STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review and interviews for one of one resident (Resident # 65) reviewed for dementia care, The facility failed to ensure that the resident and or the resident representative was informed in advance of the risk and benefits of a psychotropic medication and failed to obtain a consent before initiation of a psychotropic medication. The findings include. Resident # 65's diagnosis included adjustment disorder with mixed anxiety and depressed mood, Post-Traumatic Stress Disorder (PTSD), unspecified dementia, psychotic disturbance, mood disturbance, anxiety, and suicidal ideation. A psychiatric consultation note dated 3/18/2021 directed to add Trazadone(antidepressant) 25 Milligrams (MG) every 6 hours as needed for anxiety/sleep. A physician's order dated 6/18/2021 directed the use of Trazadone 75 MG at bedtime. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #65 was moderately cognitive impairment and required set up for bed mobility, eating and showering. The care plan dated 9/21/2022 identified a problem related to use of psychotropic drugs due to diagnosis of adjustment disorder, PTSD, and dementia. Interventions included in part to administer medications as ordered, complete an Abnormal Involuntary Movement Scale (AIMS) every 6 months, assess for dehydration, side effects, behaviors, movement disorders and changes in behavior and mood. A review of the nurse's notes and psychiatric notes dated 3/2022 to present failed the resident and or responsible party was made aware of the risk and benefits of the utilization of the Trazadone. Interview, clinical record review, and facility documentation review with the DNS on 11/03/22 at 10:50 AM indicated consent and authorization for Psychiatric services and use of Abilify (10/27/2020). However, the DNS could provide evidence of a consent for use of the Trazadone started in March 2021. The DNS further indicated that the consent if not obtained by the psychiatric Medical Doctor (MD) could have been obtained by the nurse and consent would be in the nurse's notes. A review of the nursing notes reviewed for the month of March 2021 to present identified no discussion and or documentation of the resident's responsible party consent for use of Trazadone and any discussion regarding risk and benefits for taking the medication. The DNS stated that consent was obtained, and she will continue to look for it.

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46663 Based on clinical record review, review of facility documentation and interview for 1 of 2 sampled residents (Resident #36), the facility failed to provide evidence that recommendations were followed in accordance with professional standards. the findings included: Resident #36 was admitted on [DATE] with diagnoses included transient ischemic disorder, anxiety disorder, personality disorder, adjustment disorder with depressed mood, and unsteadiness with walking. The admission Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #36 had a Brief Interview for Mental Status (BIMS) score of thirteen out of fifteen, indicating no cognitive impairment. Resident #36 required extensive assistance of one staff member with transfers, and partial assistance of one staff member with toileting and activities of daily living (ADL). The Pre-Admission Screening and Resident Review (PASRR) consult provided dated 2/8/22 identified the need for weekly individualized counseling, physical therapy (PT) and occupational therapy (OT) to help with improving strength and movement and directed the resident to allow the nursing staff to assist him/her with ADL and help manage his/her pain. The nurse's note dated 2/10/22 at 4:20 PM identified that the resident received psychiatric services. A gradual dose reduction (GDR) of Clonazepam was recommended, to decrease the morning dose from 0.5 mg to 0.25 mg. Physician's Order dated 3/22/22 directed to administer Clonazepam 0.25 mg at 9:00 AM and 0.5 mg at night. A review of the clinical record from 2/8/22 through 11/3/22 identified Resident # 36 was seen by social services on a quarterly basis. Psychiatric services were being provided monthly, not weekly as recommended by the psychiatric evaluation company. Interview with Social Worker #2 and DNS on 11/3/22 at 10:50 AM identified the resident was visited weekly by psychiatric services but was often resistant. The facility failed to inform the psychiatric evaluation company that their recommendations were not being followed for weekly individualized counsel. The DNS also indicated there was no PASARR facility policy for surveyor review.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident # 54) reviewed for skin conditions, non-pressure, the facility failed to ensure that the care plan comprehensive and individualized with goals and interventions to reflected the resident's psoriasis skin condition. The findings include: Resident #54's diagnoses included psoriasis and Type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #54 had no cognitive impairment and required extensive assistance of one person for bed mobility, transfer, toileting, bathing, and personal hygiene. Additionally, the assessment identified the resident was at risk for pressure ulcer but did not have any unhealed pressure ulcers. The care plan dated 8/21/2022 identified a problem due to a fungal rash to bilateral groin, interventions included : to ensure skin is clean and free from moisture and to provide treatment as ordered. The care plan further indicated that there was a potential for skin breakdown, pressure areas, skin tears, bruising secondary to fragile skin, aspirin use and decreased mobility. Interventions included in part to ensure skin was clean and free from prolonged moisture to provide treatment as ordered, to inspect skin daily during care and alert charge nurse of any changes and directed the licensed nurse to complete a weekly skin assessment. The physician's order dated 9/26/2022 directed to apply Triamcinolone cream 0.025% one large application to left elbow and may apply a kerlix wrap over area to help prevent scratching twice daily. The weekly body audit dated 10/6/2022 at 5:00 PM indicated dry scaly skin with abrasion with no location indicated. Treatment Administration Record (TAR) dated 10/7/2022 and discontinued on 10/13/2022 directed to cleanse left elbow self-excoriations with wound cleanser apply bacitracin followed by dry protective dressing change daily and as needed. The weekly body audit dated 10/13/2022 at 5:00PM indicated intact skin condition to elbows and knees along with abrasion related to picking skin and that treatment was ongoing. The weekly body audit dated 10/20/2022 at 3:00 PM indicated skin condition was intact and had abrasions to elbows. The weekly body audit dated 10/27/2022 at 6:28:PM indicated skin intact. Observation on 10/31/22 at 11:30 AM identified Resident #54's left arm was noted to have white patches and some bloody areas. Resident #54 indicated it was eczema and that he scratches at it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/03/22 at 09:16 AM Observation and interview with Resident #54 indicated that the resident's arms were itchy on and off and that the right elbow is bothersome. Resident # 54 further indicated s/he scratches the area a lot and the dressing if applied never stay on. Observations on 11/3/22 further revealed no dressings and dried blood was noted over the skin areas of the left and right elbows. On 11/03/22 at 9:26 AM an interview with LPN #3 indicated this was her first working independently the unit and after her med pass is completed she will complete the treatments and will consult with the APRN regarding the treatment for Resident #54's right and left arm/elbows and to see what could be done to help keep the dressing in place. On 11/03/22 at 11:00 AM an interview with RN #4 indicated she was responsible for placing care plans and updating them. RN #4 further indicated that it has been a challenge and but now she has another nurse who started on 10/18/22 assisting with care plans. Review of the resident's diagnosis list and treatment orders revealed a diagnosis of psoriasis which RN #3 indicated Resident #54 was admitted with the diagnosis. Review of the physician's orders with RN#3 identified a treatment order from 9/26/2022 for a treatment of Triamcinolone cream to left elbow and a kerlix dressing if needed. Further review of the TAR identified new treatment orders obtained on 11/3/2022 subsequent to surveyor inquiry. RN #3 could not provide evidence that the skin condition for psoriasis was addressed in Resident #54's care plan and indicated that it should have been and she would update the care plan immediately. The physician'S orders dated 11/03/2022 directed to apply Triamcinolone cream 0.025% to bilateral elbows and forearms and may apply kerlix over area to help with scratching. The physician's order dated 11/03/2022 directed to cleanse left and right elbow and left forearm unroofed scabs with normal saline apply an xeroform dressing followed by a protective dressing every three days and as needed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, review of policy and staff interviews for 1 sample resident (Resident # 337) reviewed for infection, the facility failed to monitor the resident's Vancomycin trough level according to the professional standard when resident was receiving intravenous (IV) Vancomycin medication. The findings include: Resident #337 diagnoses included sepsis, cellulitis of left lower limb, osteomyelitis, type 2 diabetes mellitus, non-pressure chronic ulcer of other part of right foot and Methicillin susceptible staphylococcus aureus infection. The physician's order dated 10/10/22 directed to administered Vancomycin reconstitute solution 1.25 gram once a day intravenously every evening. The Resident Care Plan (RCP) dated 10/10/22 identified Resident #337 required intravenously antibiotic related to gangrene. Intervention included: administered IV antibiotic per physician ordered, follow regimen when caring for IV site and laboratory per physician order. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #337 had moderate impaired cognition and required supervision to limited assistance of 1 person with toileting, dressing, transfer, personal hygiene, and ambulation. A review of the physician's orders and nurse's notes for October 10, 2022, through November 1, 2022, failed to reflect that Resident # 337's Vancomycin trough level had been monitored by the facility within accordance to professional standards. Interview with Advance Practice Registered Nurse (APRN #1) on 11/1/22 at 2:00 PM identified the attending physician would be responsible for coordinating the care of the resident. She also indicated that she would obtain a Vancomycin trough level at least weekly. Subsequent to inquiry, APRN #1 ordered a Vancomycin trough level for Resident # 337 to be done on 11/1/22. She further indicated that the Vancomycin trough level was missed and should be monitored when a patient is taking IV Vancomycin medication. Interview with physician (MD #2) on 11/2/22 at 2:30 PM identified the physician or APRN was responsible for ordering Vancomycin trough level. MD #2 also indicated that he was aware Resident #337 was taking IV Vancomycin for cellulitis/osteomyelitis. MD #2 further indicated he thought the Vancomycin trough level was included in the weekly laboratory test for the resident. He further indicated that the Vancomycin trough level should be monitored to maintain the therapeutic level of the Vancomycin medication. Interview with Director of Nursing Services (DNS) on 11/2/22 at 2:40PM identified the physician or APRN would be responsible for ordering Vancomycin trough level. She also indicated that her nursing staff would follow the physician order. Subsequent to inquiry, the DNS created a standing physician's order to prompt the nursing supervisor to check for Vancomycin trough level when a resident admitted with IV Vancomycin medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to monitor the Vancomycin trough level according to the professional standard to maintain therapeutic level of the Vancomycin medication. Although a policy for Vancomycin level monitoring was requested during the survey, the facility did not have a policy for Vancomycin trough level test.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on clinical record review, review of facility policy and interviews, for 1 of 2 residents reviewed for pressure ulcers (Resident #76), the facility failed to consult the dietician regarding a new pressure area within 7 days per facility policy. The findings include: Resident #76 was admitted with diagnoses that included vascular dementia without behavioral disturbance and displaced intertrochanteric fracture of right femur. A quarterly MDS assessment dated [DATE] identified Resident # 76 was severely cognitively impaired requiring extensive assistance of 2 staff members for bed mobility and extensive assistance of 1 staff member for personal hygiene. Additionally, the quarterly MDS dated [DATE] identified Resident #76 was at risk for development of pressure ulcers/injuries and indicated the resident did not have any unhealed pressure ulcers/injuries. The care plan reviewed on 7/27/22 identified that Resident #76 was at risk for skin breakdown-skin tears-abrasions-bruising secondary to fragile skin, at risk for further skin breakdown related to his dementia and incontinence of B&B. Interventions included Braden scale quarterly and when needed, always encourage to off load heels when in bed, and to inspect skin daily while providing care alerting the charge nurse of any changes. A weekly body audit dated 8/18/22 at 3:05PM Braden scale for prediction of pressure sore risk identified Resident #76 is at high risk for skin breakdown. Interventions included turning and positioning program, nutrition, or hydration intervention to manage skin and surgical wound care. A dietician progress note dated 8/25/22 at 9:02 AM identified] Resident #76 was readmitted secondary to status post Right hip fracture, food intake 75-100%; 7.1% weight (wt.) loss x 30 days. Wt. loss occurred in hospital; body mass index is underweight for age. Able to self-feed. Receiving modified diet and thickened liquids. No pressure injury noted, increased nutrient needs related to acute injury fracture and surgical incision. Continue supplements for nutrition adequacy. Continue plan of care. A weekly body audit dated 8/31/22 at 10:43 AM identified Resident #76 had an open area to the bottom of the resident's right heel. The area was cleaned and covered. A nursing progress not dated 8/31/22 at 1:54 PM identified Resident # 76 with an open area to left lower heel, reported to Infection Control Nurse and APRN. A wound physician's progress note dated 9/1/22 at 11:48 AM identified Resident #76 had an unstageable area due to necrosis of the right heel for at least 3 days duration measuring 7.4 Centimeter (CM x 6.2 CM x 0. 1 CM with a recommendation for daily treatment timed 30 days. A nursing progress note dated 9/1/22 at 2:02 PM identified Resident #76 was assessed by the wound care nurse and Medical Doctor (MD) for an unstageable right heel wound measuring 7.4 CM x 6.2 CM x 0.1 CM with moderate serosanguinous exudate with 100 percent necrotic tissue. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 9/1/22 identified Resident #76 had a pressure ulcer to right heel (Stage 3). Interventions include to apply dressings per MD order, provide incontinence care after each incontinent episode and to encourage the resident to turn and reposition every 2 hours. A dietician progress note dated 9/9/22 at 10:03 AM identified Resident #76 had altered skin integrity, continues supplement, will include Zinc sulfate at this time and to continue to monitor for further intervention need. Interview and review of Resident #76's medical record with the DNS on 11/3/22 at 10:00 AM identified she expected a dietician evaluation within 7 days of identification of a new pressure area and Resident #76's medical record lacked a dietician evaluation within 7 days of the nurses identifying the new pressure area on 8/31/22. The DNS continued by stating that the primary communication method for the dietician was via a communication book on the nursing units. The nursing staff would update the dietician based on a resident's change of condition such as a new pressure area to alert the dietician the resident needed to be evaluated. The nursing staff could also text the dietician if they urgently needed her. The DNS indicated in review of Resident #76's delayed dietician evaluation, she had determined on 8/31/22 when Resident #76's new pressure area was identified, Dietician #1 was on out on a leave and Dietician #2 was on vacation resulting in Dietician #1 not evaluating Resident #76 until she returned from her leave on 9/9/22. Interview with Dietician #1 on 11/3/22 at 12:00 PM identified she was on leave and had evaluated Resident #76 upon her return 9/9/22 (9 days later). She also indicated she believed the DNS was aware her coverage was on vacation the last week of August 2022 into the beginning of September 2022. She continued by stating that upon her return she immediately evaluated Resident #76. Dietician #1 also indicated after her evaluation she recommended to add a protein supplement to Resident #76's treatment plan. The facility policy: Pressure ulcer prevention and assessment plan directs in part that notification of the dietician for follow up within 7 days of admission or onset for residents with identified pressure ulcers.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based clinical record review, facility policy and interviews for 1 resident (Resident # 14) reviewed for hospitalization s, the facility failed to obtain a physician order for an increase in oxygen therapy for a resident experiencing a change in condition according to standards of practice and facility policy. The findings include: Resident #14 was admitted with diagnoses that included end stage small cell lung cancer, chronic obstructive pulmonary disease (COPD) and diabetes mellitus Type II. The MDS 5-day assessment dated [DATE] identified Resident #14 had moderate cognitive impairment and required total assist with personal care. The care plan dated 10/6/22 identified Resident #14 was at risk for altered respiratory status related to history of chronic obstructive pulmonary disease (COPD) and hypoxia. Interventions included: to administer oxygen as ordered, assess and record for signs of impaired gas exchange, to monitor oxygen saturation per physician order and to position upright for optimal breathing. The physician's orders dated 10/7/22 directed oxygen at 3 liters/minute via nasal cannula and oxygen saturation to be monitored every shift. The nursing progress note dated 10/29/22 at 11:34 PM identified Resident #14 was alert and aware. The resident was able to make needs known. The nurse Licensed Practical Nurse (LPN #4) was called by staff to assist Resident #14 who had reported difficulty in breathing. Oxygen saturation (O2 sat) was 43% on 3 Liters/minute (Baseline 88-93%) Normal Range 96- 100 percent. The supervisor was made aware. Resident #14 ' s oxygen was increased to 5 liters/minute, the head of bed was elevated, breathing treatment administered, and inhaler was administered. O2 sat went to 72%. The supervisor spoke with the family. Resident #14 was given morphine as scheduled along with Ativan to provide comfort as per family wish. O2 sat 85% on 10 L supervisor made aware. Resident # 14 was resting in bed. The plan was to continue to monitor and inform the incoming nurse. An interview on 11/2/22 at 1:16 PM and 11/03/22 at 11:35 AM with Registered Nurse (RN #1) identified she was the assigned Nursing Supervisor on the evening shift on 10/29/22, RN #1 indicated Resident #14 's health status had been declining and the resident had recent hospitalization s. The code status was recently changed to Do Not Resuscitate (DNR) with comfort care. On 10/29/22. RN #1 reported sometime during the evening shift she was called to Resident #14's bedside with a report from the charge nurse (LPN #4) that Resident # 14's O2 (oxygen) saturations were in the high 70's and low 80's. Resident #14 looked comfortable, was in no distress and the responsible party did not want him/her sent out. RN #1 increased Resident #14 ' s oxygen to a higher flow oxygenator at 5 liters/minute and Resident #14 received Ativan and morphine. Resident #14 ' s oxygen saturation improved to the 80's. RN #1 indicated she notified the on call APRN to report Resident #14 ' s O2 saturation were in the 80's that the resident received Ativan and morphine, the family did not want Resident # 14 transferred out and that the resident looked comfortable. RN #1 indicated she may have told the on call APRN Resident #14 was placed on a high liter flow of oxygen but did not obtain a physician order to increase the oxygen rate. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 11/2/22 at 5:24 PM with LPN #4 indicated she was the assigned charge nurse on the evening of 10/30/22. LPN #4 indicated she had obtained an oxygen saturation in the 40 ' s. LPN #4 notified the nursing supervisor at the time who told her to increase Resident #14 ' s oxygen to 5 liters a minute. LPN #4 also elevated the head of bed, repositioned Resident #14 and administered a nebulizer treatment. Resident #14 ' s O2 saturation increased to 69-70%. LPN #4 indicated she called an alternate nursing supervisor (RN #1) who instructed LPN #4 to increase the oxygen to 10 liters/min. RN #1 came down to assess the resident spoke with family at the bedside and then contacted the responsible party who did not want Resident #14 sent out to the hospital. Resident #14's O2 saturations remained in the 80 ' s for the remainder of the shift which was consistent with her/his baseline. LPN #4 believed the APRN was notified who indicated to continue to monitor. LPN #4 indicated she also worked the following morning, and she received information Resident #14 remained stable throughout the night. The daytime Nursing Supervisor reassessed Resident #14 and was able to reduce the oxygen down to 5 liters/minute. An interview on 11/03/22 at 11:43AM with the DNS indicated that although the administration of oxygen was a nursing measure. RN #1 should have obtained a physician's order when increasing the liter flow for a resident with COPD. An interview on 11/03/22 at 11:55AM with MD #1 indicated he was the medical Director of the facility. MD #1 indicated in an acute situation, it would be acceptable to increase the oxygen and then notify the physician to obtain orders. The facility policy for Oxygen Therapy directed oxygen is to be administered only as ordered by a physician or as an emergency measure until an order could be obtained. The physician's order would specify the rate and flow of oxygen. Attempts to interview the on call APRN were unsuccessful. 46046

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37721 Based on observation of the kitchen, review of facility documentation, facility policy review, and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner and the facility failed to ensure the dishwasher water temperatures were consistently documented and failed to ensure food was handled in accordance with infection control standards. The findings included: An observation on 10/31/21 at 10:05AM with the Food Service Director (FSD) of the kitchen identified the following: 1 A large amount of white and brown congealed buildup on the front and side of oven. 2. A large amount of brown congealed buildup behind the stove where the floor meets the wall and behind the side counter where the floor meets the wall. An interview on 10/31/22 at 10:05 AM with the FSD identified the facility used to have a contracted company who provided more comprehensive cleaning services. The facility has not utilized the cleaning company for approximately 6 months. The FSD further indicated that although the staff should have ensured the cleaning of the stove and behind counters was completed it has been difficult for staff to complete all the cleaning tasks. The FSD indicated she was responsible for ensuring cleaning tasks were completed. The facility General Cleaning Guidelines direct the cleaning and sanitization of most equipment and surfaces in the kitchen included: the daily cleaning the stove including the loosening of baked on grease or carbonized food with a stiff bush or scraper as needed, spraying with cleaner and wiping until surface is restored. Additionally, the floors were to be cleaned by sweeping under equipment, mopping away from walls and under equipment and vigorously mopping to remove food spills and stains. The housekeeping is to be contacted to clean the floor monthly with a scrubbing machine or as needed. 3. An observation on 10/31/22 at 10:05AM with the FSD identified the rinse cycle display on the high temperature dishwasher read 112 degrees (Normal 180 degrees). An interview and review of the dishwasher temperature logs dated 10/6/22 through 10/30/22 identified 36 of 72 opportunities did include documented temperature logs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 10/31/22 at 10:05AM and 11/01/22 at 12:50 PM with the FSD identified beginning approximately two weeks prior, the company who services the facility dishwasher was called out after experiencing a problem with the control panel where temperature readings were displayed. The company came out and determined there was not an issue with the rinse temperatures, only in the display reading during the rinse cycle. The FSD had instructed all staff to stop taking dishwasher temperatures because the display was not working properly. The FSD indicated she had checked the water temperatures herself at intermittent times. When not in range, the facility would utilize paper products and sanitizing solution for cleaning dishes. Although there was a note section for detailing any issues related to temperature readings for that day, there was no documented recording of low dishwasher temperatures and an alternate plan to use paper products. Additionally, the FSD indicated she had been experiencing problems with staff recording water temperatures that were not actually obtained and this was an issue she was trying to address. An interview on 10/31/22 at 12:16 PM with the Director of Maintenance identified he was aware of the issue concerning low rinse cycle readings. A vendor came out to the facility and determined there was an issue with the display readings of the rinse cycle and not actual low rinse cycle temperatures. The Director of Maintenance indicated the vendor directed that water temperatures be checked manually before use. The facility policy for High Temperature Dishwasher directed high temperature dishwasher temperatures be maintained between 150-160 degrees Fahrenheit for the wash cycle and 180 degrees Fahrenheit for the rinse cycle. Dietary staff are to record dish machine temperatures on a dish machine temperature log before they begin dishes from each meal. Any unusual or substandard readings should be reported to the Nutrition Services Director (FSD) and maintenance department., discontinue use of the dish machine and manually wash all equipment and wares. 4. An observation on 11/01/22 at 12:15 PM identified the FSD entered the walk-in refrigerator with a paper plate in the left hand, open the walk-in refrigerator with her ungloved right hand, place an unwrapped sandwich wrap on the plate using the same right hand used to open the refrigerator door and return to the food line to serve. The task was interrupted and corrected. An interview with the FSD identified she was obtaining alternate food items directly from the refrigerator as needed and, in doing so, should have been utilizing infection control standards so she was not handling the food directly to avoid cross contamination. The facility policy for Food Handling Guidelines direct food to be handled according to local guidelines to avoid contamination. Minimize hand contact with food by using utensils or disposable gloves.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 46046 Based on Facility Assessment review, facility documentation review and interviews, the facility failed to ensure that the Facility Assessment was updated yearly. The findings include: An interview on 10/31/2022 with the Director of Maintenance who stated that he was asked to find the Facility Assessment. The Director of Maintenance further indicated he could only find the Facility assessment dated 2018. The Maintenance Director also indicated that it was the Administrator's responsibility to maintain the Facility Assessment and indicated that the old administrator left last month, and the Interim administrator (Administrator #1) last day was today. A review of the facility's Facility Assessment on 10/31/22 failed to reflect that yearly Facility Assessments had been conducted for 2020, 2021 and 2022, Interview on 10/31/2022 with Administrator #1 in the presence of Maintenance Director identified she did not know if the Facility Assessment Form presented to surveyor from 2018 was the most up to date. Administrator 1 indicated her last day was today and the new Administrator was due to start on 11/1/2022. Interview on 11/2/2022 at 10:00 AM with the Maintenance Director indicated that that the Director of Nursing was placing a call to the previous administrator to ask if there was an updated Facility Assessment. Interview on 11/2/202 at 2:00 PM with the Director of Nursing identified that she believed the Facility Assessment was reviewed in March 20222 but was unable to provide evidence of a March 2022 Facility Assessment form. The DNS also indicated the Maintenance Director had placed a call to the previous administrator for any information. Interview on 11/03/22 at 8:50 AM with Administrator #2 and the Director of Nursing identified the last review and completed Facility Assessment available was completed in 2018 and could not provide evidence of yearly review for 2020, 2021 and 2022.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility policy and interviews for one resident (Resident # 14) reviewed for hospitalization s, the facility failed to ensure a complete and accurate clinical record for a resident who experienced a change of condition and for one sampled resident (Resident # 65), reviewed for dental, the facility failed to ensure the resident's dental visit was uploaded to the clinical record within accordance to facility practice. The findings included: 1. Resident #14 was admitted on with diagnoses that included end stage small cell lung cancer, chronic obstructive pulmonary disease (COPD) and diabetes mellitus Type II. The 5-day MDS assessment dated [DATE] identified Resident #14 had moderate cognitive impairment and required total assist with personal care. The care plan dated 10/6/22 identified Resident #14 was at risk for altered respiratory status related to history of chronic obstructive pulmonary disease (COPD) and hypoxia. Interventions included: to administer oxygen as ordered, assess and record for signs of impaired gas exchange, to monitor oxygen saturation per physician's order and position upright for optimal breathing. The physician's orders dated 10/7/22 directed oxygen at 3 liters/minute via nasal cannula and oxygen saturation to be monitored every shift. The nursing progress note dated 10/29/22 at 11:34 PM identified Resident #14 was alert and aware. Able to make needs known. The nurse (LPN #4) was called by staff to assist Resident #14 who had reported difficulty in breathing. Oxygen saturation (O2 sat) was 43% on 3 Liters/minute (Baseline 88-93%). The supervisor was made aware. Resident #14 ' s oxygen was increased to 5 liters/minute, the head of bed was elevated, breathing treatment administered, and inhaler was administered. O2 saturation went to 72%. The supervisor spoke with the family. Resident# 14 given morphine as scheduled along with Ativan to provide comfort as per family wish. O2 saturation 85% on 10 L supervisor was made aware. Resident #14 was noted resting in bed. The plan was for staff to continue to monitor and inform incoming nurse of any changes. However, review of the nursing progress notes dated 10/29/22 to 11/1/22 failed to include an RN assessment, documented notification to the covering on call medical provider. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 11/2/22 at 1:16 PM and 11/03/22 at 11:35 AM with RN #1 identified she was the assigned Nursing Supervisor on the evening shift on 10/29/22, RN #1 indicated Resident #14's health status had been declining and had the resident had recent hospitalization s. The code status was recently changed to Do Not Resuscitate (DNR) with comfort care. On 10/29/22. RN #1 reported sometime during the evening shift she was called to Resident #14's bedside with a report from the charge nurse (LPN #4) that the resident's O2 saturations were in the high 70's and low 80 's. During assessment, Resident #14 looked comfortable, was in no distress and the responsible party did not want him/her sent out to the hospital for an evaluation. RN #1 increased Resident #14's oxygen to a higher flow oxygenator at 5 liters/minute and Resident #14 received Ativan and morphine. Resident #14's oxygen saturation improved to the 80's. RN #1 indicated she notified the on call APRN to report Resident #14's O2 saturation were in the 80's, that s/he received Ativan and morphine, the family did not want him/her transferred out to the hospital and Resident #14 looked comfortable. RN #1 indicated she failed to document her RN assessment and notification to the on call APRN as an oversight. The facility policy for nursing documentation directs nursing documentation to follow the guidelines of good communication, be concise, clear, and accurate. 2. Resident #65's diagnosis included acute respiratory disease, adjustment disorder with anxiety and depressed mood, post-traumatic stress disorder and dementia. The annual MDS assessment dated [DATE] indicated a moderately impaired cognitive status. The MDS assessment further indicated Resident #65 required supervision of one person for personal hygiene, dressing, and bathing. The care plan dated 9/21/2022 indicated that Resident #65 would refuse activities of living including oral care showers and change of clothes at times. Interventions included in part to discuss treatment plan with resident, explain, medical consequences of not following the plan of care and if refuses care to notify the supervisor. The care plan further indicated Resident #65 had an alteration in oral status due to need for a partial denture as left upper canine with a filling hits the lower tooth. Interventions include in part to have a dental consult as needed and diet as tolerated. A dental visit note dated found in the chart dated 6/22/2021 indicated no resident concerns. Further review of the clinical record from 7/2021 to 10/30/22 failed to reflect any additional dental consultation. On 10/31/22 at 11:25 AM Resident #65 indicated s/he has not seen a dentist recently. The resident also indicated s/he is missing some teeth has only one front tooth on left lower and the upper left side tooth needs to be filled. Resident #65 also indicated s/he has no pain but can feel the dental problem areas. Resident # 65 further indicated there is only so much soft food one can eat. Interview and record review with the Director of Nursing (DNS) on 10/31/2022 at 2:15 PM indicated no dental visit notes were found in Resident #65's chart after 6/22/2021 through 10/31/22 during surveyor inquiry. The DNS indicated she would obtain the dental visits that were completed within the last year. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/2022 at 2:45 PM interview with the Scheduler identified she placed a call to the dental consultant and requested the visits be printed out and sent to the facility. The Scheduler acknowledged that Resident # 65's visits within the last year were not in the chart. She also identified that she was the person responsible for ensuring that dental consultation or visits are place in the chart. The Scheduler explained the process of how dental visit notes are obtained as the notes are emailed to her which she prints them out for the medical records person who scans the notes into the computerized chart for each resident. The Scheduler further indicated that the turnaround time from the actual visit to her receiving them in her email is usually 24 hours and indicated she was not aware the visit notes were not being uploaded into the chart. On 11/1/2022 at 2:50 PM an interview with Administrator #2 with the Scheduler present, indicated the dental visit notes should be in the Resident # 65's and that s/he would follow up to ensure visits are placed in the charts timely. 46046

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 46046 Based on facility documentation review, facility policy review and interviews, the facility failed to maintain an effective, comprehensive, data driven Quality Assurance and Performance Improvement (QAPI) program. The findings include: On 11/02/22 at 12:52 PM an Interview with Administrator #2 and the Director of Nursing (DNS) during a reviewed the QAPI meeting agenda for 10/27/2022 shared minutes and meeting attendees. The DNS indicated that the Medical Director does not attend quarterly .The DNS further indicated that a while back it was noted there was an uptick in the number of falls. The DNS further indicated that since falls were addressed in QAPI, falls had been reduced dramatically and the facility is continuing to use the audits. However, the facility was unable to share evidence of follow-up on QAPI issues regarding fall prevention and statistical data to monitor the effectiveness of the plan. The facility policy named Quality Assurance and Performance Improvement/Corporate Compliance Program dated 9/2020 indicated in part the facility would establish and maintain a Quality Assurance and Performance Improvement program (QAPI) by utilizing information and data to define and measure goals.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46046 Based on facility documentation review, facility policy review, and interviews the facility failed to ensure that the QAPI committee tracked, analyzed, and acted on data obtained. The findings include: On 11/02/22 at 12:52 PM an Interview with Administrator #2 and the Director of Nursing (DNS) indicated that they had noticed an uptick in resident falls and since brought to QAPI Falls have been dramatically reduced and they continue to complete audits. The facility was unable to share evidence of follow-up on QAPI issues that require Follow-up and documentation. The facility policy named Quality Assurance and Performance Improvement/Corporate Compliance Program dated 9/2020 indicated in part that the facility would establish and maintain a Quality Assurance and Performance Improvement program (QAPI) by utilizing information and data to define and measure goals.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46046 Based on facility documentation review, facility policy review and interviews, the facility failed to ensure the Medical Director consistently attended the quarterly QA meetings to maintain an effective and comprehensive Quality Assurance and Performance Improvement (QAPI) program. The findings include: On 11/02/22 at 12:52 PM an Interview with Administrator #2 and the Director of Nursing (DNS) during a reviewed the QAPI meeting agenda for 10/27/2022 shared minutes and meeting attendees. The DNS indicated that the Medical Director does not attend quarterly QA meetings consistently from 1/2022 to 10/27/22. She further indicated although the Medical Director does not attend all the QA meetings, she provides an update to the Medical Director of the quarterly minutes when he comes to the building. The DNS was unable to provide signature sheets from 1/2022 to 10/27/22 of the Medical Directors attendances at the QA quarterly meetings. Interview with the Medical Director on 11/2/22 at 4:00 PM identified he does not attend the scheduled QA meetings at the facility. The Medical Director further indicate he is in facility during the week at which time the DNS does update him through review of meeting minutes and indicated he would investigate other options for attending the meeting. The Facility policy for Quality Assurance Performance Improvement/Corporate compliance Program dated 9/2020 indicated the facility would establish and maintain a Quality Assurance and Performance Improvement Program (QAPI) to identify and address quality issues and to implement corrective action plans as necessary to facilitate positive outcomes. The policy further indicated the purpose of the program was to provide a means of continuous assessment of care and services to the residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on observations, review of facility policy and interviews, the facility failed to document the completion of the legionella mitigation steps as per the facility plan and for 1 sampled resident (Resident # 12) who utilized a urinary device, the facility failed to store the device in a bag to prevent the spread of infection and for 1 resident (Resident # 35) who utilized oxygen, the facility failed to store the oxygen and label tubing in the manner that was sanitary and prevent the spread of infection and or 1 of 2 residents (Resident # 54) reviewed for reviewed for Respiratory Care, the facility failed to ensure that appropriate infection control practices were followed for storage of respiratory equipment .The findings included: An Environmental Assessment and Procedure document dated January 2019 identified the facility posed a medium risk to promote growth of legionella and the mitigation steps in part were outlined to include: 1. Hot water storage area: hot water should be maintained at or above 140 degrees Fahrenheit (F) and should be verified daily. The circulation pump installed on the water lines should be verified for proper operation as well. These practices should be documented and kept in the service records of this plan. The hot water storage tank should be flushed at its lowest point at least quarterly to help blow down any sediment that may be building at the bottom of the tank. 2. Showers, tubs, and faucet taps: hot and cold-water taps. Shower heads and tubs should be periodically flushed to mitigate the potential for stagnation. 3. Eyewash stations: Plumbed eyewash stations should also be flushed for 3 minutes monthly. This practice should be documented. Interview and review of facility documents with the Maintenance Director on 11/1/22 at 1:00 PM identified this was the first time he had seen the Environmental Assessment and Procedure document dated January 2019 and although he had completed the mitigation steps as outlined in the Environmental Assessment and Procedure document dated January 2019, he lacked documentation of verification of Hot water storage area daily temperature checks, circulation pump installed on the water lines should be verification for proper operation, and that the hot water storage tank should be flushed at its lowest point at least quarterly. The Maintenance Director also lacked documentation that the Shower heads and tubs were periodically flushed and that the eye wash stations were flushed for 3 minutes monthly. He continued by stating he started employment at the facility in 2020 and that the previous Maintenance Director had already left. He further indicated he was never told he was on the Water Management Committee, nor had he attended meetings of that committee since his hire. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 11/2/22 at 9 AM identified that she had just started her employment at the facility on the previous day (11/1/22) and did not know why the Maintenance Director did not document the elements of the Environmental Assessment and Procedure document dated January 2019 as it was his responsibility. She continued by stating subsequent to inquiry, she reviewed the Environmental Assessment and Procedure document dated January 2019 and updated the Water Compliance Committee Members to include herself, the DNS, the Infection Control Nurse, the Director of Maintenance, and the Food Service Director on 11/1/22. The administrator also indicated she was currently working with the Director of Maintenance to ensure proper documentation will be completed in the future as outlined in Environmental Assessment and Procedure document dated January 2019. 4. Resident # 12's diagnoses included congestive heart failure, urinary tract infection and retention of urine. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #12 was cognitively intact and required supervision of one person for bed mobility transfer and personal hygiene. The MDS assessment further indicated Resident #12 required limited assistance of one person for toilet use and bathing. The Resident Care Plan (RCP) dated 10/27/2022 identified that Resident # 12 has a diagnosis of Congestive heart failure with interventions that include in part to monitor and record intake of food and fluids and to monitor and record output. The Resident Care Plan further indicated that Resident # 12 has a potential for fluid volume deficit related to use of a diuretic (water pill) with interventions that included in part, to monitor intake and output per MD order. Observation made on 10/31/2022 at 10:40 AM identified a white specimen collection device (urine Hat) sitting in the front part of the toilet seat to catch a sample for urine or to measure urine, was upside down on the bathroom floor near the trash can but in front of the toilet in Resident # 12's bathroom. It was also noted that there was no bag or other container to keep the urine collection device in when not in use. Observation and interview with LPN #1 on 10/31/22 at 2:30 PM identified the urine hat (white specimen collection device) upside down on the floor in Resident # 12's bathroom and LPN #1 indicated the hat should not have been on the floor and verbalized the resident does not need to use that anymore. LPN #1 further indicated that there should have been a bag available on the rail to place the hat in when not in used. LPN #1 removed the hat from the floor and placed it in the trash. On 11/1/22 at 9:30AM an interview with the Director of Nursing identified when she spoke to Resident #12 s/he indicated urine hat was on the floor because he/she did not want to use it. Interview with Resident #12 on 11/3/2022 at 11:50 AM indicated s/he does not use the toilet but instead use the commode at my bedside. Interview on 11/3/2022 at 12:15PM with RN # 3 indicated Resident #12 as of today would have urinary output measured and recorded and will use the urine hat collection device. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/3/2022 at 12:30 PM of Resident # 12's bathroom with a bag for the urine hat collection device attached to the handrail on the wall next to the toilet. 5. Resident #35's diagnoses included fracture of the left femur with routine healing, unspecified dementia, and chronic obstructive pulmonary disease (COPD). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #35 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen, indicating severe cognitive impairment and the resident required extensive assistance of a staff member with activities of daily living (ADL). A physician's order dated 10/24/22 directed to check Oxygen (O2) saturation and lung sounds every shift and to chart the results. Additionally, the physician's orders directed to apply O2 at 2 liters/minute via nasal cannula as needed. The Resident Care Plan (RCP) dated 10/24/22 identified the resident was diagnosed with COVID-19 which could cause severe illness by worsening the pre-existing condition of COPD. Interventions directed to check lung sounds every shift, document in the progress notes, to apply O2 if ordered by MD, and to change O2 tubing as ordered. The nurse's note dated 10/27/22 at 5:22 AM identified Resident #35's oxygen saturation was 87-89%, and O2 was administered at 2 liters/minute via nasal cannula. Subsequently, the resident's O2 saturation was 94%. Flow sheets for Resident #35 dated from 10/25/22 through 11/3/22 identified that his/her lung sounds ranged from clear to diminished. Observations on 10/31/22 at 10:40 AM identified Resident #35 was lying in bed with the head of the bed raised. The resident was dressed and had his/her eyes closed. An oxygen machine was noted at the beside and the resident's oxygen tubing was laying on the floor, unlabeled as to when it was last changed. Interview with LPN #2 indicated the facility's policy was to store oxygen tubing in a clean bag at the bedside. Further, the policy directed staff to change the tubing when stained, fell on the floor, and at least every week during the 11:00 PM -7:00 AM shift. LPN #2 indicated leaving it on the floor could cause spread of infection. Observations on 11/01/22 at 9:59 AM identified the resident was lying in bed, with his/her eyes closed. An oxygen machine remained beside his/her bed with the oxygen tubing unlabeled and on the floor. Review of facility Replace O2 tubing & Setup Policy directed in part: To replace O2 tubing for nasal cannula every week or as needed, to record date and initials on tape and label tubing and to place O2 tubing and accessories in a plastic bag when not in use. The facility failed to follow its policy on storage and labeling of oxygen tubing to ensure a sanitary oxygen delivery system and prevent the spread of infection. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5.: Resident # 54's diagnoses included Type 2 Diabetes, morbid obesity, Chronic Obstructive Pulmonary Disease (COPD), acute respiratory infection, pneumonia, and obstructive sleep apnea. The physician's orders dated 8/2/2022 in part directed to apply continuous Positive airway Pressure (CPAP) at bedtime at setting of 16 cmH2O) and to remove in the AM, to cleanse the CPAP mask with soap and water daily on 7-3 PM shift, to hand wash headgear with soap and water monthly and as needed. Admission Minimum Data Set, dated dated dated [DATE] identified Resident #54 was cognitively intact and required extensive assistance of one person for bed mobility, transfers, toilet use, personal hygiene, and bathing. The Resident Care Plan dated 8/31/2022 indicated in part that Resident #54 had an ineffective airway clearance related to COPD, asthma, and sleep apnea. Interventions included in part to administer medications and oxygen as ordered, observe for signs of ineffective airway clearance, monitor oxygen saturations, and assist with positioning for optimal breathing. The Resident Care Plan further indicated Resident #54 required Continuous Positive Airway Pressure (CPAP) machine at night due to obstructive sleep apnea. Interventions included in part to administer CPAP per physician's order, to clean the CPAP machine per orders, ensure appropriate setting prior to start of use and monitor respiratory status. Observation on 10/31/22 at 11:45 AM in Resident #54's bedside noted Resident #54 had a CPAP and an oxygen concentrator with attached tubing and mask that was noted on the floor under the bed. On 10/31/22 at 2:15 PM observation and interview with LPN # 1 indicated the tubing and CPAP mask should not have been on the floor, and they should have been labeled and in a bag. LPN #1 indicated that the equipment on the floor will need to be cleaned. The Facility Policy for maintaining CPAP, dated 11/1/2022 signed by the Director of Nursing, indicated CPAP units must be cleaned daily and disinfected weekly, run under warm water and dried before placing back into the unit and if the unit has a humidifier, it must be cleaned with soap and water every morning and allowed to air dry. 46046 46663

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 41223 Based on clinical record reviews, review of facility policy and interviews, the facility failed to obtain written signatures for consent or refusal of required vaccinations for 5 of 5 residents) reviewed for vaccinations (Resident #21, #25, #47, #63) and for (Resident #76 the facility failed to provide documentation of screening for eligibility and education provided for pneumococcal vaccination within accordance to facility practice and policy. The findings included: 1. a. Resident #21 was admitted to the facility on [DATE]. A Preventative Health report with a run date of 11/1/22 at 3:24 PM identified that from 3/8/22 to 11/1/22, Resident #21 refused the pneumococcal vaccination on 3/14/22. The report also identified that Resident #21 had received a COVID 19 booster shot at the facility on 4/11/22. b. Resident #25 was last admitted to the facility on [DATE]. A Preventative Health report with a run date of 11/1/22 at 5:46 PM identified that from 3/7/15 to 11/1/22, Resident #25 received the influenza vaccination on 10/28/20 and 10/28/21 as well as Covid 19 vaccinations on 9/30/22 10/8/21, 1/8/21, 1/29/21 at the facility. c. Resident # 47 was admitted to the facility on [DATE]. A Preventative Health report with a run date of 11/1/22 at 5:50 PM identified that from 5/30/17 to 11/1/22, Resident #47 received the influenza vaccination on 10/28/20 and 10/28/21, pneumococcal vaccination on 10/28/21 as well as Covid-19 vaccinations on 10/8/21, 1/11/21, 1/29/21 and 4/11/22 at the facility. d. Resident # 63 was admitted to the facility on [DATE]. A Preventative Health report with a run date of 11/1/22 at 3:22 PM identified that from 1/31/17 to 11/1/22, Resident # 63 received a pneumococcal vaccination on 2/4/20 and 10/8/21, Influenza vaccinations on 10/28/20 and 10/28/21, Covid 19 vaccinations on 1/11/21, 1/29/2, 10/8/21 at the facility. 2. Resident #76 was admitted to the facility on [DATE]. A Preventative Health report with a run date of 11/1/22 at 3:22 PM identified that from 1/31/17 to 11/1/22, Resident #76 received Covid 19 vaccinations on 8/12/22, 9/12/22. The medical record lacked documentation of screening for eligibility, education provided for pneumococcal vaccination. The facility was unable to provide documentation of a signed consent form and education for adverse side-effects of the medication as requested for Residents #21, #25, #47, #63 and #76 and additionally for Resident #76, the facility could not provide documentation of screening for eligibility and education provided for pneumococcal vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the RN #3, the infection control nurse, on 11/2/22 at 12:00 PM identified that it is the facility's policy that consent for vaccination can be obtained either by a written consent form signed by the resident or responsible party or obtained verbally from the resident or responsible party. She provided medical record progress note entries for Residents #21, #25, #47, #63 and #76 that identified that verbal consent and education was provided to each resident. She stated that the CDC vaccine information sheets were utilized to educate the Resident or responsible part prior to obtaining the consent or refusal. She continued by stating that she could not speak directly about the consent and education process for the identified residents as she had just stated in the role about 3 weeks ago. Interview with the DNS on 11/3/22 at 10 AM identified that it is the responsibility of the Infection Control nurse to educate and obtain consent either by written consent form signed by the resident or responsible part or obtained verbally from the resident or responsible party prior to administration of the vaccines. She indicated that per CDC guidance, signed consent forms were not required prior to vaccine administration of the vaccine to the resident. Interview with RN #3 (previous infection control nurse) on 11/3/22 at 11 AM identified that she was educated on vaccinations utilizing the CDC vaccine information sheets and received either consent or refusal for Residents #21, #25, #47, #63 and #76 verbally and documented the discussions in the resident's respective medical records prior to administration of a vaccination. She stated that for Resident #76, they were working with his/her decision maker and had not yet screened Resident #76 or gotten consent/refusal for the pneumococcal vaccination as there had been communication issues with Resident #76's decision maker. The facility policy, Vaccine administration directs in part that consent can be obtained by written or verbal consent from the resident or responsible part by an RN or verified by 2 nurses. This policy is not consistent with CMS requirements for consents.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 37721 Based on facility documentation, facility policy and interviews, the facility failed to ensure essential kitchen equipment was maintained in safe working condition. The findings include: Invoice for services performed dated 8/29/22 noted a problem with the control board with the display board being replaced. Recommendations were made at that time to replace the dishwasher. A quote dated 9/22/22 noted the cost of a new dishwasher. An observation on 10/31/22 at 10:05AM with the FSD identified the rinse cycle display on the high temperature dishwasher read 112 degrees. The company who services the facility dishwasher was called out after experiencing a problem with the control panel where temperature readings were displayed. The company came out and determined there was not an issue with the rinse temperatures, only in the display reading during the rinse cycle. Subsequent to surveyor inquiry, purchase order dated 11/2/22 for a new dishwasher was placed with a delivery date of 11/17/22. An interview on 11/03/22 at 1:31 PM with the Director of Maintenance identified all previous recommendations regarding replacement of the dishwasher were submitted to corporate for review and as he was unable to make independent decisions with corporate approval. Although a policy for maintaining essential kitchen equipment in safe working condition was requested, none was provided.