will review with the resident or the Responsible Party what the bathing preferences are for newly admitted residents effective 4-1-25 and place that in the appropriate assignment notebook	

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F 561	Continued From page 6 02/25/25 and 02/28/25. The UM revealed she filled out the shower assignment using room numbers to identify which residents NA staff were to provide a shower/bathe. After reviewing the assignment, the UM revealed Resident #104's room number was not added, and the assigned NA would not have known to provide the shower and was an oversight on her part. During an interview on 03/07/25 at 9:24 AM in presence of the UM, Resident #104 stated she had received only one shower (3/4/25) since her admission and wanted two showers a week and it was her preference not to receive a bed bath in place of a shower. The UM reassured Resident #104 her bathing preference for a shower twice a week would be honored. An interview was conducted with the Administrator on 03/07/25 at 6:10 PM. The Administrator revealed she expected resident bathing preferences for two showers a week were honored.	F 561	5) The bathing frequency and preferred method will be reviewed with the resident or RP at least quarterly with the scheduled care plan and the resident and/or RP will also be able to notify UM if changes are needed/requested in between care plan meetings. Changes will be communicated to respective UM by the Interdisciplinary Team (IDT) and the UM will make changes in the assignment notebooks effective 4-1-25. The UM will audit 5 random residents 3 times a week for 4 weeks to ensure compliance, and then 5 residents 2 times a week for 4 weeks to ensure compliance, and then 5 residents weekly to ensure compliance for a period of 4 weeks. Any issues of non-compliance will be corrected immediately by the assigned caregiver. The results of these audits will be presented in the monthly Quality Assurance and Process Improvement (QAPI) committee meeting by the Director of Nursing starting the month of April 2025. This will continue for a period of 3 months or longer if needed to achieve compliance. The QAPI committee may adjust or changes to this plan if deemed necessary by the QAPI committee to achieve compliance with this citation. Completion date: 4-1-25	
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.	F 565		4/1/25

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F 565	Continued From page 7 (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to communicate resolution to concerns voiced for 1 of 2 Resident Council meetings reviewed (January 2025).	F 565	The facility failed to communicate resolution to concerns voiced for 1 of 2 Resident Council meetings reviewed (January 2025). The concern resolution from January 2025 Resident Council was	

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F 565	Continued From page 8 Findings included: A review of the Resident Council Meeting policy revised 01/01/25 stated the facility would act upon concerns and recommendations of the Resident Council, make attempts to accommodate recommendations to the extent practicable and communicate its decisions to the Resident Council. The Resident Council meeting minutes dated 01/31/25 noted under new business that residents communicated to the Dietary Manager, who was in attendance at the meeting, their preferences for specific beverages with an outcome noted as "resolved-still monitoring." It was also noted under new business that residents voiced laundry concerns regarding clothing being placed in the wrong closets. The action to the concern indicated a grievance form regarding missing items would be completed and the outcome was noted as "resolved-still monitoring." A grievance form dated 01/31/25 noted attendees of the Resident Council meeting voiced concerns about laundry staff putting clothing in the wrong resident closets. There was no staff member assigned to investigate the concern and no summary of the investigation. The plan to resolve the grievance indicated the concern would be reviewed with the Environmental Services Director and noted the concerns was ongoing. It was further noted the investigation results and resolution was provided to the Resident Council. There were no other details listed on the grievance form. The Resident Council meeting minutes dated	F 565	reviewed with the resident council by social worker on 3/25/2025. Current facility residents are at risk of being affected by the deficient practice. The Administrator reviewed Resident Council Meeting minutes for the past 3 months to ensure all concerns had been addressed and communicated to the Resident Council to be completed by 3/31/2025. The measures that have been put into place to ensure that the deficient practice does not recur, are as follows: 1) The Administrator educated the activities director (AD), social worker (SW), director of nursing (DON), and the Interdisciplinary team members (IDT team) ensuring concerns that are voiced during the resident council meeting are addressed and review of the resident council meeting policy by 3-31-25. Newly hired activities directors, social workers, director of nursing, or IDT members not educated by 4/1/2025 will be educated upon hire and or prior to working their next scheduled shift by the administrator or Director of Nursing. 2) All grievances voiced at the Resident Council meeting will be placed on grievance forms by the AD and then given to the SW. 3) The SW will follow through with the resolution with the appropriate department and resolution will be in writing and reviewed at the following Resident Council meeting by the SW starting 4-1-25. The Administrator will review Resident	

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F 565	Continued From page 9 02/26/25 revealed the last meeting's minutes was read and approved. There was no notation under old or new business that the facility's efforts (response, action and/or rationale) to address the concerns voiced during the 01/31/25 meeting was communicated to the Resident Council. A Resident Council group interview was conducted on 03/05/25 at 3:32 PM with Resident #4, Resident #11, Resident #35, Resident #42, Resident #51, Resident #62, and Resident #74 in attendance. The residents stated when they voiced concerns during meetings, they rarely received communication from facility staff regarding what was done to address the concerns. The residents stated they did not feel the ongoing concerns they voiced related to clothing not being returned from laundry and dietary, specifically meals being served late, had been resolved. They stated if facility administration did attempt to address their concerns, it took a long time and the situation might get better for a little while but improvement didn't last long. The residents all stated they felt when they voiced concerns either in the Resident Council meetings or directly to the Administrator, Director of Nursing or Social Worker (SW), it didn't do any good. During an interview on 03/07/25 at 12:15 PM, the Activities Director (AD) revealed she just started conducting Resident Council meetings in January 2025 and most of the groups concerns revolved around dietary or laundry. She verified that residents had voiced concerns with late meals. She explained she followed up with residents regarding resolution to individual concerns but did not follow-up with the Resident Council regarding resolution to group concerns. She stated she	F 565	Council meeting minutes for three months to ensure all concerns voiced have been reviewed and the resolution has been communicated to Resident Council in writing. The status of the concerns will be documented in the minutes. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 4/1/2025	

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F 565	Continued From page 10 was still learning the process and would do much better about that in the future. During an interview on 03/07/25 at 3:44 PM, the SW revealed the staff member who facilitated the Resident Council meeting was the one responsible for communicating the resolution of group concern(s) to the members of the Resident Council. During an interview on 03/07/25 at 4:34 PM, the Administrator revealed she was aware of the issue with meals being served late and confirmed residents had brought their concerns regarding late meals to her attention. She stated she was not sure what the root cause was regarding late meals but felt it could be more of a process issue rather than a staffing issue. The Administrator expressed she was not aware that residents felt they did not receive communication regarding resolution to their concerns or that they felt voicing their concerns would not do any good. The Administrator stated resolution to concerns voiced during the Resident Council meetings should be discussed with and communicated to the Resident Council attendees at the next meeting.	F 565		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been	F 585		4/1/25

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furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is

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responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents'

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F 585	Continued From page 13 rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to implement their grievance policy for 1 of 1 resident (Resident #8) reviewed for grievances. Findings included: Review of the facility's grievance policy revised 01/01/25 read in part as follows: "It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. [Prompt Efforts to Resolve] include facility acknowledgement of a complaint grievance and actively working toward resolution of that complaint/grievance. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; and issuing written grievance decisions to the resident. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. The Grievance Official will take steps to resolve the grievance and record information about the grievance and those actions on the grievance form. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on	F 585	The facility failed to implement their grievance policy for 1 of 1 resident (Resident #8) reviewed for grievances. The corrective action for Resident #8 was to provide a written statement explaining how the grievances were addressed and corrected. This was completed by 3-31-25 by the Social Worker (SW). Current facility residents are at risk of being affected by the deficient practice. The SW reviewed grievances completed from 2/1/2025 to 3/25/2025. Grievances without written responses were completed and given to residents or responsible party by the SW. This was completed on 3/31/2025. The measures that have been put into place to ensure that the deficient practice does not recur, are as follows: 1) the administrator educated the SW regarding the Grievance Policy on 3-25-25. 2) the SW will provide residents or the person filing a grievance with written notification including: a) the date the grievance was filed, b) steps taken to investigate the grievance, c) summary of the pertinent findings or conclusions regarding the concern, f) statement as to whether the grievance was confirmed or not confirmed, g) any corrective action taken	

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F 585	Continued From page 14 the grievance to the resident or representative at the conclusion of the investigation. If the resident or complainant do not wish to have a written copy of the decision, verbal discussion is acceptable. The written decision will include at a minimum: (a). The date the grievance was received (b). The steps taken to investigate the grievance (c). A summary of the pertinent findings or conclusions regarding the resident's concern (f). A statement as to whether the grievance was confirmed or not confirmed (g). Any corrective action taken or to be taken by the facility as a result of the grievance (h). The date the written decision was issued." Resident #8 was admitted to the facility 11/24/23 with diagnoses including non-Alzheimer's dementia. Review of the quarterly Minimum Data Set assessment dated 12/07/24 revealed Resident #8 was cognitively intact and was always incontinent of bowel and bladder. Review of the facility's grievance logs from December 2023 through March 2025 revealed Resident #8 had filed 2 grievances. A grievance filed by Resident #8 on 01/08/24 regarding "various care concerns". The nursing department investigated the grievance and findings of the investigation were blank. The form indicated the plan to resolve the grievance included staff counseling and medication review. An in-service dated 01/08/24 revealed nursing staff were educated on "Respectful Talk to Residents" and the grievance was considered resolved. The results of the investigation were verbally communicated to Resident #8 on	F 585	or to be taken by the facility as a result of the grievance, and h) the date the written decision was issued. Effective 3-25-2025. The SW will review all grievances with the Administrator to ensure that all have been addressed. Weekly for 12 weeks. The administrator will audit all grievances reviewing the forms for completion and the written responses to ensure that all required information is present. If the information is not present, the SW will correct the information missing before presenting the notification to the person filing the grievance. The results of this audit will be presented to the monthly Quality Assurance and Process Improvement (QAPI) team starting with the April 2025 QAPI meeting and continuing for at least 3 months. Necessary changes may be made by the QAPI team to achieve compliance. Completion date: 4-1-25	

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01/09/24. The grievance form did not contain any additional information regarding the care concerns and was not signed by Resident #8.

A grievance was filed by Resident #8 on 02/10/25 regarding "timely response to incontinence care". The Director of Nursing (DON) investigated and determined Resident #8 received incontinence care, but had to wait until care staff were done with another resident. The plan to resolve the grievance was to encourage staff to notify Resident #8 they "will be right there" or as soon as possible when she is waiting. Resident #8 verbalized understanding that staff were to "notify and respond to call lights in timely manner". The result of the investigation was verbally communicated to Resident #8 and the grievance was considered resolved 02/10/25. The grievance did not contain any additional information regarding Resident #8's concern and was not signed by Resident #8.

In an interview with the Social Worker (SW) on 03/05/25 at 9:31 AM he confirmed he was the Grievance Officer. When he was asked what "various care concerns" meant on the grievance filed by Resident #8 on 01/08/24 he stated her concerns were usually the same and were concerns regarding not receiving water, call light response time, or the length of time it took to receive incontinence care. The SW stated when Resident #8 filed a grievance he verbally discussed the resolution with her, and she seemed to be satisfied. He confirmed he did not provide written resolutions to grievances.

An interview with Resident #8 on 03/05/25 at 4:22 PM revealed she had never been provided with a resolution to any grievance she filed. She stated

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F 585	Continued From page 16 she would like to receive a resolution to her grievances in writing so she would know what had been done to address the grievances, but she didn't know that was an option. An interview with the Administrator on 03/07/25 at 5:16 PM revealed grievance forms could probably contain a little more information about what the grievance was regarding and what had been done to resolve the grievance.	F 585		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a thorough investigation of an allegation of staff-to-resident abuse for 1 of 9 residents reviewed for abuse (Resident #8).	F 610	The facility failed to complete a thorough investigation of an allegation of staff-to-resident abuse for 1 of 9 residents reviewed for abuse (Resident #8). The cited incident has been completed and	4/1/25

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F 610	Continued From page 17 Findings included: The facility's "Abuse, Neglect, and Exploitation" policy revised 03/02/23 read in part as follows: "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: 1. Identifying staff responsible for the investigation 2. Investigating different types of alleged violations 3. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations 4. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause 5. Providing complete and thorough documentation of the investigation". Review of the medical record revealed Resident #8 was admitted to the facility 11/24/23. Review of the quarterly Minimum Data Set (MDS) assessment dated 03/01/24 revealed Resident #8 was cognitively intact and had a diagnosis of non-Alzheimer's dementia.	F 610	closed at time of citation. Current facility residents are at risk of being affected by the deficient practice. An audit was completed of facility reported incidents from the past 30 days to ensure a thorough investigation was completed. No further concerns were noted. The measures that have been put into place to ensure that the deficient practice does not recur, are as follows: The Vice President of Clinical Operations (VPCO) educated the administrator and director of nursing (DON) on completing a thorough investigation including statements from staff and residents. The company abuse investigation packet was reviewed with the Administrator and DON to ensure there is understanding on completion of the full packet for all abuse, neglect, and misappropriation allegations. This occurred on 3-25-25. The VPCO will audit facility reported investigations (FRI) prior to conclusion of investigation to ensure a complete and thorough investigation has been completed. The VPCO will review all Facility Reportable Incidents (FRI)s for 12 weeks. The results of this audit will be presented to the monthly Quality Assurance and Process Improvement (QAPI) team by the administrator starting with the April 2025 QAPI meeting and continuing for at least 3 months. Necessary changes may be made by the QAPI team to achieve compliance.	

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F 610	Continued From page 18 A summary of the initial investigation report completed by the Director of Nursing (DON) indicated the incident date was 05/14/24 and the facility became aware of the incident on 05/15/24 10:15 AM. The fax date and time revealed the report was submitted at 12:18 PM on 05/15/24. A summary of the investigation was as follows: Resident #8 reported on the night of 05/14/24 as she was being put to bed, Nurse Aide (NA) #1 pushed her head onto the bed. A facility investigation was initiated, NA #1 was suspended pending the investigation, and the Physician, Responsible Party (RP), Adult Protective Services (APS), and Transylvania Police were notified of the incident. Resident abuse questionnaires were initiated with alert and oriented residents and body audits for residents with impaired cognition were initiated. Staff abuse education was being completed. The investigation was ongoing. A summary of NA #1's written statement dated 05/15/24 is as follows: First shift reported they assisted Resident #8 to bed the evening of 05/14/24 but she had since gotten up in her wheelchair. The statement indicated Medication Aide (MA) #1 informed her Resident #8 was asking about her mother, so NA #1 went to the resident's room to check on her. The statement further stated as NA #1 walked into Resident #8's room she was trying to get in bed, but she was going down to the floor, so she grabbed the back of Resident #8's pants and pulled her up and onto the bed. An undated document titled "Root Cause" is as follows: The Interdisciplinary Team (IDT) determined the incident occurred because the	F 610	Completion date: 4-1-25	

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resident did not wait for assistance to transfer. The resident did get moved quickly onto the bed, but her face was not "pushed" into/onto the bed. The resident was re-assured and reminded to use her call bell for assistance.

An unnamed typed document dated 05/20/25 revealed the Director of Nursing (DON) had NA #1 do a re-enactment of how she transferred Resident #8 to bed the night of 05/14/25 and determined NA #1 prevented Resident #8 from falling.

A summary of the facility 5-day report completed by the Administrator and faxed on 05/20/24 at 5:01 PM is as follows: Resident #8 reported as she was being assisted to bed on the night of 05/14/24, NA#1 pushed her head down onto the bed. Resident abuse questionnaires and body audits revealed no concerns of abuse. A written statement was obtained from NA #1 on 05/15/24 and did not address whether Resident #8's head was pushed into the bed or not. The facility determined Resident #8 was trying to self-transfer from the wheelchair to the bed and was falling. The investigation further determined NA #1 grabbed Resident #8 and pulled her up and onto the bed. The allegation of abuse was not substantiated.

The investigation did not include a statement from Resident #8.

An interview with the Director of Nursing (DON) on 03/06/25 at 2:52 PM revealed he could not recall how he became aware of the allegation of abuse from Resident #8 and was unable to provide an answer for why the investigation did not contain a statement from Resident #8. He

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F 610	Continued From page 20 confirmed there were no other interviews included in the investigation. An interview with the Administrator on 03/07/25 at 5:15 PM revealed she could not recall how she became aware of the allegation of abuse from Resident #8 and was unable to provide an answer for why the investigation did not contain a statement from Resident #8. She stated she did not have concerns with the way the abuse investigation was conducted. The Administrator confirmed she was not aware of any other interviews obtained during the course of the investigation.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of restraints (Resident #71), dental (Resident #20), and falls (Resident #4) for 3 of 26 resident assessments reviewed for accuracy. Findings included: 1. Resident #71 was admitted to the facility 06/12/24. Review of Resident #71's quarterly Minimum Data Assessment (MDS) dated 01/15/25 indicated Resident #71 had bed rails that were used daily as a restraint.	F 641	The facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of restraints (Resident #71), dental (Resident #20), and falls (Resident #4) for 3 of26 resident assessments reviewed for accuracy. Corrective action for the quarterly Minimum Data Assessment (MDS) dated 1-16-25 for resident #1, significant change MDS dated 1-13-25 for resident #20, and the discharge MDS dated 1-17-25 for resident #4 were all corrected by the MDS nurse on 3-7-25, 3-21-25, and 3-6-25, respectively. Current facility residents are at risk of	4/1/25

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F 641	Continued From page 21 Observations of Resident #71's bed on 03/05/25 at 8:49 AM and 03/07/25 at 9:17 AM revealed no bed rails were observed on his bed. An interview with the MDS Coordinator on 03/07/25 at 3:52 PM revealed Resident #71's quarterly MDS assessment was coded by an employee that did not work in the building. He stated it was difficult to accurately code MDS assessments if you were not present in the building. The MDS Coordinator stated that the MDS should not have reflected that bed rails were used as a restraint, and it was a coding error. An interview with the Director of Nursing (DON) on 03/07/25 at 4:11 PM revealed he expected MDS assessments to be coded correctly and no residents in the facility used a restraint. An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected MDS assessments to be coded correctly and be an accurate reflection of the resident. 2. Resident #20 was admitted to the facility 04/06/23. Review of a dentist's note dated 01/08/25 revealed Resident #20 had multiple teeth that were broken to the gum line and had "hopeless dentition (teeth that are severely compromised due to gum disease or other problems)". Review of the significant change Minimum Data Set (MDS) assessment dated 01/13/25 indicated she did not have any dental problems.	F 641	being affected by the deficient practice. To ensure that there are no other residents affected by this same alleged deficient practice, the Regional Director of Reimbursement (RDR) will complete an audit reviewing MDS assessments on falls, restraints, and dental status completed over the past 30 days. The audit will be completed by March 31, 2025. Errors identified in this audit will be corrected by the facility MDS nurses or RDR upon discovery and resubmitted. The measures that have been put into place to ensure that the deficient practice does not recur, are as follows: 1) education regarding the citation and the regulatory requirements of F 641 was provided by the RDR to the MDS nurses and the Interdisciplinary team on 3-27-25 2) the RDR will conduct an audit reviewing the accuracy of random MDS assessments reviewing the accuracy of siderail coding, dental status, and falls. These audits will be conducted in this cadence: 5 resident assessments will be reviewed three times a week for a period of 4 weeks, then 5 resident assessments will be reviewed 2 times a week for a period of 4 weeks, and then 5 resident assessments will be reviewed weekly for a period of 4 weeks. Errors identified through this auditing process will be communicated to the Facility MDS nurses and then corrected immediately by the facility MDS nurses. The results of this audit will be presented to the Quality Assurance and Process	

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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 641	Continued From page 22 Review of Resident #20's dental care plan last updated 03/05/25 revealed she had poor dentition/broken and carious teeth (teeth with cavities). Interventions included providing her diet as ordered and monitoring and reporting any signs or symptoms of oral problems. An observation of Resident #20's teeth on 03/05/25 at 8:29 AM revealed multiple broken teeth. An interview with the MDS Coordinator on 03/07/25 at 3:47 PM revealed Resident #20's teeth were not in good shape, and they had been that way for a while. He stated the significant change MDS assessment should have reflected Resident #20 had obvious or likely cavities. The MDS Coordinator stated another staff member coded the section for Oral/Dental Status, but he was responsible for ensuring it was correct, and it was an oversight. An interview with the Director of Nursing (DON) on 03/07/25 at 4:11 PM revealed he expected MDS assessments to be coded correctly. An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected MDS assessments to be coded correctly and be an accurate reflection of the resident. 3. Resident #4 was admitted to the facility on 7/23/24 with diagnoses including poly-osteoarthritis (arthritis that involves at least five joints). A review of the nurse's progress note dated 1/17/25 at 3:54 PM revealed when assisted to the bathroom Resident #4 was unable to complete	F 641	Improvement (QAPI) team at the monthly meetings starting in April of 2025 and will be presented by the MDS nurse. This will continue for a period of 3 months or possibly longer if compliance has not been achieved. The QAPI team may adjust the plan if that is necessary to achieve compliance. Completion date: 4-1-25	

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F 641	Continued From page 23 the transfer and was lowered to the floor using a gait belt and two person assistance. A review of the discharge MDS assessment dated 1/17/25 indicated Resident #4 had not had any falls since the prior assessment. During an interview on 3/6/25 at 2:16 PM the MDS Coordinator confirmed he completed the discharge MDS assessment on 1/17/25 for Resident #4 and did not code the fall. He revealed the discharge MDS assessment dated 1/17/25 should reflect Resident #4 had a fall with no injury. During an interview on 03/07/25 at 4:12 PM the Director of Nursing (DON) revealed the discharge MDS assessment dated 1/17/25 should reflect Resident #4 had fall. An interview was conducted on 03/07/25 at 5:17 PM with the Administrator. The Administrator revealed she expected MDS coding to be accurate and reflect Resident #4 had a fall.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to provide assistance with nail care and shaving for 1 of 5 dependent residents reviewed for activities of daily living (Resident #99).	F 677	The facility failed to provide assistance with nail care and shaving for 1 of 5dependent residents reviewed for activities of daily living (ADL) (Resident #99). Corrective action for resident # 99	4/1/25

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F 677	Continued From page 24 Findings included: 1. Resident #99 was admitted to the facility on 2/7/25 with diagnoses including a right femur (upper leg bone) fracture, presence of artificial hip joint, and epilepsy (a brain condition causing recurring seizures with varying symptoms). The admission Minimum Data Set (MDS) assessment dated 2/10/25 indicated Resident #99's cognition was moderately impaired with no rejection of care behaviors during the lookback period. Resident #99 had impaired range of motion affecting one side of the lower extremity and required setup/clean up assistance for personal hygiene and substantial to maximal assistance for shower/bathing. The care plan revised on 2/12/25 revealed Resident #99 had a deficit in the ability to perform activities of daily living related to a fracture of the right femur, epilepsy, and pain. Interventions included provide extensive assistance using one person assist for shower/bathing and personal hygiene. A review of the shower assignment revealed Resident #99 was scheduled to receive a shower every Tuesday and Friday. The Shower sheets documented Resident #99 had received two showers since admission on 2/17, and 2/24 and a bed bath on 2/7, 2/11, 2/20, and 3/4. There was no shower sheet completed for 2/14 and 2/28 to indicate bathing was provided. During an observation and interview on 03/03/25 at 2:32 PM Resident #99 fingernails were approximately one-half inch past the tip of the	F 677	was achieved by trimming her fingernails and removing her unwanted chin hair on 3-7-25 by her assigned Certified Nursing Assistant (CNA). Current residents who are dependent for ADL care are at risk for A facility-wide audit was completed on 3-25-25 through 3-28-25 observing all residents for unwanted facial hair and fingernails in need of trimming. This was completed by the Unit Managers (UM). Any identified issues were corrected immediately by the CNA or UM by 3-28-25. The measures that have been put into place to ensure that the deficient practice does not recur, are as follows : 1) an in-service was conducted for all facility and agency nursing staff by the Director of Nursing (DON) and Unit Managers (UM) on the significance of this citation and the expectation that residents be offered assistance with removal of unwanted facial hair and fingernail trimming. This will be completed by 3-31-25. 2) Staff members who do not receive this education by 3-31-25 will receive it from the DON or UM on their first day back at work, 3) Agency staff will also receive this same education by the DON or UM by 3-31-25 or on their first day back at work. 4) newly hired nursing staff will receive this education during new hire orientation by the UM, 5) During daily rounds, the UM and charge nurses will observe residents and identify any in need to having their nails trimmed or unwanted facial hair removed. Issues will be verbally	

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F 677	Continued From page 25 finger, and she had multiple patchy areas of overgrown gray chin hairs. When asked Resident #99 revealed her fingernails were long and she wanted them cut and she was not aware of the chin hair but if she had a pair of tweezers would pull them out. Resident #99 revealed she had not requested her fingernails be trimmed or to shave her chin hair and was not offered assistance by staff. During an interview on 03/07/25 at 8:58 AM Nurse Aide (NA) #2 revealed fingernails were trimmed and chin hairs shaved during bath days. An interview and observation was conducted on 03/07/25 at 9:21 AM with Resident #99 in the presence of the Unit Manager (UM). The UM observed Resident #99's long fingernails and multiple patchy areas of overgrown gray chin hairs and revealed if chin hairs needed to be shaved, and fingernails trimmed it was done during a bed bath or shower and as needed. Resident #99 shared with the UM a staff member recently gave her a pair of nail clippers, but she was unable to cut her own fingernails because they were too hard. Resident #99 shared she did not like long chin hairs and normally plucked them. The UM reassured Resident #99 her fingernails would be trimmed and chin hair shaved. An interview was conducted with the Administrator on 03/07/25 at 6:10 PM. The Administrator stated she would expect Resident #99 to be offered assistance to shave long chin hairs and clip long fingernails and was typically done by the NA during a bed bath or shower.	F 677	communicated to the direct care givers. 6) Residents will receive Activities of Daily Living (ADL) care including removal of unwanted facial hair and trimming of the fingernails routinely when showers or bed baths are given by the CNAs and more frequent if requested or needed. 7) An audit will be conducted by the DON and/or UM such that residents will be observed for the need of service including fingernail care and removal of unwanted facial hair. This audit will be conducted in the following cadence: 3 times per week for 4 weeks, 5 residents at random will be observed for the need of fingernail care and unwanted facial hair removal, then 2 times per week, for 4 weeks, 5 residents at random will be observed for the need of fingernail care and unwanted facial hair removal, then weekly for 4 weeks, 5 residents will be observed for the need of fingernail care and the removal of unwanted facial hair. The results of this audit will be presented by the DON to the Quality Assurance and Process Improvement (QAPI) committee at the monthly meetings. This will continue for a period of 3 months or longer if needed. This will begin at the April 2025 meeting. The QAPI committee may adjust this plan to achieve compliance if this plan has not been successful. Compliance Date: 4-1-25	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		4/1/25

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F 803	Continued From page 26 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on an observation of the lunch meal tray preparation, record review, and interviews with the Dietary Manager and staff, the facility failed to provide the correct portion size of beef hamburger steak for residents receiving a mechanically altered diet. This failure had the potential to affect 18 of 97 residents who received a lunch meal tray with a mechanically altered diet.	F 803	The facility failed to provide the correct portion size of beef hamburger steak for residents receiving a mechanically altered diet. This failure had the potential to affect 18 of 97 residents who received a lunch meal tray with a mechanically altered diet. The meal was served to the residents prior to notification of deficient practice.	

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F 803	Continued From page 27 Findings included: The facility's diet consistency census report dated 03/03/25 revealed 18 of 97 residents received a mechanically altered diet. The facility's planned menu for Wednesday (03/05/25) listed beef hamburger steak as the protein being served for lunch. The portion size listed on the menu indicated each plate received one beef hamburger steak. The beef hamburger steak packaging revealed each steak was a 4-ounce portion. A continuous observation of lunch trays being prepared for residents was conducted on 03/05/25 at 11:54 AM through 1:38 PM. The Dietary Manager served one (4 ounce) beef hamburger steak for residents that received a regular diet. The Dietary Manager and Cook used a ladle with a red colored handle (2 ounce) to portion each plate of beef hamburger steak for residents that received a mechanically altered diet. During an interview on 03/05/25 at 12:50 PM the Cook confirmed the red handle ladle was used to portion the beef hamburger steak for residents receiving a mechanically altered diet and confirmed the ladle was for plating a 2-ounce portion. The Cook revealed for portion sizes he used a guide to select the correct one based on the color of the handle and pointed to a guide posted on wall behind the steam table. The guide was a picture of kitchen scoop sizes in ounces and milliliters but did not include ladles or other utensils.	F 803	Current facility residents on a mechanically altered diet are at risk of being affected by the deficient practice. The Aramark Branch Manager for Culinary Services reviewed mechanically altered diet trays for 3 meals to ensure that residents were getting the correct portions according to the recipes during the week of March 24-31, 2025. To ensure the deficient practice does not recur, the following has been put into place: 1) the Regional Director of Operations (RDO) for Aramark Culinary educated the Dietary Manager and cooks on ensuring the residents are served the approved portions and educated on the use of the color coded system used to measure out portions to ensure portions are correct according the approved menu items. Educated on if a substitution is made, it must be approved by the registered dietician including approval of the portion size prior to serving. Education completed by 3/31/2025. 2) Newly hired Dietary Managers and cooks or staff not educated by 3/31/2025 will be educated upon hire or before working their next scheduled shift. The education also included the use of the proper sized ladle and the color-coding system. The Dietary Manager will observe 1 meal tray line to ensure menu and nutritional accuracy weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The Dietary Manager will present the results of the monthly for three (3) months. At that time the QAPI committee	

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F 803	Continued From page 28 During an interview on 03/05/25 at 1:30 PM the Dietary Manager confirmed the correct portion size for the beef hamburger steak being served to residents was 4 ounces. The Dietary Manager stated residents receiving a mechanically altered diet received half a portion because the incorrect ladle was used to portion the beef hamburger steak onto the plate. The Dietary Manager confirmed the incorrect ladle had a red handle and was a 2-ounce portion used by him and the Cook by mistake and was an oversight. During an interview on 03/07/25 at 6:14 PM the Administrator revealed she expected the residents who received a mechanically altered diet to be served the correct portion size. The Administrator revealed she expected the correct utensil to be used by dietary staff when plating food to ensure portion sizes were accurate.	F 803	will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 4/1/2025	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative	F 809		4/1/25

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F 809	Continued From page 29 meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, family and staff interviews, the facility failed to serve the lunch meal at the posted times on 03/05/25 and 03/06/25 in the main dining room during 2 of 3 meal observations. The findings included: Review of the facility's meal times schedule revealed lunch was to be served in the main dining room at 12:30 PM. a. Resident #54 was admitted to the facility on 09/22/21. The quarterly Minimum Data Set (MDS) assessment dated 02/14/25 indicated Resident #54 had severe cognitive impairment, required partial/moderate assistance with eating and received a mechanically altered diet. Resident #101 was admitted to the facility on 02/04/25. The admission MDS assessment dated 02/15/25 indicated Resident #101 had severe cognitive impairment, required setup or cleanup assistance with eating and received a mechanically altered diet. An observation of the lunch meal service in the main dining room on 03/05/25 at 1:10 PM revealed residents were seated at various tables	F 809	The facility failed to serve the lunch meal at the posted times on 03/05/25 and 03/06/25 in the main dining room during 2 of 3 meal observations. Meals had already been served at time of notification of citation. Current facility residents who eat meals in a communal setting are at risk of being affected by the deficient practice. The Administrator monitored 3 meals in the main dining room and the memory care unit dining room to identify other residents being affected and to ensure meals were served timely during 3-24-25 and 3-27-25. No other concerns noted. The measures that have been put into place to ensure the deficient practice does not recur, are as follows: 1) Meal times reviewed by Aramark Corporate Support team and Facility Dietary Manager to determine reasonable delivery times of meals 2) Current facility and agency nursing staff, dietary staff, and interdisciplinary team were educated by the Administrator or Director of Nursing (DON) on scheduled mealtimes and ensuring residents obtain their meal trays in a timely manner by 3/31/2025. 3) Newly hired facility and agency nursing staff, dietary staff, and interdisciplinary team members and staff not educated by	

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F 809	Continued From page 30 eating their lunch. Resident #54 was seated at a table in the back of the dining room by herself and had not received her meal tray. Resident #101 was seated at a table in the middle of the dining room and had not received her meal tray. There were three other residents sitting at the table with Resident #101 who all had received their meal tray and were eating their lunch. At 1:20 PM, both Resident #54 and Resident #101 received their lunch meal tray. During the lunch meal observation, an interview was conducted with the Responsible Party (RP) for another resident on 03/05/25 at 1:11 PM. The RP stated they came to the facility every day to sit with their family member during lunch. The RP expressed it was a regular occurrence that meals were often served late, which was why they made sure they were at the facility daily for at least one meal. During the lunch meal observation, an interview was conducted with the Speech Therapist on 03/05/25 at 1:13 PM. The Speech Therapist stated she was working with Resident #101 for therapy and was not sure why Resident #101 had not received her lunch meal tray. The Speech Therapist stated the Administrator was aware that both Resident #54 and Resident #101 had not received their meal trays. During an interview on 03/05/25 at 1:20 PM, the Administrator confirmed that meal trays were delivered late to the main dining but could not provide an explanation for the delay. The Administrator stated both Resident #54 and Resident #101 did not normally eat in the main dining room and their meal trays were delivered to the hall. She acknowledged that it was too late	F 809	3/31/2025 will be educated upon hire or prior to working their next scheduled shift by their department supervisor. 5) The Administrator and/or DON will audit the delivery times of 5 meal carts weekly for 4 weeks, then 3 meal carts for 4 weeks, and then 1 meal cart for 4 weeks to ensure meals are being served at designated times and receiving their trays in a timely manner. 6) Issues related to meal delivery times will be communicated to the Dietary Manager by the Administrator and/or DON. * The results of the audits will be presented to the Quality Assurance and Process Improvement (QAPI) meeting monthly starting in April of 2025. The QAPI team may make adjustments to the plan if compliance is not achieved. Completion Date: 4/1/2025	

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F 809	Continued From page 31	F 809		

for both residents to just now receive their meals.

A Resident Council group interview was conducted on 03/05/25 at 3:32 PM with Resident #4, Resident #11, Resident #35, Resident #42, Resident #51, Resident #62, and Resident #74 in attendance. The residents all voiced meals were served late on a daily basis regardless if they ate in their rooms or the main dining room.

b. A continuous observation of the lunch meal service in the main dining room was conducted on 03/06/25 from 12:00 PM to 1:30 PM. At 12:00 PM, there were several residents already seated at various tables while staff continued to bring other residents into the dining room for lunch. Staff were observed assisting residents with donning clothing protectors and providing drinks to residents at the tables while they waited on lunch to be served. At 12:30 PM, meal carts had not arrived to the main dining room. At 12:40 PM, the meal cart arrived in the main dining room and there were five staff present who immediately started passing out meal trays to residents seated at the tables in the front of the main dining room. At 12:55 PM, the residents who were able to eat independently had all received their meal tray and were eating their lunch while the residents in the back of the main dining room, who needed staff assistance, had not been served their meal. At 1:00 PM, another meal cart arrived in the main dining room and staff started sitting down at the tables assisting dependent residents with their meal. At 1:25 PM the last two residents were provided their meal tray and staff proceeded to assist the residents with eating lunch.

During the lunch meal observation on 03/06/25 at 1:21 PM, the Responsible Party (RP) for another

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F 809	Continued From page 32	F 809		

resident, who was seated at the table with her family member, expressed "now you understand why I make sure I am present for at least one meal."

During an interview on 03/07/25 at 2:50 PM, the Dietary Manager (DM) revealed he was aware of the issue with meals being served late and there were several contributing factors. He explained one contributing factor was dietary had a limited amount of dinnerware to serve resident meals such as plates, plate covers and base, and silverware. He had ordered more dinnerware but the vendor had trouble getting certain items. The DM stated he requested facility staff collect and return meal trays by a certain time after each meal so that dietary staff could get the dinnerware clean and ready for the next meal service but that did not always happen. As a result, he stated there had been times they had to stop meal service just to wash dishes in order to finish serving meals. The DM stated he was provided a list of residents who ate in the main dining room and if a resident was not on that list, their meal tray was sent in the meal cart to the hall. He stated when a resident's meal tray was not delivered on the meal cart for the main dining room staff called the kitchen requesting they bring a meal tray to the dining room which took one of the three dietary staff off the meal line slowing production. He explained if a resident who normally ate in their room decided they wanted to eat in the main dining room, he relied on staff to let him know prior to the start of meal service so the resident's meal tray would be delivered to the correct location.

During an interview on 03/07/25 at 4:34 PM, the Administrator revealed she was aware of the

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SAPPHIRE RIDGE HEALTH AND REHABILITATION	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 809	Continued From page 33 issue with meals being served late and confirmed residents had also brought their concerns regarding late meals to her attention. The Administrator stated when meal trays were not on the meal cart, facility staff would go down to the kitchen to get a resident's meal tray to help out but dietary staff were usually in the middle of tray line production and if they stopped to look for a certain meal ticket it would disrupt the process causing further delay. The Administrator acknowledged she knew there was a shortage of dinnerware for residents' meals and explained when meals were served late, she was not going to have staff rush residents to finish the meal so that dietary staff could get the dinnerware washed at a certain time. She stated when the lunch meal was served late, she expected dietary staff to push back the time dinner was served so that residents were not going throughout the night hungry. The Administrator stated she was not sure what the root cause was regarding late meals but felt it could be more of a process issue rather than a staffing issue.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		4/1/25

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F 812	Continued From page 34 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to remove food items stored and available for use that had signs of spoilage or were past the expiration date from the walk-in refrigerator and dry goods storage area located in the kitchen. The facility also failed to date an opened container of nectar thick milk stored in the nutrition refrigerator used for residents on the memory care unit for 1 of 2 nutrition refrigerators. This deficient practice had the potential to affect food and beverages served to residents. Findings included: The initial tour of the kitchen with the Dietary Manager on 3/3/25 at 7:55 AM revealed the following: 1a. A container of enchilada sauce with an expiration date 01/2024 stored in the walk-in refrigerator and available for use. b. A container of sliced lemons with a white, slimy discoloration with a use by date 2/28/25 stored in the walk-in refrigerator and available for use. c. A container of sliced bananas mixed with pineapple tidbits with the slices of banana that had turned brown to black in color. The use by	F 812	The facility failed to remove food items stored and available for use that had signs of spoilage or were past the expiration date from the walk-in refrigerator and dry goods storage area located in the kitchen. The facility also failed to date an opened container of nectar thick milk stored in the nutrition refrigerator used by residents on the memory care unit for 1 of 2 nutrition refrigerators. The expired and undated items were disposed of by the dietary staff and the unit manager of the west unit when notified of the issues with the items. Current facility residents are at risk of being affected by the deficient practice. The Dietary Manager and Aramark Corporate Support Staff completed an audit of all nourishment rooms, dry storage, emergency supplies, coolers, and freezers to ensure all open items are dated and no items are past their listed expiration date. The audit was completed by 3/31/2025. Issues noted were fixed To ensure the deficient practice does not recur, 1) the Vice President of Operations educated the Regional Director of Operations (RDO) for Culinary, Dietary	

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F 812	Continued From page 35 date written on the container was 3/13/25 and stored in the walk-in refrigerator available for use. d. A 32-ounce container of vanilla flavored nutritional drink supplement with a use by date 12/30/24 stored in the dry goods storage area of the kitchen and available for use. e. Forty-eight 4 ounce containers of thickened lemon flavor water of honey thick consistency with a use by date 2/4/25 stored in the dry goods storage area of the kitchen and available for use. f. Nine 32 fluid ounce containers of vanilla protein drink supplement with an expiration date 3/1/24 stored in the dry goods storage area of the kitchen and available for use. During an interview on 3/3/25 at the Dietary Manager revealed for open food containers dietary staff were expected to the label with an open and use by date and the item was kept available for use in the walk-in refrigerator for seven days then discarded. The Dietary Manager stated he checked food items stored in the walk-in refrigerator daily to ensure foods were labeled and discarded if there were signs of spoilage or it was out of date. He revealed today (3/3/25) he was busy and had not had time to check the walk-in refrigerator for out of date or spoiled food. The Dietary Manager revealed he checked the dates on food items in dry goods storage area when putting away newly delivered items. He revealed the expired items in the dry goods storage area were stored on the shelf designated for emergency food and he had not checked the expiration dates on those. An interview was conducted with the	F 812	Manager, cooks and aides on ensuring the kitchen and food storage areas remain clean and sanitary environment, ensuring food products are dated when opened and show their use by date, ensuring food items are thrown out when they are expired, and following the assigned cleaning schedule for the kitchen and food storage areas. Education completed by 3/31/2025. Newly hired RDO's, Dietary Managers cooks and aides not educated by 3/31/2025 will be educated upon hire or before working their next scheduled shift.2) The Dietary Manager will observe the kitchen and nourishment rooms weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The results of the audit will be presented monthly to the Quality Assurance and Process Improvement (QAPI) committee starting in April 2025 and will continue for 3 months or longer if deemed necessary to achieve compliance. Completion Date: 4/1/2025	

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F 812	Continued From page 36	F 812		

Administrator on 03/07/25 at 6:14 PM. The Administrator revealed she expected food items were appropriately discarded. The Administrator revealed she expected food items were discarded based on expiration or use by dates and not left available for use.

2. An observation of the nutrition refrigerator designated for residents located on the memory care unit was conducted on 3/5/25 at 12:41 PM in the presence of Nurse #1. Stored and available for use was an open 32-ounce container of nectar-thick milk with an expiration date of 8/10/25. The label on the container read discard 4 days after opening. There was no date on the container to identify when it was opened.

During an interview on 3/5/25 at 12:41 PM Nurse #1 revealed nutritional supplements were provided to residents by the nursing staff and she did not know when the container of nectar-thick milk was first opened or how long it was in use. Nurse #1 revealed she was unsure how long a container of nectar-thick milk could be kept in use after opened but thought it was good for seven days. Nurse #1 revealed it was the responsibility of the person who opened the container to write the date it was opened and confirmed the label read to discard 4 days after opened. Nurse #1 discarded the container of milk.

An interview was conducted with the Administrator on 03/07/25 at 6:14 PM. The Administrator revealed she expected food items were appropriately discarded. The Administrator revealed she expected food items served to residents were discarded based on expiration or use by dates and not left available for use.

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F 883	Continued From page 37	F 883		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		4/1/25

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F 883	Continued From page 38 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include documentation in the medical record of refusal or acceptance of influenza and pneumonia vaccinations for 5 of 5 residents (Resident #20, Resident #44, Resident #37, Resident #80, and Resident #62) reviewed for immunizations and failed to assess the eligibility to receive the influenza and pneumonia vaccines for 2 of 5 (Resident #44 and Resident #37). Findings included: 1. (a). Resident #20 was admitted to the facility 04/06/23. Review of an unsigned "Vaccine Declination Form" dated 08/01/24 for influenza and pneumonia vaccines revealed multiple attempts to contact Resident #20's Power of Attorney	F 883	The facility failed to include documentation in the medical record of refusal or acceptance of influenza and pneumonia vaccinations for 5 of 5 residents (Resident #20, Resident #44, Resident#37, Resident #80, and Resident #62) reviewed for immunizations and failed to assess the eligibility to receive the influenza and pneumonia vaccines for 2 of 5 (Resident #44 and Resident#37). The consent and declinations for Residents #20, 44, 37, 80, and 62 were uploaded into residents medical records by the medical records clerk (MRC) by 3/31/2025. The assessment form was completed on resident #44 and #37 by the Director of Nursing (DON) by 3/31/2025. Current facility residents are at risk of being affected by the deficient practice.	

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F 883	Continued From page 39 (POA) were unsuccessful. The significant change Minimum Data Set (MDS) assessment dated 01/13/25 reflected Resident #20 was severely cognitively impaired. The MDS reflected Resident #20 had not received the influenza or pneumonia vaccine. Review of Resident #20's electronic medical record revealed the "Vaccine Declination Form" dated 08/01/24 was not included in her medical record. (b). Resident #44 was admitted to the facility 05/05/23. Review of a "Vaccine Consent Form" dated 07/18/24 revealed Resident #44's Guardian had provided a verbal consent for Resident #44 to receive the pneumonia vaccine, and he received the pneumonia vaccine on 07/18/24. Review of a "Vaccine Consent Form" dated 10/04/24 revealed Resident #44's Gurdian had provided email consent dated 07/09/24 to receive the influenza vaccine, and he received the influenza vaccine on 10/04/24. The quarterly Minimum Data Set (MDS) assessment dated 01/24/25 revealed Resident #44 was severely cognitively impaired. The MDS reflected Resident #44 received the influenza vaccine 10/04/24 and was up to date with the pneumonia vaccine. Review of Resident #44's electronic medical record revealed the "Vaccine Consent Form" dated 07/18/24 and 10/04/24 were not included in his medical record.	F 883	An audit was completed by the MRC and there were other electronic health records (EHR) identified that also needed the Vaccine Declination Form or Vaccine Consent Form were uploaded into the EMR. The MRC will have all been uploaded by 3/31/25. To ensure this deficient practice does not recur, the following education has been completed. The Vice President of Clinical Operations completed education with the DON, Unit Manager (UM), and MRC on maintaining accurate medical records and ensuring all records are complete and accurate. The education was completed on 3/31/2025. Newly hired DONs, unit managers, and MRCs and staff not educated by 3/31/2025 will be educated upon hire and prior to working their next scheduled shift. A weekly audit will be completed by the DON or Unit Manager ensuring that the Vaccine Declination Forms or Vaccine Consent Forms are uploaded and a part of the EMR. This audit will be completed for 5 resident EMRs 3 times per week for 4 weeks, then 5 resident EMRs 2 times a week for 4 weeks, and then 5 resident EMRs weekly for 4 weeks. The results of this audit will be presented to the Quality Assurance and Process Improvement (QAPI) team at the monthly meeting starting in April of 2025 by DON and will continue for 3 months or longer if necessary. The QAPI team may adjust in the plan to achieve compliance if necessary.	

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F 883	Continued From page 40 (c). Resident #37 was admitted to the facility 10/11/23. Review of the "Vaccine Declination Form" dated 07/09/24 revealed Resident #37 declined the influenza and pneumonia vaccines. Review of a "Vaccine Consent Form" dated 10/04/24 revealed Resident #37 consented to receive the influenza vaccine, and the vaccine was administered 10/04/24. The quarterly Minimum Data Set (MDS) dated 01/24/25 revealed he was cognitively intact. The MDS reflected he received the influenza vaccine 10/04/24, was not up to date on the pneumonia vaccine, and had been offered and declined the pneumonia vaccine. Review of Resident #37's electronic medical record revealed the "Vaccine Declination Form" dated 07/09/24 and "Vaccine Consent Form" dated 10/04/24 were not included in his medical record. (d). Resident #80 was admitted to the facility 05/12/24. Review of a "Vaccine Declination Form" dated 07/10/24 revealed Resident #80's family member verbally declined the influenza vaccine. The quarterly Minimum Data Set (MDS) assessment dated 02/07/25 revealed Resident #80 was severely cognitively impaired. The MDS reflected resident #80 received the influenza vaccine on 09/08/24 and was not up to date on the pneumonia vaccine.	F 883	Completion Date: 4/1/2025	

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F 883	Continued From page 41	F 883		

Review of Resident #80's electronic medical record revealed the "Vaccine Declination Form" dated 07/10/24 was not included in her medical record.

No consent or declination form for the pneumonia vaccine was present in Resident #80's medical record.

(e). Resident #62 was admitted to the facility 04/05/23.

The quarterly Minimum Data Set (MDS) assessment dated 12/18/24 revealed Resident #62 was cognitively intact. The MDS reflected Resident #62 was offered and declined the influenza and pneumonia vaccines.

Review of Resident #62's electronic medical record revealed no documentation of acceptance or declination of the influenza and pneumonia vaccines.

An interview with the Director of Nursing (DON) on 03/06/25 at 11:23 AM revealed he tried to keep all resident consents or declinations for vaccines in a binder in his office and he was not aware that they needed to be included in the resident's medical record.

An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected vaccination consents or declinations to be a part of the medical record.

2. (a). Resident #44 was admitted to the facility 05/05/23.

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F 883	Continued From page 42	F 883		

Review of a document titled "Vaccine Consent Form" dated 07/18/24 for Resident #44 read in part as follows: "Please answer the following questions so we can assess the safety and the appropriateness of vaccination". Each of the fourteen questions had a box for "yes" or "no" and all of the questions were blank.

The "Vaccine Consent Form" dated 07/18/24 revealed Resident #44 received the pneumonia vaccine on 07/18/24.

Review of a document titled "Vaccine Consent Form" dated 10/08/24 for Resident #44 read in part as follows: "Please answer the following questions so we can assess the safety and the appropriateness of vaccination". Each of the fourteen questions had a box for "yes" or "no" and all of the questions were blank.

The "Vaccine Consent Form" dated 10/04/24 revealed Resident #44 received the influenza vaccine on 10/04/24.

The quarterly Minimum Data Set (MDS) assessment dated 01/24/25 revealed Resident #44 was severely cognitively impaired. The MDS reflected Resident #44 received the influenza vaccine 10/04/24 and was up to date with the pneumonia vaccine.

(b). Resident #37 was admitted to the facility 10/11/23.

Review of a document titled "Vaccine Consent Form" dated 10/08/24 for Resident #37 read in part as follows: "Please answer the following questions so we can assess the safety and the appropriateness of vaccination". Each of the

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F 883	Continued From page 43 fourteen questions had a box for "yes" or "no" and all of the questions were blank. The "Vaccine Consent Form" dated 10/04/24 revealed Resident #37 received the influenza vaccine on 10/04/24. The quarterly Minimum Data Set (MDS) dated 01/24/25 revealed he was cognitively intact. The MDS reflected he received the influenza vaccine 10/04/24, was not up to date on the pneumonia vaccine, and had been offered and declined the pneumonia vaccine. An interview with the Director of Nursing (DON) on 03/06/25 at 11:23 AM revealed influenza and pneumonia vaccines were administered through an outside vaccination company that came to the facility at least every six months but his staff were responsible for obtaining consent. He stated the staff member obtaining consent for the influenza or pneumonia vaccine was responsible for determining if it was appropriate to offer the resident the vaccine or not and the questions for vaccine appropriateness should have been answered. An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected vaccine consents to contain all the required information and questions should not be left blank.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the	F 887		4/1/25

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F 887	Continued From page 44	F 887		

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

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F 887	Continued From page 45 (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include documentation in the medical record of refusal or acceptance of the COVID-19 vaccination for 5 of 5 residents (Resident #20, Resident #44, Resident #37, Resident #80, and Resident #62) reviewed for immunizations and failed to assess the eligibility to receive the COVID-19 vaccine for 1 of 5 (Resident #44) residents reviewed for immunizations. Findings included: 1. (a). Resident #20 was admitted to the facility on 04/06/23. Review of an unsigned "Vaccine Declination Form" dated 08/01/24 for COVID-19 revealed multiple attempts to contact Resident #20's Power of Attorney (POA) were unsuccessful. The significant change Minimum Data Set (MDS) assessment dated 01/13/25 reflected Resident #20 was severely cognitively impaired.	F 887	The facility failed to include documentation in the medical record of refusal or acceptance of the COVID-19 vaccination for 5 of 5 residents (Resident #20, Resident #44, Resident #37, Resident #80, and Resident #62) reviewed for immunizations and failed to assess the eligibility to receive the COVID-19 vaccine for 1 of 5 (Resident #44) residents reviewed for immunizations. Corrective action for residents #20, #44, #37, #80 and #62 was completed on 3-24-25 when the Medical Records Clerk (MRC) uploaded their Vaccine Declination Form or Vaccine Consent Form into each of their Electronic Medical Record (EMR). Current facility residents are at risk of being affected by the deficient practice. An audit was completed by the MRC and there were other EMRs identified that also needed the Vaccine Declination Form or Vaccine Consent Form uploaded into the EMR. The MRC will have all uploaded by	

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	345208	A. BUILDING _____ B. WING _____	C 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 887	Continued From page 46 Review of Resident #20's electronic medical record revealed the "Vaccine Declination Form" dated 08/01/24 was not included in her medical record. (b). Resident #44 was admitted to the facility on 05/05/23. Review of a "Vaccine Consent Form" dated 07/18/24 revealed Resident #44's Guardian had provided a verbal consent for Resident #44 to receive the COVID-19 vaccine, and he received the COVID-19 vaccine on 07/18/24. The quarterly Minimum Data Set (MDS) assessment dated 01/24/25 revealed Resident #44 was severely cognitively impaired. Review of Resident #44's electronic medical record revealed the "Vaccine Consent Form" dated 07/18/24 was not included in his medical record. (c). Resident #37 was admitted to the facility on 10/11/23. Review of the "Vaccine Declination Form" dated 07/09/24 revealed Resident #37 declined the COVID-19 vaccine. The quarterly Minimum Data Set (MDS) dated 01/24/25 revealed he was cognitively intact. Review of Resident #37's electronic medical record revealed the "Vaccine Declination Form" dated 07/09/24 was not included in his medical record. (d). Resident #80 was admitted to the facility on	F 887	3-31-25. The Director of Nursing and Unit Manager will review vaccine forms for upcoming vaccine clinic to ensure assessments are completed prior to resident receiving vaccine. To ensure the deficient practice does not recur, the following has been put into place: 1) Educating the Director of Nursing (DON), Unit Manager (UM), and MRC on the significance of this citation and the regulation. This education will be provided on 3-24-25 by the Vice President of Clinical Operations (VPCO). 2) Upon completion, a copy of the Vaccine Declination Form or Vaccine Consent form will be given to the MRC so that it can be uploaded into the EMR by the UM effective 4-1-25. 3) VPCO educated the DON and UM on the importance of ensuring that the assessments are completed PRIOR to the vaccine being administered on 3-24-25. 4) A weekly audit will be completed by the DON or Unit Manager ensuring that the Vaccine Declination Forms or Vaccine Consent Forms are uploaded and a part of the EMR. This audit will be completed for 5 resident EMRs 3 times per week for 4 weeks, then 5 resident EMRs 2 times a week for 4 weeks, and then 5 resident EMRs weekly for 4 weeks. The results of this audit will be presented to the Quality Assurance and Process Improvement (QAPI) team at the monthly meeting starting in April of 2025 by DON	

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F 887	Continued From page 47 05/12/24. Review of a "Vaccine Declination Form" dated 07/10/24 revealed Resident #80's family member verbally declined the COVID-19 vaccine. The quarterly Minimum Data Set (MDS) assessment dated 02/07/25 revealed Resident #80 was severely cognitively impaired. Review of Resident #80's electronic medical record revealed the "Vaccine Declination Form" dated 07/10/24 was not included in her medical record. (e). Resident #62 was admitted to the facility on 04/05/23. The quarterly Minimum Data Set (MDS) assessment dated 12/18/24 revealed Resident #62 was cognitively intact. Review of Resident #62's electronic medical record revealed no documentation of acceptance or declination of the COVID-19 vaccine. An interview with the Director of Nursing (DON) on 03/06/25 at 11:23 AM revealed he tried to keep all resident consents or declination forms for vaccines in a binder in his office and he was not aware that they needed to be included in the resident's medical record. An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected vaccination consents or declination forms to be a part of the medical record. 2. Resident #44 was admitted to the facility on	F 887	for a period pf 3 months or longer if necessary to achieve compliance. Compliance date: 4-1-25	

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F 887	Continued From page 48	F 887		

05/05/23.

Review of a document titled "Vaccine Consent Form" dated 07/18/24 for Resident #44 read in part as follows: "Please answer the following questions so we can assess the safety and the appropriateness of vaccination". Each of the fourteen questions had a box for "yes" or "no" and all of the questions were blank.

The quarterly Minimum Data Set (MDS) assessment dated 01/24/25 revealed Resident #44 was severely cognitively impaired.

The "Vaccine Consent Form" dated 07/18/24 revealed Resident #44 received a COVID-19 vaccine on 07/18/24.

An interview with the Director of Nursing (DON) on 03/06/25 at 11:23 AM revealed the COVID-19 vaccine was administered through an outside vaccination company that came to the facility at least every six months but his staff were responsible for obtaining consent. He stated the staff member obtaining consent for the COVID-19 vaccine was responsible for determining if it was appropriate to offer the resident the vaccine or not and the questions for vaccine appropriateness should have been answered.

An interview with the Administrator on 03/07/25 at 5:16 PM revealed she expected vaccine consents to contain all the required information and questions should not be left blank.