STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375094	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care Center Tulsa	2425 South Memorial Tulsa, OK 74129

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41318 Based on record review and interview, the facility failed to ensure staff notified residents' representatives when a change in condition occurred for two (#1 and #120) of three sampled residents reviewed for notifications. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents resided in the facility. Findings: A Notification of Condition Change policy, revised on 12/17/18, read in part, .A change in a resident's condition will be reported to the physician and responsible party in a timely manner . 1. Resident #1 had diagnoses which included chronic pain and generalized anxiety disorder. An Order Note, dated 01/20/23, documented Resident #1 received a new order from the physician to treat for anxiety. There was no documentation the resident's representative had been notified. An Alert Note, dated 01/31/23 at 10:04 p.m., documented Resident #1 was complaining of pain and the staff received a new order from the physician. There was no documentation the resident's representative had been notified. An Order Note, dated 02/01/23 at 4:11 p.m., documented Resident #1 was seen by physician's assistant and new orders were provided. There was no documentation the resident's representative had been notified. On 02/27/23 at 8:55 a.m., the DON was asked when staff were to notify residents' representatives. She stated, Anytime there is a change in anything. She was asked to reviewed the notes from 01/20/23, 01/31/23, and 02/01/23. She was asked if the resident's representative was notified. She stated she didn't see it was documented. The DON stated the resident's representative should have been notified. 46702 2. Resident #120 was diagnosed with Covid on 11/30/22 at 10:00 p.m. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 12/01/22, read in part, .Covid positive test 10:00 pm 11/30/2022 . There was no documentation the resident's representative had been notified. The Resident's electronic health records were reviewed for November and December 2022. There were no notifications of Resident #120's family representative being notified of the positive Covid diagnosis . On 02/24/23 at 9:20 a.m., Social Services Director was asked when a family representative was notified about Resident #120's Covid diagnosis on 11/30/22. They stated there were no records in the electronic health system documenting Resident #120's family representative was notified. The Social Services Director was asked what their policies were for notifying family representatives of change in condition. They stated, We know its a problem and are working on that. They were asked if there was a written policy for notifications. They stated, Not really sure. On 02/27/23 at 08:40 a.m., the DON was asked if Resident #120's family representative was notified of their positive Covid diagnosis on 11/30/22. The DON stated,No, sir.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41318 Based on record review and interview, the facility failed to provide the appropriate liability notice prior to a resident coming off of skilled services for three (#21, 44, and #48) of three sampled residents reviewed for beneficiary notices. The DON identified 23 residents who were discharged from Medicare Part A services with benefit days remaining in the past six months. Findings: Resident #21's last covered day of Part A service was 12/08/22. The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Resident #48's last covered day of Part A service was 12/14/22. The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Resident #44's last covered day of Part A service was 02/16/23. The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. There was no SNF ABN of non-coverage provided to the residents or residents' representatives. On 02/24/23 at 11:31 a.m., the Administrator stated SNF ABNs were a business office function and the current business office manager was new and wasn't aware to be doing this. She stated the SNF ABNs had not been provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on record review, observation, and interview, the facility failed to provide maintenance services necessary to ensure the following: a. floor tile was in good repair and not a trip hazard, b. wall paper was not peeling from the walls in Resident rooms and common areas, c. sheet rock was not damaged with cracks and deteriorating in common areas, and d. a clean and sanitary home like environment. The Resident Census and Condition of Residents, dated 02/22/23, documented 63 residents resided in the facility. Findings: On 02/24/23 at 9:30 a.m., a family representative stated that the room mate smeared excrement on the privacy curtain between the beds in room [ROOM NUMBER]. They stated a report to previous administrator was made and no action was taken. On 02/24/23 at 9:56 a.m., a brown unknown substance was observed on the wall above the trash can located in room [ROOM NUMBER] by the bedside. A brown substance was observed on the lower section of the privacy curtain located between beds A and B in the room. The wall paper above the trash can was observed to be peeling off of the wall. On 02/24/23 at 10:00 a.m., House Keeper #1 was asked what were the policies for ensuring a clean and sanitary home like environment. They stated,I've never got told anything about policies. They stated, They hired me on and did not show me anything. They stated, I just follow the lead of other house keepers. They stated, I was trained at my other job, but not here. On 02/24/23 at 1:04 p.m., no grievances were located for room [ROOM NUMBER]'s soiled curtains in the facility grievance log book. On 02/27/23 at 6:40 am., the light gray and dark gray tiles in the front commons area were observed to be raised creating a fall and trip hazard in seven places. On 02/27/23 at 6:45 a.m., no maintenance logs for raised damaged tiles, damaged wall paper, and damaged sheet-rock were located in the facility maintenance log book. No repair orders were located in the maintenance log book for sheet-rock repair, damaged tile, or damaged wall paper. On 02/27/23 at 7:00 a.m., the wall paper in the front commons area was observed peeling from the wall where the ceiling and wall meet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/27/23 at 7:01 a.m., water damage to the sheet rock was flaking from wall in areas around the ice machine in the dining room was observed. A previously repaired area was not patched and unfinished with cracks not repaired. [NAME] rust stains were at the feet of ice machine on floor. On 02/27/23 at 10:28 a.m., the Maintenance Supervisor was asked what were the policies for maintaining a clean and sanitary home environment. They Maintenance Supervisor stated, The house keepers have those policies. They stated, I have not seen any policies on anything like that. The Maintenance Supervisor was asked what kind of training they received for maintaining a clean and sanitary home like environment. They stated, Here, none yet. The Maintenance Supervisor was asked if they received a request to repair tiles. The Maintenance Supervisor stated, They mentioned when I came in. They stated, A couple people mentioned it, but it's not in repair log book yet. They stated, It's just one tile, and I need something heavy for it. The Maintenance Supervisor was asked if they received any repair request for sheet rock. They stated, No , nope, not yet and its not in the repair log book. The Maintenance Supervisor was asked if they received any repair request for wall paper repair. They stated, No, Not yet. They stated, I hate wall paper, I would rather paint it. On 02/27/23 at 11:20 a.m., the wall paper in room [ROOM NUMBER] was observed peeling from wall above the bed in a estimated two feet by two feet area. On 02/27/23 at 11:34 a.m., the DON stated the facility did not have a policy for maintaining a clean and sanitary home like environment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21731 Based on record review and interview, the facility failed to ensure a baseline care plan had been completed within 48 hours of admission for one (#2) of three sampled residents reviewed for admission assessments. The DON identified 20 residents were admitted within the past 30 days. Findings: A Baseline Care Plan policy, dated 11/17, read in parts, .The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care .The baseline care plan will .Be developed within 48 hours of a resident's admission . Resident #2 was admitted to the facility on [DATE], with diagnoses which included dementia, seizures, and depression. The clinical record did not contain documentation a base line care plan had been completed within 48 hours of admit. On 11/02/23 at 10:45 a.m., the DON was asked if a base line care plan had been completed. The DON stated they couldn't find one had been completed. 41318

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 35749 Based on record review and interview, the facility failed to develop a comprehensive care plan for dialysis for one (#47) of of one sampled resident reviewed for dialysis services. The Resident Census and Conditions of Residents report, dated 02/22/23, documented nine residents received dialysis services. Findings: A Care Plan Process policy, revised 02/19, read in parts, .The plan of care must describe the services that are to be furnished to attain the resident's highest practicable physical, mental, and social well-being .Plans of care have key areas, to include but not limited to .Medications .Treatments .Daily Care Needs . Resident #47 had diagnoses which included dependence on renal dialysis. A Five Day Resident Assessment, dated 11/29/22, documented the resident received dialysis while a resident of the facility. A Quarterly Resident Assessment, dated 01/11/23, documented the resident received dialysis while a resident of the facility. A Care Plan, last revised 01/06/23, read in parts, .Focus .DIALYSIS: I am at risk for COVID 19 due to going out into the community for dialysis treatment .Goal .I will be placed in isolation between dialysis trips to be observed for infection and to ensure I don't transmit it to other residents .Interventions .All my trash and laundry will be placed in the proper containers that are placed in my room .I will wear a mask when entering and leaving the facility for dialysis and in the hallway . On 02/22/23 at 11:30 a.m., Resident #47 was asked if nurses assessed their vitals signs prior to going to dialysis. They stated, No. On 02/24/23 a 10:46 a.m., MDS Coordinator #1 was asked how they determined what items would be care planned. They stated their problem areas, diagnoses and any areas staff brought up that they felt needed to be care planned would be included in a resident's care plan. They were asked if a resident received dialysis, should that be included in the care plan. They stated it should. They were asked to locate a care plan related to Resident #47 receiving dialysis services. MDS Coordinator #1 pointed to the above Dialysis care plan. They were asked what the care plan showed related to Resident #47's dialysis. They stated, It doesn't.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review, observation, and interview, the facility failed to: a. provide bathing assistance for two (#65 and #120) and, b, provide assistance to a dependent resident during the lunch meal service for one (#9) of 24 sampled residents reviewed for ADL assistance. The Resident Census and Condition of Residents, dated 02/22/23, documented 63 residents resided in the facility. Findings: A Dining Experience policy, revised 01/02/19, read in parts, .The dining experience will be safe and satisfying for the resident .Residents are assisted in a dignified and timely manner . 1. Resident #9 had diagnoses which included anoxic brain damage and quadriplegia. An Admission Resident Assessment, dated 10/27/22, documented Resident #9 had moderately impaired cognition and required total dependence of one staff physical assist for the task of eating. A Quarterly Resident Assessment, dated 01/23/23, documented Resident #9 had moderately impaired cognition and required total dependence of one staff physical assist for the task of eating. Resident #9's care plan did not address the type of assistance they required for eating. On 02/22/23 at 11:30 a.m., Resident #9 was asked how the food in the facility was. They stated, Not good, it's nasty. They stated they did receive their meals as ordered by the physician and they were unsure if they had experienced any weight loss. They stated they did feel staff were qualified to care for them. On 02/23/23 at 12:14 p.m., CNA #9 was observed pushing the hall tray cart on Hall B. CNA #9 reported it was there first day working at the facility. On 02/23/23 at 12:18 p.m., CNA #10 was observed placing a meal tray on the bedside table located next to Resident #9's bed. CNA #10 exited the room and began delivering other meal trays on the hall. On 12/23/23 at 12:23 p.m., Resident #9 was observed lying in bed, eyes open, with their meal tray still on the bedside table untouched. On 02/23/23 at 12:24 p.m., CNA #10 left Hall B to assist on Hall D. On 02/23/23 at 12:30 p.m., Resident #9 was observed lying in their bed with the same meal tray untouched on their bedside table. CNA #9 continued to deliver meal trays on Hall B. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/23/23 at 12:39 p.m., Resident #9 was heard stating I'm hungry over and over again. The surveyor could hear the resident from the hallway. On 02/23/23 at 12:40 p.m., CMA #4 was observed at the medication cart located on Hall B. Resident #9 could be heard at the medication cart yelling, I'm hungry over and over. CMA #4 did not respond to the yelling. On 02/23/23 at 12:41 p.m., Resident #9 was heard hollering, I'm hungry, I'm hungry. On 02/23/23 at 12:43 p.m., Resident #9 was heard again hollering out, I'm hungry over and over again. On 02/23/23 at 12:44 p.m. Resident #9 was still hollering they were hungry. On 02/23/23 at 12:45 p.m., Resident #9 was still hollering, CNA #9 was observed in the hall where the hollering could be heard. On 02/23/23 at 12:47 p.m., CNA #9 entered Resident #9's room. Resident #9 stated, Thank you. CNA #9 donned gloves and began assisting Resident #9 with their meal. Each time the resident was given a bite of food or a drink, they stated thank you to CNA #9. CNA #9 stayed with the resident through the meal, explaining each bite/drink and offering more to the resident until they were finished. On 02/23/23 at 1:12 p.m., CNA #9 was asked how they were made aware of the needs of the residents they were caring for today. They stated when they first arrived, the night shift CNA went room to room and explained each resident. CNA #9 was asked if they knew what type of assistance Resident #9 required for eating. They stated they knew staff had to feed the resident. CNA #9 was asked to explain the reason Resident #9's meal tray was placed on their bedside table prior to staff being able to assist them with their meal. They stated staff were not supposed to take a tray in and just set it there. They stated they did not know the reason CNA #10 did that. CNA #9 was asked if they heard Resident #9 hollering I'm hungry prior to entering the room. They stated, Yes.' On 02/23/23 at 1:23 p.m., the Wound Care Nurse (who was identified as being familiar with the resident by the DON) was asked what the policy was for delivering meal trays on the hall. They stated they were not sure. They were asked what type of assistance Resident #9 required for eating. They stated one staff member had to assist the resident for eating and drinking. They were asked if Resident #9 was capable of picking up items to eat or drink on their own. They stated, No. They were asked who would be familiar with the facility policy for hall meal trays. They stated they did not know. On 02/23/23 at 1:32 p.m., the DON stated Corporate Nurse #1 would be able to answer policy questions. On 02/23/23 at 1:40 p.m., Corporate Nurse #1 was asked the facility policy for hall meal trays. They stated they were not supposed to speak to State. They were asked who would be able to answer questions related to the polity for meal trays. They stated they would find someone. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/23/23 at 1:45 p.m., the Administrator was asked the policy for delivering meal trays on the hall. They stated meals were to be delivered to residents to conserve proper temperatures. They stated if the resident required assistance, staff were to assist them with their meals. They stated staff should assist the resident at the time the meal tray was delivered. The Administrator was made aware of the above observations and acknowledged the findings. 41318 2. Resident #65 had diagnoses which included age related physical debility. An admission assessment, dated 01/31/23, documented Resident #65's cognition was moderately impaired. It documented Resident #65 required extensive assistance with bathing. A Bathing report, did not document Resident #65 received or was offered a bath after 02/01/23. On 02/22/23 at 11:06 a.m., Resident #65 was asked if they received their bath as often as they wanted. They stated,No. They stated the last bath was two weeks ago. On 02/27/23 at 10:07 a.m., the DON was asked when staff were to offer a bath. She stated she couldn't find a policy but she thought residents should be offered three times a week. She was asked to review the bathing documentation for Resident #65. She stated if a bath was offered after 02/01/23, it hadn't been documented. 46702 Findings: 3. Resident #120 had a diagnosis of vascular dementia, dysphasia, and atriovetricular block. A comprehensive assessment, dated 11/21/22, documented Resident #120 required physical help in part of bathing and one person physical assist for baths. A Documentation Survey Report, dated 11/22, documented Resident #120 did not receive a bath for 13 days from admission on 11/17/22 until the day of discharge on 12/01/22. Resident #120's Care Plan dated 11/25/22, read in part, .Provide supportive care, assistance with mobility as needed. Document assistance as needed . On 02/24/23 at 10:30 a.m., the ADON was asked for bath sheets for Resident #120. The ADON stated they faxed them to corporate and were looking for additional bath records. On 02/24/23 at 10:51 a.m., CNA #5 was asked what was the process for ensuring residents received showers. They stated the day shift completed all A beds and night shift completed B beds. CNA #5 was asked where they charted baths. They stated ,In the computer They stated they charted daily when residents received showers. They stated bath sheets were also completed on paper and placed in a box on the hall outside the DON's office. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41318 On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure CPR was provided to Resident #66 who had a physician ordered full code status. On [DATE] at 7:30 p.m., a hospice nurse had came to evaluate Resident #66 for services and found resident without audible heart tones, absent respirations and unable to obtain palpable blood pressure. There was no documentation a facility staff member assessed the resident during this time. On interview, CMA #1 and an agency nurse had been in there 15 minutes prior to reposition resident. RN #1 stated they were alerted the resident had expired and knew the resident was a full code. CPR was not provided. On [DATE] at 9:07 a.m., The Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On [DATE] at 9:13 a.m., the Administrator and the DON were notified of the IJ situation. On [DATE] at 2:14 p.m., an acceptable plan of removal was submitted to The Oklahoma State Department of Health. The plan of removal read in part, .Meeting Date: [DATE] .Meeting Attendees .Medical Director . ADMIN .DON .ADON .MDS .SSD .HR .Identified Opportunity for Improvement/Deficient Practice .Code Status Process and Not performing CPR .1. Immediate Corrective Action for those affected by the deficient practice .Resident affected is deceased .2. Process/Steps to identify others having the potential to be impacted by the same deficient practice .All nurses including agency staff are educated on the CPR policy with a focus on checking chart-electronic medical record for code status (Dashboard). Immediate initiation. Assure that no one works until educated on this policy. Compliance date [DATE] 00:01 .Sweep of all Residents charts to see that advance directives/code status match what is in PCC and care planned. All areas of chart match. Compliance date [DATE] 1800 .Audit to assure that all nurses and necessary ancillary staff are CPR certified and current .Orientation for Emerald staff and/or agency reviewed and revised to include process of where to find code status .First mock code drill initiated within same week on every shift . All Code status will be removed from report sheets Immediately .Pending review to verify accuracy-will put back on once verified .3. Measures put in to place/systematic changes to ensure the deficient practice does not recur .Admission Coordinator educated on obtaining advance directives on admission with an immediate upload to PCC .Medical Records will upload final signed copy into PCC miscellaneous .ADON or Designee (DON) will be notified of advance directives upon admission to place an order into PCC on dashboard . Clinical stand-up will be initiated to include code status follow up and verification .Resuscitation Policy reviewed and revised for updated procedure .Quarterly Education to all staff on Resuscitation Policy .4. Plan to monitor performance to ensure solutions are sustained .Random audit of 6 CPR certified staff questioning procedure when finding a resident without a pulse and respirations. Weekly audit X 4 weeks for 1 month, then monthly X3 .Daily audit in clinical start up to assure code status is accurate in PCC, care plan, dashboard, etc-on-going .On-going quarterly Mock Code drills .The plan of correction reviewed in Adhoc QAPI on .The plan of correction will be reviewed monthly by the QAPI committee for the next 3 months and longer if needed . On [DATE], staff were interviewed regarding recent training/updates in regards to the CPR policy and protocol. Staff stated information provided in the in-service pertaining to the plan of removal. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:49 a.m., the IJ was removed when all components of the plan of removal had been completed. This was effective as of [DATE] at 5:00 a.m. The deficiency remained as an isolated event at level of potential harm. Based on record review and interview, the facility failed to ensure CPR was provided to one (#66) of one sampled resident reviewed for a death in the facility. The Resident Census and Conditions of Residents report, dated [DATE], documented 63 residents resided in the facility. The DON identified 53 residents had full code status. Findings: A Procedure for CPR policy, dated ,d+[DATE], read in parts, .The facility shall provide basic life support, including CPR to a resident who requires such emergency care prior to the arrival of emergency medical services, consistent with the resident's advance directives and physician orders .Identify code status/advance directive preferences .If no DNR order .begin resuscitation efforts .If no pulse, begin CPR . Resident #66 had diagnoses which included hypertension. An Order Summary Report, dated [DATE], documented Resident #66 was a full code. A Social Service note, dated [DATE] at 3:16 p.m., read in part, .Care plan meeting held with patient. Guardian .No plan for discharge needs LTC. No Directives. Code status is full code . A Physician Follow up note, dated [DATE], documented Resident #66 was a Full code. A Physician Follow up note, dated [DATE], documented Resident #66 was a Full code. An Alert Note, dated [DATE] at 7:30 p.m., read in part, .[hospice nurse] here in facility to perform assessment intake on this resident. Upon entering resident room, resident was noted without audible heart tones, absent respirations and unable to obtain palpable blood pressure. [Physician #1] was notified and declared resident expired [at 7:30 p.m.] . The note did not document the facility notified the physician Resident #66 was a full code. There was no documentation in Resident #66's clinical record CPR was attempted. On [DATE] at 8:01 a.m., LPN #2 was asked how the staff knew the residents' code status. They stated, I'm sure we have it in the chart. LPN #2 was asked what the process was if they found a resident without heart tones, respirations and blood pressure. They stated they would call someone to help and check if the resident had a DNR. LPN #2 was shown Resident #66's EHR. They were asked if they would have started CPR if the resident didn't have heart tones, respirations or blood pressure. They stated, Yes. On [DATE] at 8:19 a.m., RN #1 was asked how staff were aware of the residents' code status. They stated they would look in the EHR. RN #1 was asked what they would do if they found a resident without heart tones, respirations, and blood pressure. They stated they would start CPR if the resident was a full code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:27 a.m., RN #1 and CMA #1 stated there were here the day Resident #66 expired. CMA #1 stated they had been in Resident #66's room about 15 minutes prior to the hospice nurse evaluating the resident. CMA #1 stated Resident #66 was alive and the resident had their eyes open. RN #1 stated CMA #1 told them when the hospice nurse went in to admit the resident, [the resident] was gone. RN #1 stated they knew Resident #66 was a full code. RN #1 stated they didn't assess Resident #66. RN #1 was asked if they had a copy of a DNR for Resident #66. They shook their head no. RN #1 and CMA #1 were asked if Resident #66 had been admitted to hospice. CMA #1 stated, No. [The resident] was being evaluated.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review and interviews, the facility failed to fully complete an admission assessment for one (#20) of three sampled residents reviewed for admission assessments. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents. Findings: Resident #20 was admitted to the facility on [DATE]. A Nursing Admission Data Collection form, dated 01/19/23, was blank in the following areas: a. Reason for admission b. Lifestyle c. Height and Weight d. Oral Status e. History of skin issues f. Skin issue site, description, type, and measurements g. Neurological h. Cardiovascular I. Respiratory- the only section filled out was oxygen saturation j. Gastrointestinal k. Foot care l. Antibiotic Stewardship m. Pain n. Braden Scale o. Bladder and Bowel p. Fall risk q. Elopement risk and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	r. Safety. The form was not signed by any staff member. On 02/24/23 at 8:14 a.m., the DON was asked who was responsible for filling out the admission data collection form. She stated, I would think whoever is doing the admission. She was asked if the form for Resident #20 documented who filled it out. She stated, No. She stated she assumed the nurse obtained the information on admission. The DON was asked to explain the reason for all of the blanks. She stated, Incompetence, improper training. She acknowledged the form was not completed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 35389 Based on observation, record review, and interviews the facility failed to: a. obtain weekly measurements of a pressure ulcer as ordered, b. ensure an effect communication for wound care orders from a third party contract provider was in place, c. provide wound care as ordered and d. assess and monitor a pressure ulcer for changes for one (#20) of three sampled resident reviewed for pressure ulcers. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 15 residents with pressure ulcers. Findings: A Prevention of Skin Breakdown policy, revised 10/01/21, read in parts, .It is the policy of this facility to implement interventions to assist in preventing skin breakdown .Weekly skin evaluation is to be completed for each resident by a licensed nurse . The facility contract with Contract Agency #1, dated 01/19/23, read in parts, .Contract Services shall mean the services which Provider commonly performs within Provider's scope of practice .nursing services (including but not limited to basic skin care .non-skilled custodial care .Interdisciplinary Team shall mean the [Contract Agency #1] program team, which is responsible for controlling the delivery, quality, and continuity of care to Participants. The Interdisciplinary Team's responsibilities include, but are not limited to, assessing a prospective Participant's level of care needs, developing and implementing a treatment plan for each Participant, and authorizing Contract Services which meet the specific needs of each Participant . Resident #20 had diagnoses which included osteomyelitis and iron deficiency anemia. A Nursing Admission Data Collection form, dated 01/19/23, documented Resident #20 had a current skin issue but failed to document what the skin issue was, where it was located, description of the skin issue, or measurements of the skin issue. A Physician Order, start date 01/25/23, documented weekly skin observation tool one time a day every Wednesday. A Skin/Wound Weekly Observation form, dated 01/25/23, documented Resident #20 did have current skin issues, however it failed to document the site of the skin issue, description, measurements, or staging. It documented Contract Agency #1 was providing wound care. The note was signed by LPN #5. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The January 2023 TAR did not document Resident #20 received any wound care treatment to their coccyx or their left heel. An Activities note, dated 02/01/23 at 4:43 p.m., read in parts, .[Contract Agency #1 Case Manager] PROVIDED A .PHONE NUMBER TO TEXT .AND THE ON CAL PHONE NUMBER .PLEASE LEAVE A VOICEMAIL IF NO ANSWER .RECEIVED ORDER FOR WOUND CARE OF SACRUM AND LEFT HEEL. THESE ORDERS ARE FROM 1-20-23 WHICH THIS FACILITY DID NOT RECEIVE. ORDERS PUT IN AS OF TODAY BY THIS NURSE . The note was signed by the Wound Care Nurse. A note from Contract Agency #1 Nurse Practitioner, dated 02/02/23 at 12:42 p.m., read in parts, .[Resident #20] was seen today .for a wound assessment and monthly visit. The facility nurse states I didn't know she had wounds, [sic] then states they thought [Contract Agency #1] does the wound care. The dressing to [Resident #20's] heel was not changed for eight days. There has been no documentation of wounds or dressing changes in facility .Updated pictures were taken .Left heel wound, unstageable .new wound care orders faxed and a note was placed in facility [electronic records] . The note did not document the size of the left heel wound or appearance, it did not document the sacrum wound however the order attached to the note addressed a coccyx wound care order. An Order Note, dated 02/02/23 at 2:00 p.m., read in parts, .Wound care orders: Cleanse left heel with NS or wound cleanser. Apply medihoney, telfa, ABD pad, then wrap in kerlix. Change heel dressing three times per week and as needed. Cleanse Coccyx wound. Apply duoderm extra thin. Change thee times weekly and as needed. Measure wounds weekly. Call [Contract Agency #1 for any changes] . The note was signed by Contract Agency #1 Nurse Practitioner. The measure wounds weekly order was not put into Resident #20's wound orders until 02/07/23. A Physician Order, start date 02/02/23, documented wound care for coccyx; cleanse with wound wash, pat dry, apply medihoney to wound bed, cover with border foam dressing three times a week and PRN. It documented the treatment was to be completed on the day shift every Tuesday, Thursday, and Saturday for wound healing. This order was discontinued on 02/14/23. The February 2023 TAR documented blanks for the above treatment on 02/04, 02/07, and 02/14/23. It documented the first treatment provided to Resident #20's coccyx was on 02/02/23. A Physician Order, start date 02/07/23, documented cleanse left heel with NS or wound cleanser, apply medihoney, telfa, ABD pad, then wrap with kerlix. Change heel dressing three times per week and as needed. The same order included: cleanse coccyx wound, apply duoderm extra thin, change three times weekly and as needed. Measure wounds weekly. The order did not specify what three days to change the dressing. The order was discontinued on 02/17/23. The February 2023 TAR documented this dressing was changed on 02/08, 02/09, 02/10, 02/13, 02/14/23. It documented blanks on 02/07, 02/11, 02/12, 02/15, 02/16, and 02/17/23. A Skin/Wound Weekly Observation form, dated 02/15/23, documented the resident had current skin issues: site #1 type of skin issue: pressure, site: left heel. There was no description, staging or measurements on the form. It documented site #2 type of skin issue: pressure, site: sacrum. There was no description, staging or measurements on the form. It documented the sites were not new as of this assessment and had not had any clinically significant changes since the last assessment. The note was signed by LPN #5. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician Order, start date 02/17/23, documented wound care orders; cleanse left heel with NS or wound cleanser, apply medihoney, telfa, ABD pad, the wrap in kerlix. It documented staff were to change heel dressing three times a week and as needed. The same order included: cleanse coccyx wound, apply duoderm extra thin, change three times weekly and as needed. Measure wounds weekly. It documented every 12 hours as needed and every day shift on Monday, Wednesday, and Friday. An Email Communication between the Wound Care Nurse and Contract Agency #1 Case Manager, dated 02/21/23, read in parts, .Hey [Contract Agency #1 Case Manager], I was wondering when the wound doctor will be coming out of [sic] if hes [sic] been out. I fell pretty uncomfortable with the status and overall deterioration. {Resident #2]'s wound does not appear to be getting better at all. I was wondering about . biopsy results . The email was from the Wound Care Nurse. Contract Agency #1 Case Manager's response to the above mail, dated 02/21/23, read in parts, .The biopsy showed chronic osteomyelitis, we have been working on getting [Resident #20] in to see a general survery [sic] for consultation. Unfortunately, the wound will not get better when [Resident #20] still has osteo. [Contract Agency #1 Nurse Practitioner] and I looked at it last week while [Resident #20] was here in the clinic . An Email Communication between the Wound Care Nurse and Contract Agency #1 Case Manager, dated 02/10/22, documented Contract Agency #1 was unable to see any wound care notes in the electronic record and wanted to know how Resident #20's wounds were doing. It documented a request for the facility staff to send photos of the wounds. The Wound Care Nurse responded to the email asking how often the wound care physician would see the resident. It documented the resident's wound looked about the same and the Wound Care Nurse would send photos of the resident's wounds. The above email communications were not part of Resident #20's clinical record. There was no documentation of Resident #20's wounds being measured weekly per physician orders. There was no documentation staff provided description of how the wounds looked located in the resident's clinical record. There were no photos of the residents wound in the clinical record. On 02/23/23 at 10:44 a.m., the Administrator was asked to explain the role of Contract Agency #1 for Resident #20. She stated Contract Agency #1 provides the residents needs, medication and therapy. She stated wound notes should be getting uploaded into Resident #20's electronic record. She stated the facility staff should be completing the wound care for the resident. On 02/24/23 at 9:30 a.m., the Resident #20's wound to the left heel and bottom of foot was observed to have necrotic tissue on the medial edge of the wound which was boggy in nature. There were two visible areas of tunneling present toward the center of the heel. The lateral edge of the wound appeared dark gray/purple in nature and the center of the wound was observed to be pink. On 02/24/23 at 11:02 a.m., the Wound Care Nurse was asked to explain the email provided which documented they were uncomfortable with the status and overall deterioration of the Resident #20's wound. They stated one day when they went to change the resident's dressing, there was a significant amount of drainage and odor. They stated the wound looked really bad. They stated they could not say the wound had gotten better or worse because of the massive infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/24/23 at 12:10 p.m., the Administrator was asked to explain the process of Resident #20 receiving care from Contract Agency #1. They stated the orders were supposed to come over from Contract Agency #1. The Administrator stated they had found out that staff from Contract Company #1 had been completing wound care for the resident, but they had not provided the facility with notes. They stated they were supposed to go into the facility electronic medical record for Resident #20 and document. They stated Contract Agency #1 had been coming into the facility, providing wound care and treating the resident's wounds. The Administrator stated they should have been documenting in Resident #20's record. They stated Contract Agency #1 was contacted yesterday and they had no physical documentation of Resident #20's wounds. On 02/27/23 at 9:18 a.m. Contract Agency #1 Case Manager and Contract Agency #1 Nurse Practitioner were asked who was responsible for treating Resident #20's wounds. The Nurse Practitioner stated both the facility and the Agency was responsible. Contract Agency #1 Nurse Practitioner stated they did the orders and monitored them, and the facility staff changed the dressing three times a week. They were asked who was responsible for measuring and staging the wounds. The Nurse Practitioner stated they did the initial measurement and staging of the wound, then the wound nurse at the facility was supposed to measure it and send pictures. They were asked how often. The Case Manager stated they should be doing this weekly. They stated they had asked for pictures from the facility and they have not provided any photos or measurements. The Nurse Practitioner stated the initial was in their system and they had sent the information over to the facility. They stated the facility had not scanned it in yet. The Nurse Practitioner stated they had access to the facility electronic records, however they were unable to put in orders. They stated they went into progress notes and put in an order note for wound dressing orders. They stated Resident #20 did not have a dressing changed for seven days as a result. They stated all orders were hand delivered, faxed, or sent over to the facility. They stated that was the reason they started putting them in the progress notes.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 35749 Based on record review and interview, the facility failed to obtain physician ordered Pre/Post dialysis vitals and weights for one (#47) of one sampled resident reviewed for dialysis. The Resident Census and Conditions of Residents report, dated 02/22/23, documented nine residents received dialysis services. Findings: A Dialysis Care policy, revised 09/01/21, read in parts, .Residents ordered dialysis therapy will be monitored and documentation will be maintained in the medical record. All residents receiving dialysis will be assessed before and after dialysis treatment and for compliance with their individualized plan of care All residents receiving dialysis treatment will have their access site assessed every shift . Resident #47 had diagnoses which included dependence on renal dialysis. A Physician Order, start date 12/29/21, documented obtain and chart Pre/Post dialysis vitals and weight upon return from dialysis two times a day every Monday Wednesday and Friday. The September 2022 TAR documented blanks for the above order on 09/07 and 09/18 for the 7:00 a.m.- 11:00 a.m. shift, and on 09/02, 09/07, and 09/09 for the 7:00 p.m. to 11:00 p.m. shift. The October 2022 TAR documented blanks for the above order on 10/17, 10/19, and 10/26 for the 7:00 a.m.- 11:00 a.m. shift, and on 10/10, 10/14, and 10/21 for the 7:00 p.m. to 11:00 p.m. shift. The November 2022 TAR documented blanks for the above order on 11/2, 11/7, 11/09, 11/11, 11/14, 11/16, 11/18, 11/21, 11/23, and 11/25 for the 7:00 a.m.- 11:00 a.m. shift, and on 11/09, 11/11, 11/14, 11/16, 11/18, 11/21, and 11/25 for the 7:00 p.m. to 11:00 p.m. shift. The December 2022 TAR documented blanks for the above order on 12/05 and 12/3 for the 7:00 a.m.- 11:00 a.m. shift, and on 12/09, 12/14, 12/16, 12/21, 12/30 and 12/31 for the 7:00 p.m. to 11:00 p.m. shift. The January 2023 TAR documented blanks for the above order on 01/23, 01/25 and 01/31 for the 7:00 a.m.- 11:00 a.m. shift, and on 01/06, 01/13, 01/18, 01/20, 01/25 and 01/31 for the 7:00 p.m. to 11:00 p.m. shift. A Quarterly Resident Assessment, dated 01/11/23, documented the resident received dialysis while a resident of the facility. The February 2023 TAR documented blanks for the above order on 02/01, 02/10 and 02/17 for the 7:00 a.m. - 11:00 a.m. shift, and on 02/01, 02/03, 02/06, 02/08, 02/10, 02/13, 02/15 and 02/17 for the 7:00 p.m. to 11:00 p.m. shift. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/22/23 at 11:30 a.m., Resident #47 was asked if nurses assessed their vitals signs prior to going to dialysis. They stated, No. On 02/24/23 at 8:08 a.m., RN #1 was asked how dialysis residents were monitored. They stated staff checked the fistula site, auscultated for a bruit and felt for a thrill. They stated staff also did pre/post dialysis assessments. They were asked where the information was located. They stated it was at the nurses station. LPN #1, who was present during the interview, stated residents had a dialysis binder. On 02/24/23 at 8:20 a.m., LPN #1 stated Resident #47 did not have a dialysis binder. They were shown all of the above blanks in the resident's record and were asked if there was documentation the staff completed vitals signs and weights as ordered. They stated they would look. On 02/24/23 at 8:28 a.m., LPN #1 stated they did not think they were done.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35389 Based on record review and interview, the facility failed to ensure an RN worked eight consecutive hours a day, seven days a week for four of 31 days reviewed in the month of January 2023. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents. Findings: The time cards for RN coverage for the month of January 2023 documented: a. RN #2 worked from 10:09 a.m. to 5:12 p.m. on 01/02/23 b. No RN on 01/21/23 c. RN #1 worked from 2:17 p.m. to 9:00 p.m. on 01/23/23 and d. RN #1 worked from 3:13 p.m. to 8:10 p.m. and RN #2 worked from 1:20 p.m. to 4:31 p.m. on 01/27/23. On 02/27/23 at 1:22 p.m., the DON was asked the policy for ensuring RN coverage at least eight consecutive hours every day. She stated she did not know the specific policy, but she knew it was a requirement. The DON was asked if the facility had met the requirements for the above dates. She stated she thought there would have been coverage. On 02/27/23 at 1:25 p.m., the DON stated the 21st did match no RN coverage based off of what the Staffing Coordinator provided her. She stated she wanted to speak with HR to see if there were any Missed punches. On 02/27/23 at 1:29 p.m., HR stated if a staff member had missed punches, they would have put them in and they would have shown up on the time cards provided. She stated she could pull the former DON's [RN #2] timecard to see if they worked these dates. On 02/27/23 at 1:45 p.m. HR provided RN #2's time card and acknowledged the above dates were still short of eight hour RN coverage.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on observation, record review, and interview, the facility failed to: a. medications were administered as ordered for two (#20 and #56) of five sampled residents reviewed for unnecessary medications, and b. controlled medications awaiting destruction were verified by two licensed staff for 15 (#17, 35, 52, 69, 70, 71, 72, 73, 75, 76, 77, 78, 79, 80 and #81) of 15 sampled residents whose discontinued medications were observed. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents. Findings: A Drug Destruction policy, dated 2021, read in part, .In the event that the facility must destroy medications . the facility will adhere to the rules and regulations of their specific State Health Department as well as any other regulatory body including but not limited to the Drug Enforcement Agency . A Medication Administration and General Guidelines policy, dated 2021, read in parts, .Medications are administered as prescribed . 1. Resident #20 had diagnoses which included type two diabetes mellitus. A Physician Order, dated 01/20/23, documented Humalog KwikPen SQ solution pen-injector 100 u/ml (insulin Lispro) inject 4 u sq before meals for high blood sugar. The order was discontinued on 02/11/23. The January 2023 TAR documented blanks for this medication on 01/26 at 4:00 p.m. and on 01/28 at 6:30 a.m. The February 2023 TAR documented blanks for the 6:30 a.m. dose on 02/01 and 02/02, the 4:00 p.m. dose on 02/03, RF for the 6:30 a.m. dose on 02/03 the 11:00 a.m. dose on 02/02 and the 4:00 p.m. dose on 02/02 and 02/08. A Physician Order, dated 01/25/23, documented Lantus SQ solution 100 u/ml inject 10 u sq at bedtime for blood sugar. The February 2023 TAR documented RF for the dose on 02/15 and 02/18. A Physician Order, dated 01/27/23, documented to give sliding scale insulin for FSBS over 50, recheck in one hour and notify Contract Agency #1. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician Order, dated 01/27/23, Humalog KwikPen SQ solution pen-injector 100 u/ml (Insulin Lispro) Inject per sliding scale: if 141-180 give 4 u, 181-220 give 6 u, 221-260 give 8 u, 261-300 give 10 u, 301-350 give 12 u, 351-400 give 14 u, 401-450 give 16 u, 451-500 give 18 u SQ before meals and at bedtime. The January 2023 TAR documented a blank on 01/28/23 at 6:00 a.m. and OR and OR on 01/28/23 at 9:00 p.m. for a FSBS of 492. The February 2023 TAR documented blanks for the 6:00 a.m. dose on 02/01, 02/02, 02/12, 02/18 and for the 4:00 p.m. dose on 02/03, RF for the 11:00 a.m. dose on 02/02, for the 4:00 p.m. dose on 02/02 and 02/15 and the 9:00 p.m. dose on 02/01, 02/02 and 02/15, and no insulin required for the 11:00 a.m. dose on 02/08 with a fsbs of 256 and on 02/21 with no FSBS listed. A Physician Order, dated 02/05/23, documented Humalog KwikPen SQ solution pen-injector 100 u/ml (Insulin Lispro) Inject per sliding scale: if 141-180 give 4 u, 181-220 give 6 u, 221-260 give 8 u, 261-300 give 10 u, 301-350 give 12 u, 351-400 give 14 u, 401-450 give 16 u, 451-500 give 18 u, every two hours related to DM. The order was discontinued on 02/11/23. The February TAR documented a blank for the 10:00 p.m. dose on 02/09, RF for the 2:00 a.m. dose on the 10th and no insulin required for the 2:00 a.m. dose on 02/11 with no FSBS listed. A Physician Order, dated 02/11/23, documented Humalog KwikPen SQ solution pen-injector 100 u/ml (Insulin Lispro) inject 6 u sq before meals and at bedtime for DM. The February 2023 TAR documented blanks for the 6:00 a.m. dose on 02/12 and 02/18, RF for the 4:00 p.m. dose on 02/13 and 02/15 and RF for the 9:00 p.m. dose on 02/15 and 02/18. An Order Note, dated 02/15/23 at 12:38 p.m., documented discontinue lispro six units at meals and follow sliding scale before meals and at bedtime. There was no documentation this was acted on. On 02/24/23 at 9:23 a.m., the ADON was asked what interventions were in place to treat Resident #20's diabetes. They stated the resident received scheduled humalog insulin before meals and per sliding scale and received lantus 10 u at bedtime. The ADON stated there had been order issues with Contract Agency #1 because they would put in orders under activity notes without notifying the staff. The ADON was asked to explain the blanks on the January 2023 TAR for insulin administration. They reviewed the record and was unable to identify the reason. They were asked to explain the OR documentation on the 28th. They stated it meant out of range, however the FSBS was 492 which was not out of range. The ADON was unable to locate documentation of the resident receiving insulin for this FSBS. The ADON was asked to explain the reason Resident #20 had orders and was receiving scheduled Humalog insulin and per sliding scale at the same time each day. They stated several residents in the facility had orders like that. They stated when staff were checking the resident's fsbs they were administering both the sliding scale and scheduled humalog insulin. The ADON was asked to explain the RF documentation on the resident's TARs. They stated it meant the resident refused. They were asked what staff were instructed to do when an insulin dependent diabetic resident refused insulin. The ADON stated staff were to try to re-approach the resident and explain the importance of taking insulin, but if the resident continued to refuse, they were to document the refusal and notify the physician. The ADON was unable to locate any documentation the physician was notified of the above refusals. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADON was given the opportunity to review Resident #20's February TAR and was unable to locate documentation explaining the reason for the no insulin required or documentation of the reason insulin was not administered as ordered. The ADON was asked if the order note dated 02/15/23 documented to discontinue Resident #20's lispro 6 units. They stated, Yes. They stated Contract Agency #1 staff were going in and putting orders under notes without communicating with the facility staff. They were asked if Resident #20's lispro six units had been discontinued. They stated, Not, it had not been discontinued. On 02/27/23 at 9:19 a.m. Contract Agency #1 Case Manager and Contract Agency #1 Nurse Practitioner were asked who was the physician responsible for overseeing Resident #20's care. They stated Contract Agency #1 Physician who was also the agency's medical director. They were asked to explain the resident's insulin orders. They stated the sliding scale insulin orders and the scheduled four units of insulin came form them. They stated they never ordered the six units of scheduled insulin. They stated they had discontinued the scheduled insulin and Resident #20 should only have sliding scale insulin at this point. 41318 2. Resident #56 had diagnoses which included arthritis. A Physician's Order, dated 02/22/23, documented Resident #56 was to receive tramadol four times a day routinely and ever six hours as needed. A Medication Administration Record, dated February 2023, documented a 9 and the resident did not receive tramadol the following days and times: a. from 02/04/23 at 4:00 p.m. to 02/07/23 at 8:00 p.m. and b. from 02/08/23 12:00 p.m., to 02/14/23 at 12:00 p.m An Admission Assessment, dated 02/08/23, documented Resident #56's cognition was intact. On 02/22/23 at 10:05 a.m., Resident #56 stated they didn't receive their pain medications for several days a couple of weeks ago. On 02/27/23 at 11:20 a.m., CMA #1 was asked how staff ensure pain medication was administered as ordered. CMA #1 stated they followed the MAR and signed out the medication. CMA #1 was asked what a 9 indicated on the MAR. They stated, I use it to let them know the medication is on order. CMA #1 was asked to look at the MAR for Resident #56 and was asked if the tramadol had been administered. CMA #1 stated when Resident #56 came from the hospital with seven tramadol pills. CMA #1 stated they kept telling the nurse the resident was out of the medication and the CMA #1 sent a fax to the physician's office. On 02/27/23 at 11:27 a.m., the DON was asked how staff ensured pain medications were administered as ordered. She stated the staff followed the MAR. The DON was asked how staff ensured they didn't run out of pain medications. She stated, That's a good question. I haven't been here long enough to review the process. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47453 3. On 02/22/23 at 3:08 p.m., the DON was asked for the controlled drug destruction log. She stated, I haven't found that book yet. She was asked where the controlled medications awaiting destruction were kept. She stated the medications were kept in a safe. She stated the facility hadn't destroyed medications in awhile. The DON stated the safe required two keys to open and they only had one of the keys. They stated the other key was lost. On 02/23/23 at 7:12 a.m., the DON reported a lock [NAME] was coming to open the safe around 8:00 a.m. - 10:00 a.m. She was asked what medications awaiting destruction were in the safe. She stated she did not know. She stated she was informed the sheet was wrapped around each medication card. The DON was asked how often controlled medications were destroyed and by whom. She stated, Beings honest, I don't think they have been destroyed for over a year. She was asked how she ensured medications were not misappropriated. She stated she had started going around to medication carts and conducting random audits between the electronic record, the count sheets, and the medication on hand. On 02/23/23 at 9:39 a.m., the DON stated staff had not been putting discontinued medications in the safe. The DON stated the safe was too full to add to. She stated staff had been leaving discontinued medications on the medication carts and pharmacy was destroying straight from the carts with staff. The DON was unable to identify how long this process had been going on. The DON stated she had spoken to the pharmacist who reported they had not destroyed form the safe in a year. On 02/23/23 at 11:30 a.m., the lock [NAME] arrived at the facility and unlocked the safe. The following items were observed in the safe: The following medications did not have two signatures present verifying the count prior to the medications being placed into the safe: Resident #69 hydro/apap 5-325mg Rx #03871809 QTY 54 Resident #35 Oxycodone 15mg Rx #03871142 QTY 2 Resident #35 Oxycodone 15mg Rx #03871142 QTY 60 Resident #70 Tramadol 50mg Rx #05013575 QTY 18 Resident #70 Tramadol 50mg Rx #05013575 QTY 59 Resident #70 Pregabalin 25mg Rx #05013539 QTY 18 Resident #71 Morphine 10mg/0.5ml Rx #69698 QTY 30 Resident #71 Morphine 10mg/0.5ml Rx #69697 QTY 27 Resident #71 Lorazepam 0.5mg/0.25ml Rx #337457 QTY 19 Resident #72 Norco 7.5-325 Rx #2053939 QTY 90 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #38 Tramadol 50mg Rx #05011114 QTY 65 Resident #38 Tramadol 50mg Rx #05012587 QTY 60 Resident #73 Tramadol 50mg Rx #05014208 QTY 44 Resident #73 Tramadol 50mg Rx #05014263 QTY 60 Resident #75 Lorazepam 1mg Rx #4036514 QTY 36 however the count sheet showed 41 Resident #72 Oxycontin 15mg Rx #2054010 QTY 2 Resident #76 Lorazepam 2mg/ml Rx #4035736 QTY 7 Resident #77 Norco 7.5-325mg Rx #03870985 QTY 132 Resident #78 Norco 7.5-325mg Rx #03871418 QTY 84 Resident #79 Norco 7.5-325mg Rx #03871555 QTY 98 Resident #79 Chlordiazepoxide 25mg Rx #05014359 QTY 30 Resident #80 Temazepam 30mg Rx #05013484 QTY 12 Resident #52 Lorazepam 2mg/ml Rx #56069 QTY 21 The following medication had no count sheet present: Resident #72 Lorazepam 2mg/ml Rx #4035644 QTY20 On 02/23/23 at 1:50 p.m., the DON verified the above medications awaiting destruction with no signatures present as well as the medication card with no sheet present.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46702 Based on record review and interview, the facility failed to ensure a monthly drug regimen review was completed by a licensed pharmacist for one (#32) of five sampled residents reviewed for unnecessary medications. The Resident Census and Condition of Residents report, dated 02/22/23, documented 63 residents resided in the facility. Findings: A Medication Regimen Review policy, dated 5/22, read in part, .The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist .The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and the reports acted upon . Resident #32 had diagnoses of type two diabetes, hypertension, and depression. Resident #32's Physician Order Summary documented Oxycodone HCl oral tablet 10 MG effective on 02/11/23, hydroxyzine HCl oral tablet for anxiety effective 02/11/23, aspirin oral capsule 81 MG effective 02/11/23 , and sertraline HCl tablet 50 mg for depression effective 10/12/22. The facility did not provide any documentation the resident's medications were reviewed by a licensed pharmacist in November or December 2022. The January and February 2023 pharmacist monthly medication reviews, provided by the facility, did not document the pharmacist had reviewed Resident #32's medications. On 02/27/23 at 11:24 a.m., the DON was asked if Resident #32's monthly medication review by a licensed pharmacist was conducted for November and/or December of 2022. She stated the records were not readily accessible and she could not locate any documentation to support Resident #32's medications were reviewed monthly by a licensed pharmacist during that time frame.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41318 Based on record review and interview, the facility failed to ensure the physician responded to a GDR for one (#37) of five sampled residents reviewed for unnecessary medications. A Resident Census and Conditions of Residents report, dated 02/22/23, documented 26 residents received psychoactive medications. Findings: Resident #37 had diagnoses which included neurotic depression. A Medication Regimen Review, dated 01/06/23, read in part, .Gradual Dose Reduction Attempt .Abilify 5 mg daily .Recommendation: Do you feel a reduction could be attempted on the above medication . There was no documentation the physician had been notified of or responded to the recommendation. A Quarterly assessment, documented Resident #37 received an antipsychotic on a routine basis and no GDR had been attempted. On 02/27/23 at 11:25 a.m., the DON was asked how staff ensured GDRs were acted upon/responded. She stated she wasn't sure. On 02/27/23 at 2:06 p.m., the DON stated they were unable to find a physician response to Resident #37's GDR.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35389 Based on record review and interview, the facility failed to ensure an effective administration for the coordination and continuity of care for one (#20) of one sampled resident reviewed for third party contract services. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents. Findings: Resident #20 had diagnoses which included osteomyelitis and iron deficiency anemia. An Activities note, dated 02/01/23 at 4:43 p.m., read in parts, .[Contract Agency #1 Case Manager] PROVIDED A .PHONE NUMBER TO TEXT .AND THE ON CAL PHONE NUMBER .PLEASE LEAVE A VOICEMAIL IF NO ANSWER .RECEIVED ORDER FOR WOUND CARE OF SACRUM AND LEFT HEEL. THESE ORDERS ARE FROM 1-20-23 WHICH THIS FACILITY DID NOT RECEIVE. ORDERS PUT IN AS OF TODAY BY THIS NURSE . The note was signed by the Wound Care Nurse. An Order Note, dated 02/15/23 at 12:38 p.m., documented discontinue lispro six units at meals and follow sliding scale before meals and at bedtime. There was no documentation this was acted on. On 02/22/23 at 9:38 a.m., during the Entrance Conference, the DON stated the previous facility Administrator had quit Friday. They stated the Corporate Administrator was over the facility for two days until the new Administrator started this Monday (02/20/23). The DON was unable to give me the full name of the Corporate Administrator. The DON stated the previous DON had walked out on Monday (02/13/23) and they had stepped in as the DON at that time. On 02/24/23 at 9:23 a.m., the ADON was asked if the order note dated 02/15/23 documented to discontinue Resident #20's lispro 6 units. They stated, Yes. They stated Contract Agency #1 staff were going in and putting orders under notes without communicating with the facility staff. They were asked if Resident #20's lispro six units had been discontinued. They stated, Not, it had not been discontinued. On 02/24/23 at 11:02 a.m., the Wound Care Nurse was asked to review the activities note dated 02/01/23 and explain the wound care order for Resident #20's sacrum and heel. They stated they knew there had been issues with the Contract Agency #1 Case Manager putting in progress notes without having the actual order input into the electronic record. They stated this was the first time for them to see the note dated 02/01/23. On 02/27/23 at 10:34 a.m., the Administrator was asked how the facility ensured continuity of care with residents with the recent turn over in administration. They stated they would not be able to answer that. They stated they would have to research to find out what the facility had been doing prior to them being there. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was asked what their involvement was with the third party contract with Contract Agency #1. They stated the only thing the Administrator did was sign the contract. They stated they did not negotiate the contract. They stated that was done at the Corporate level. The Administrator was asked who was responsible for communicating with Contract Agency #1 where they were to document on Resident #20. They stated they were unable to answer the question because they were not present when the contract went into affect. The Administrator was made aware of staff reporting Contract Agency #1 putting in orders related to Resident #20's insulin and wound care under activity notes, and the orders not being received by facility staff. The Administrator was asked if the administration oversight was effective for the care of Resident #20. They stated they were not even aware of the concern.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 35389 Based on interview, the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for the residents competently during both day-to-day operations and emergencies. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents. Findings: On 02/22/23 at 9:38 a.m., the DON was asked to provide the facility assessment. On 02/27/23 at 6:57 a.m., the DON was asked to verify the facility did not have an up to date facility assessment. She stated she thought the Administrator had provided it and she would check. On 02/27/23 at 7:42 a.m., the DON stated the Administrator had left some papers on her desk to be completed for the facility assessment. She was asked to verify the facility assessment had not been completed. She stated, No.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 35389 Based on record review and interviews, the facility failed to ensure a PICC line for IV antibiotic administration was placed in a timely manner by a third party contract service for one (#20) of one sampled resident reviewed for third party contract services. The DON identified two residents who received services from Contract Agency #1. Findings: The facility contract with Contract Agency #1, dated 01/19/23, read in parts, .Contract Services shall mean the services which Provider commonly performs within Provider's scope of practice .nursing services . including but not limited to basic skin care .non-skilled custodial care .Interdisciplinary Team shall mean the [Contract Agency #1] program team, which is responsible for controlling the delivery, quality, and continuity of care to Participants. The Interdisciplinary Team's responsibilities include, but are not limited to, assessing a prospective Participant's level of care needs, developing and implementing a treatment plan for each Participant, and authorizing Contract Services which meet the specific needs of each Participant . Resident #20 had diagnoses which included osteomyelitis. An Alert Note, dated 02/21/23 at 3:34 p.m., documented Contract #1 Case Manager results of the resident's recent biopsy of the left foot showed osteomyelitis. It documented the facility was awaiting a new order for an antibiotic. There was no biopsy results in Resident #20's records. An Alert Note, dated 02/22/23 at 11:51 a.m., documented Contract #1 Case Manager stated they had an order for a PICC to be placed to administer IV antibiotics for osteomyelitis of the left lower extremity. It documented no new orders at this time. Email communication between the Administrator and Contract #1 Case Manager, dated 02/22/23 at 3:48 p.m. , documented Resident #20 was going to be transported on 03/01/23 at 11:30 a.m. for a PICC line placement. It documented IV antibiotics for chronic osteomyelitis would be started following the PICC line placement. On 02/23/23 at 10:44 a.m., the Administrator was asked to explain the role of Contract Agency #1 for Resident #20. She stated Contract Agency #1 provided the residents needs, medication and therapy. She stated Contract Agency #1 acted as Resident #20's insurance. On 02/24/23 at 11:24 a.m., the Wound Care Nurse was asked if the facility had the lab results for Resident #20 which indicated osteomyelitis. They stated they did not have the results. They stated they had to call Contract Agency #1 for the results. They stated they emailed Contract Agency #1's Case Manager back and forth for communication related to Resident #20's care. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Care Nurse was asked to explain the notes dated 02/22/23 related to the Contract Agency #1 Case Manager stating a PICC line had been ordered for antibiotics. They stated the PICC line was scheduled to be placed on 03/01/23. They were asked who made the appointment. They stated Contract Agency #1. The Wound Care Nurse explained if Resident #20 was not under the care of Contract Agency #1, then the facility could have someone come to the facility to place a PICC line. They stated due to Resident #20 being under the care of Contract Agency #1, the facility was not allowed to do that. They stated Contract Agency #1 did all orders for the resident and scheduled all appointments. They were asked to verify Resident #20 was not going to receive antibiotics to treat their osteomyelitis until the PICC line was placed. They stated, Correct. The Wound Care Nurse was asked if Contract Agency #1 Case Manager had given any indication of the reason they were waiting until March 1st. They stated, No. On 02/24/23 at 12:10 p.m., the Administrator was asked if Resident #20 had osteomyelitis, was 03/01/23 an acceptable time to wait for IV antibiotic treatment. They stated, No. On 02/27/23 at 9:18 a.m., Contract Agency #1 Case Manager and Contract Agency #1 Nurse Practitioner were asked to explain the reason Resident #20 was having to wait until March 1st to receive IV antibiotic treatment. Contract Agency #1 Nurse Practitioner stated the resident was stable enough to transfer to a wheelchair, therefore they had to do an ambulance transfer to get the PICC line placement. They stated they were unaware the facility had the ability to have someone come out and place a PICC line there. They stated they were doing the best they could with the information they had. Contract Agency #1 Case Manager stated they had email communication with the facility regarding the matter and they hadn't mentioned being able to place the PICC line in the facility. They were asked the reason the facility did not have the medical records for Resident #20's osteomyelitis results. Contract Agency #1 Nurse Practitioner stated the Case Manager had hand delivered, faxed, or sent over to the facility all of Resident #20's medical records. They stated the facility should have all of it.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35389 Based on record review and interview, the facility failed to ensure records were accessible and complete for one (#20) of 24 sampled residents whose records were reviewed. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents. Findings: Resident #20 had diagnoses which included osteomyelitis and iron deficiency anemia. A Nursing Admission Data Collection form, dated 01/19/23, documented Resident #20 had a current skin issue but failed to document what the skin issue was, where it was located, description of the skin issue or measurements of the skin issue. A Physician Order, start date 01/25/23, documented weekly skin observation tool one time a day every Wednesday. A Skin/Wound Weekly Observation form, dated 01/25/23, documented Resident #20 did have current skin issues, however it failed to document the site of the skin issue, description, measurements, or staging. It documented Contract Agency #1 was providing wound care. The note was signed by LPN #5. An Order Note, dated 02/02/23 at 2:00 p.m., read in parts, .Measure wounds weekly. Call [Contract Agency #1 for any changes] . The note was signed by Contract Agency #1 Nurse Practitioner. The measure wounds weekly order was not put into Resident #20's wound orders until 02/07/23. A note from Contract Agency #1 Nurse Practitioner, dated 02/02/23 at 12:42 p.m., read in parts, .[Resident #20] was seen today .for a wound assessment and monthly visit. The facility nurse states I didn't know she had wounds, [sic] then states they thought [Contract Agency #1] does the wound care. The dressing to [Resident #20's] heel was not changed for eight days. There has been no documentation of wounds or dressing changes in facility .Updated pictures were taken .Left heel wound, unstageable .new wound care orders faxed and a note was placed in facility [electronic records] . The note did not document the size of the left heel wound or appearance, it did not document the sacrum wound however the order attached to the note addressed a coccyx wound care order. An Email Communication between the Wound Care Nurse and Contract Agency #1 Case Manager, dated 02/10/22, documented Contract Agency #1 was unable to see any wound care notes in the electronic record and wanted to know how Resident #20's wounds were doing. It documented a request for the facility staff to send photos of the wounds. The Wound Care Nurse responded to the email asking how often the wound care physician would see the resident. It documented the resident's wound looked about the same and the Wound Care Nurse would send photos of the resident's wounds. There were no photos of the resident's wounds in the record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/23/23 at 10:44 a.m., the Administrator was asked to explain the role of Contract Agency #1 for Resident #20. She stated Contract Agency #1 provided the resident's needs, medication and therapy. She stated wound notes should be getting uploaded into Resident #20's electronic record. She stated the facility staff should be completing the wound care for the resident. On 02/24/23 at 11:02 a.m., the Wound Care Nurse was asked who was responsible for assessing Resident #20's wounds. They stated Contract Agency #1 Case Manager was responsible. They were asked if they could locate any measurements, staging, or description of Resident #20's wounds. They stated they did not measure it. They were asked if they ever staged a wound. They stated, No. They stated Contract Agency #1 Case Manager took pictures and measured the wounds and should be staging it. The Wound Care Nurse stated none of the information was provided to the facility from Contract Agency #1. On 02/24/23 at 12:10 p.m., the Administrator was asked to explain the process of Resident #20 receiving care from Contract Agency #1. They stated the orders were supposed to come over from Contract Agency #1. The Administrator stated they had found out staff from Contract Agency #1 had been completing wound care for the resident, but they had not provided the facility with notes. They stated they were supposed to go into the facility electronic medical record for Resident #20 and document. They stated Contract Agency #1 had been coming into the facility, providing wound care and treating the resident's wounds. The Administrator stated they should have been documenting in Resident #20's record. They stated Contract Agency #1 was contacted yesterday and they had no physical documentation of Resident #20's wounds. On 02/27/23 at 10:34 a.m., the Administrator was asked if Resident #20's records were readily accessible. They stated it did not appear so. They stated they still did not have documentation related to the resident's wounds the survey team had asked for last week. They stated there had been issues getting Resident #20's records from Contract Agency #1 when they provided care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35389 Based on observation, record review and interview, the facility failed to: a. provide wound care in a manner which prevented cross contamination for one (#20) of three sampled residents reviewed for pressure ulcers, and b. implement their infection control policy for a system for regular surveillance of all infections. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents. Findings: An Infection Control policy, revised 06/07/20, read in parts, .a system for regular surveillance and reporting of all infections. This included the collection, analysis, interpretation, and dissemination of data .To detect infections, plan control activities, and identify and manage potential outbreaks of disease .Track new infections each month .Differentiate between nosocomial and community acquired infections .Analyze listing for potential outbreaks .Review and analyze data monthly to identify trends . 1. Resident #20 had diagnoses which included osteomyelitis and iron deficiency anemia. A Physician Order, start date 02/17/23, documented wound care orders; cleanse left heel with NS or wound cleanser, apply medihoney, telfa, ABD pad, the wrap in kerlix. It documented staff were to change heel dressing three times a week and as needed. The same order included: cleanse coccyx wound, apply duoderm extra thin, change three times weekly and as needed. Measure wounds weekly. It documented every 12 hours as needed and every day shift on Monday, Wednesday, and Friday. On 02/24/23 at 9:30 a.m., the Wound Care Nurse disinfected their hands, donned gloves, removed Resident #20's left heel dressing, cleaned the wound with wound cleanser, then applied the resident's new dressing per physician's orders. The Wound Care Nurse did not to change gloves or sanitize hands after removing the resident's soiled dressing and did not change gloves or sanitize hands prior to applying the new clean dressing. The Wound Care Nurse sanitized their hands and donned a pair of gloves, turned Resident #20 on their left side. There was no dressing present on the resident's coccyx. They used wound cleanser on gauze and cleaned the resident's wound and applied duoderm. The Wound Care Nurse did not change gloves or sanitize hands after cleaning the resident's wound and did not change gloves or sanitize hands prior to applying the new clean dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/24/23 at 11:02 a.m., the Wound Care Nurse was asked the policy for changing gloves or washing hands during wound care. They stated anytime gloves were soiled, staff were to change their gloves. They stated staff were to wash their hands or sanitize anytime they changed gloves or left the room. They were asked if they had changed their gloves after removing Resident #20's soiled dressing and cleaning the heel wound prior to applying the clean dressing. They stated, No. They were asked if they changed gloves/cleaned hands after cleaning the wound on the sacrum prior to applying the clean dressing. They stated, No. 2. On 02/22/23 at 9:42 a.m., during the Entrance Conference, the DON was asked to provide information on infection prevention and control program, policies and procedures, to include the surveillance plan. On 02/23/23 at 10:35 a.m., the DON was asked if they had located any infection control tracking and trending. They stated they were not really hopeful on that, but they would go look for it. On 02/24/23 at 1:27 p.m., the DON was asked if the facility had located any tracking and trending for the past year. They stated, Zero. They stated there was nothing they could find on general tracking and trending. 35749

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review and interview, the facility failed to: a. ensure residents were offered the pneumonia vaccine for one (#47) and b. ensure residents were offered the flu vaccine annually for three (#14, 21, and #47) of five sampled residents reviewed for vaccinations. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents. Findings: An Influenza Vaccination policy, undated, read in parts, .It is our policy to offer our residents .annual immunization against influenza .The resident's medical record will include documentation that the resident and/or resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal . A Pnuemococcal Vaccine policy, undated, read in parts, .It is our policy to offer our residents .immunization against pnuemococcal disease .The resident's medical record shall include documentation that indicates at a minimum .The resident or resident's representative was provided education regarding the benefits and potential side effects of pnuemococcal immunization .The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal . 1. Resident #47's was admitted to the facility on [DATE]. The clinical record did not document the resident had been offered the flu or pneumonia vaccine since admission to the facility. 2. Resident #21's record documented the resident received a flu vaccine on 11/21/21. It did not document the resident was offered a flu vaccine for the 2022/2023 flu season. 3. Resident #14's record documented the resident received a flu vaccine on 11/11/21. It did not document the resident was offered a flu vaccine for the 2022/2023 flu season. On 02/27/23 at 10:23 a.m., the DON was asked what the policy was for offering flu and pneumonia vaccines to the residents. They stated they would think residents were offered the vaccines around October or November. The DON was asked if every resident was offered a flu and pneumonia vaccine. They stated they should, unless they were allergic. They were asked to review Resident #47's record and identify if they had been offered the flu or pneumonia vaccine. They DON stated they did not see any documentation the vaccines were offered or declined by the resident. The DON was asked if there was any documentation Resident #21 had been offered a flu vaccine since 11/11/21. They stated they did not find anything. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was asked if there was any documentation Resident #14 had been offered a flu vaccine since 11/11/21. They stated, No.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 35749 Based on record review and staff interview, the facility failed to maintain documentation of the vaccination status of each resident to include exemptions for unvaccinated residents for 63 residents who resided in the facility. The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents. Findings: A COVID-19 policy, revised 09/27/22, read in parts, .Each resident .are offered the COVID-19 vaccine and any Booster shots following unless the immunization is medically contraindicated . The DON was asked to provide a list of all residents and their COVID-19 vaccination status on: A. 02/22/23 at 9:42 a.m. during the Entrance Conference, B. 02/23/23 at 8:52 a.m. and C. 02/23/23 at 10:35 a.m. They stated they were not very hopeful, but would look for it. On 02/23/23 at 3:02 p.m., the Administrator was informed the survey team had not been provided a list of all residents and their COVID-19 vaccination status. On 02/24/23 at 1:27 p.m., the DON stated they were unable to locate any documentation of exemptions for unvaccinated residents. They stated when they attempted to pull the information, Zero came up under the residents COVID-19 vaccination status.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure staff are vaccinated for COVID-19 35749 Based on record review and interview, the facility failed to implement: a. A process for tracking and securely documenting the COVID-19 vaccination status of all staff and residents The Resident Census and Conditions of Residents report, dated 02/22/23, documented 63 residents. Findings: A COVID-19 policy and procedure, dated 12/27/22, read in parts, .all staff are offered and fully vaccinated with either the Primary Series refers to staff who have received a single-dose vaccine or all required doses of multi-dose vaccine for COVID-19 .or have an approved exemption under religious or medical condition and/or beliefs . Medical Exemptions and Temporary Delays .Medical exemption documentation when appropriate will specify which authorized or licensed COVID-19 vaccine is clinically contraindicated for the staff member and the recognized clinical reasons for the contraindication . Process for tracking staff vaccine status .each staff member's vaccination status .any staff member who has obtained any booster doses .staff who have been granted an exemption from vaccination .staff whom COVID-19 vaccination must be temporarily delayed . The DON was provided a COVID-19 staff vaccination matrix to complete and return to the survey team on : A. 02/22/23 at 9:42 a.m., during the Entrance Conference, B. 02/23/23 at 8:52 a.m. and C. 02/23/23 at 10:35 a.m. They stated they were not very hopeful, but would look for it. On 02/23/23 at 3:02 p.m., the Administrator was informed the survey team had not been provided the completed COVID-19 staff vaccination matrix. On 02/24/23 at 1:27 p.m., the DON stated they had no documentation of exemptions for unvaccinated staff. They provided a copy of the Healthcare Personnel COVID-19 Cumulative Vaccination Summary for Long-Term Care Facilities which documented the facility had 36 employees who were offered but declined the COVID-19 vaccine. There was no documentation provided related to the reason the staff declined the vaccination. The facility did not provide a completed COVID-19 staff vaccination matrix prior to the survey exit.