STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215058	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alice Byrd Tawes Nursing Home	201 Hall Highway Crisfield, MD 21817

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 47200 Based on observation, interview and record review it was determined the facility failed to ensure advance directives for a resident were maintained and readily retrievable by any facility staff in their medical record. This was evident for 1 (Resident #50) out of 4 residents reviewed for advanced directives during the facility's recertification survey. The findings include: On 11/13/24 at 8:51AM the surveyor observed and reviewed the medical record which included both the hard chart and electronic health record for Resident #50 which revealed that a living will and power of attorney was documented for the resident, however, no evidence of the living will or power of attorney documents could be found within the medical record of the resident. The surveyor noted upon review of the resident's Maryland Medical Orders for Life Sustaining Treatment form that it referred to the resident as having a healthcare agent, however, no advanced directives were present within the resident's medical record. On 11/14/24 at 10:43AM the surveyor reviewed the medical record which revealed a physician's note dated 2/26/24 which notated advanced directives counseling/discussion had occurred. On 11/14/24 at 11:33AM the surveyor conducted an interview with Social Worker (SW) #6. When the surveyor inquired during the interview as to why the resident's advanced directives were not located within their medical record, SW #6 stated the following to the surveyor: It was an oversight. SW #6 confirmed with surveyors that they had checked, and the resident's advanced directive was not in their medical record. At this time, the surveyor shared their concern with SW #6 who acknowledged and confirmed understanding of the concern. On 11/20/24 at approximately 4:15PM during the exit conference, the surveyor again shared the concern.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER: Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 Hall Highway Crisfield, MD 21817	

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 49304 Based on review of the medical record and interview with facility staff, it was determined that the facility failed to document in the medical record when the determination was made that a resident met the criteria for a Significant Change in Status Assessment (SCSA). This was evident for 1 (Resident #24) out of 33 residents reviewed during the recertification survey. The findings include: A Significant Change in Status Assessment (SCSA) is a comprehensive assessment that must be completed within 14 days after the Interdisciplinary Team (IDT) has determined that a resident meets the guidelines for significant change for either major improvement or decline. On 11/18/24 at 8:09AM review of the facility's Change in a Resident's Condition or Status policy revealed, A significant change of condition is a major decline or improvement in the resident's status that: a.Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b.Impacts more than one area of the resident's health status; c.Requires interdisciplinary review and/or revision to the care plan; and d.Ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument (a process to ensure residents receive the highest quality of care and can maintain the highest quality of life). The policy also indicated that, the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. On 11/18/24 at 4:38PM review of Resident #24's medical record revealed a SCSA dated 10/11/21. There was no evidence in the medical record indicating when the IDT determined that the resident met the criteria for a significant change. On 11/18/24 at 4:58PM in an interview with MDS Coordinator #11, when asked to show documentation where Resident #24 met the criteria for significant change, she asked if the surveyor was referring to the 10/11/2021 SCSA and stated she could not find anything to determine Resident #24 met the criteria for a significant change assessment. On 11/19/24 at 12:19 PM in an interview with the Director of Nursing she stated there is no documentation showing the resident met the criteria for a significant change on 10/11/2021.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 14894 Based on review of reporting data, clinical records and interview it was determined that the facility staff failed to ensure assessments were sent to the Centers for Medicare and Medicaid Services as required. This was evident for 4 (#11, #51, #56, and #69) out of the 7 residents reviewed for late reporting. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. A review of seven residents' clinical records was conducted secondary to the survey process triggering this task for missing resident assessments. Records for Residents #11, #51, #56, #62, #63, #67, and #69 were reviewed on 11/20/24. The electronic health records revealed that some of the residents had an assessment that was listed as in progress. The MDS director was interviewed on 11/20/24 at 9:39 AM. She was provided with the names of the residents and the survey team requested the validation report for the submission of the MDS assessments. She wrote down the names of the residents and said she thought most of the assessments were late then added that she knew a couple of these were definitely late. A review of the Validation report revealed that Resident #11's discharge MDS was still in Progress and not transmitted. Resident #51 had a discharge MDS that is also in Progress and not transmitted. Resident #56 had a discharge MDS that is in Progress and not transmitted. Resident #69 had a discharge MDS that was in progress but not transmitted. The facility administrative staff were informed of the deficiency at the exit conference.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51213 Based on review of medical records and interview with facility staff, it was determined that the facility failed to provide a baseline care plan summary to residents and/or resident's representative within 48 hours after admission. This was evident for 6 (#57, #8, #19, #36 # 30, and #10) out of 12 residents reviewed for baseline care plans during the recertification survey. The findings include: A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP as well as a list of the resident's current medications must be given to each resident and/or his/her representative. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. 1.) On 11/18/24 at 3:15PM the DON was asked for a copy of Resident # 10's Baseline Care Plan along with Resident #30 and Resident #36. On 11/19/24 05:00PM The DON was asked to provide documentation to show that the resident/resident representative were presented with their Baseline Care Plan and given a written copy of their Baseline Care Plan within 48 hours of admission. The DON acknowledged that they do not have any documentation to verify that the resident/resident representative were presented with a written copy of their Baseline Care Plan within 48 hours of admission. On 11/19/24 at 6:00PM a paper copy of their Baseline Care Plan was reviewed and showed that Resident #36 was admitted on [DATE] and their Baseline Care Plan was completed on 8/15/2024. Further record review showed that the Baseline Care Plan had no signature for staff and no signature for the resident/resident representative that acknowledged that they had been given a written copy of their Baseline Care Plan within 48 hours after being admitted On 11/19/24 06:07PM a paper copy of the Baseline Care Plan was reviewed and showed Resident #30 was admitted on [DATE]. Further record review showed that the Baseline Care Plan had no signatures for staff or for when the Baseline Care Plan was completed and no signature for when the Baseline Care Plan was reviewed with the resident/resident representative and when the resident/resident representative received a written copy of their Baseline Care Plan. On 11/19/24 6:12PM a paper copy of the Baseline Care Plan was reviewed and showed that Resident #10 was admitted on [DATE] and the Baseline Care Plan was completed on 6/21/2018. Further record review showed that the Baseline Care Plan had no signature for staff and no signature for the resident/resident representative that acknowledged that they had been given a written copy of their Baseline Care Plan within 48 hours after being admitted . 49304 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 201 Hall Highway Crisfield, MD 21817	

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) On 11/15/24 at 10:54 AM, review of Resident #57's medical record revealed an admitted [DATE]. Further review of the medical record revealed the first care plan initiated for this resident was dated 4/25/23, however there was no documentation that the resident received a BLCP summary including a summary of the resident's medications. The surveyor requested a BLCP summary for Resident #57. On 11/15/24 at 11:04 AM, the SW was interviewed. During the interview, she stated that all residents should be given copies of their BLCPs within 48 hours. On 11/15/24 at 12:38 PM the Director of Nursing (DON) provided a copy of Resident # 57's BLCP dated 4/25/23. The field where it stated Resident signature and date on page 8 of 9 was blank/empty. The surveyor requested documentation that the resident received a summary of his/her BLCP including a list of his/her medications. On 11/15/24 at 1:05 PM in an interview with the DON she stated, No, there is no documentation that Resident #57 received his/her BLCP, including a list of their medications. We do have residents sign their Baseline Care Plans now, but no, there is no documentation Resident #57 received his/her BLCP summary. 3.) On 11/15/24 at 12:15 PM Resident #19's medical record was reviewed. The review included an admitted [DATE], however, no note or other documentation could be found that stated the resident had received a summary of his/her BLCP. The surveyor requested documentation that the resident received a summary of his/her BLCP including a list of their medications. On 11/15/24 at 1:05 PM in an interview with the DON she stated, no, there is no documentation that Resident #19 received their BLCP summary, including a list of their medications. 4.) On 11/15/24 at 11:52 AM review of Resident #8's medical record revealed an admitted admitted [DATE]. Upon further review, there was no documentation that the resident received a BLCP summary. The surveyor requested documentation that the resident received a summary of his/her BLCP summary including a list of their medications. On 11/15/24 at 1:05 PM in an interview with the DON she stated, no, there is no documentation that Resident #8 received their BLCP summary, including a list of their medications.

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NAME OF PROVIDER OR SUPPLIER Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hall Highway Crisfield, MD 21817	

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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. 47200 Based on observation, record review and interview it was determined the facility failed to ensure a resident's care plan was comprehensively developed and person centered. This was evident for 1 (Resident #50) out of 1 resident reviewed for activities during the facility's recertification survey. The findings include: On 11/12/24 at 11:27AM the surveyor observed residents of the unit engaged in the community area, however, Resident #50 was observed to be in their bed awake with no activity materials observed within reach of the resident. On 11/13/24 at 9:18AM the surveyor observed Resident #50 in bed sleeping, and no activity materials were observed within reach of the resident. On 11/14/24 at 10:59AM the surveyor reviewed the medical record which revealed the resident had the following incomplete care plan intervention dated as initiated beginning on 3/14/24 for activities: Provide the resident with materials for individual activities as desired. The resident likes the following independent activities: (SPECIFY). On 11/14/24 at 11:01AM the surveyor conducted an interview with Activities Coordinator #27 who confirmed that Resident #50 prefers specific individual activities rather than participating in group activities. At this time, the surveyor shared their concern with Activities Coordinator #27 who observed the resident's incomplete care plan intervention and acknowledged and confirmed understanding of the concern and further reported that they would be revising the care plan intervention to include the resident's individualized preferences. The surveyor subsequently shared their concern with the facility's Administrator who confirmed understanding of the concern. On 11/20/24 at approximately 4:15PM during the exit conference, the surveyor again shared the concern.

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NAME OF PROVIDER OR SUPPLIER Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hall Highway Crisfield, MD 21817	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on resident interview, review of the medical record, and interview with facility staff, it was determined that the facility failed to hold care plan meetings for residents and/or their representatives at the time of their admission. This was evident for 1 (Resident #18) out of 33 residents reviewed during the recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 11/13/24 at 11:49 AM in an interview with Resident #18 she stated she had attended a care plan meeting since her admission to the facility. On 11/13/24 at 12:08PM review of the resident's paper chart did not reveal any documentation that care plan meetings had occurred. On 11/14/24 at 10:07AM review of Resident #18's medical record revealed the resident was admitted on [DATE] and that the resident had an admission MDS assessment completed on 2/12/24. Further review of the medical record revealed 2 care plan meeting notes. One was dated 5/29/24 and the other note was dated 8/29/24. There was no evidence in the medical record that a care plan meeting had been held with the resident and/or resident representative and the interdisciplinary team around the time of the admission MDS assessment. The surveyor interviewed the MDS Coordinator #11 on 11/14/24 at 11:49AM. During the interview, the MDS Coordinator #11 stated, yes, she was the staff member responsible for coordinating care plan meetings with residents and/or their resident representative. During the interview she stated, no, there was not a care plan meeting held in February 2024 for Resident #18. In addition, she stated, she looked in her calendar and saw she did not schedule it, and that it looked like it just got missed. The surveyor requested that the MDS Coordinator #11 provide the survey team with any evidence that a care plan meeting had taken place for Resident #18 around the time of the admission MDS assessment in February 2024. No such records were provided to the survey team by the time of survey exit.

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NAME OF PROVIDER OR SUPPLIER Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hall Highway Crisfield, MD 21817	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47200 Based on observation, interview and record review it was determined the facility failed to: 1) ensure and monitor the implementation of fall interventions, and 2) monitor for effectiveness of fall interventions. This was evident for 1(Resident #25) out of 2 residents reviewed for accidents during the facility's recertification survey. The findings include: On 11/13/24 at approximately 9:18AM the surveyor observed Resident #25, who was awake and laying in their bed. Upon interview of Resident #25 they expressed to the surveyor that they wanted to get up out of their bed and did not understand why they ate breakfast in their room instead of in the dining area. On 11/19/24 at 12:20PM the surveyor reviewed the medical record of Resident #25 which revealed they had extensive fall history, including four recent falls in October 2024. Review of the resident's care plan revealed the resident was at high risk for falls, and after a fall on 10/15/24 and a fall on 10/18/24, the following intervention was not implemented until 10/24/24 and was to currently be in place: low bed with mat when in bed. Review of the resident's medical record additionally revealed, that after 10/24/24, the resident had sustained two falls on 10/31/24 in which they were found on the floor. Observation by the surveyor of the resident's room on 11/19/24 at 12:24PM revealed there was no fall mat in place. On 11/19/24 at 12:25PM the surveyor observed the second floor nursing unit dry erase board information which documented that Registered Nurse (RN) #31 was assigned to the care of Resident #25 for the current shift. At this time, the surveyor inquired to RN #31 as to if they were familiar with Resident #25, and what fall precautions were currently supposed to be in place for them, to which they responded: I don't know the resident well, I would have to ask my supervisor. When the surveyor inquired to RN #31 as to if they were assigned to the care of Resident #25, they reported to the surveyor that they had to check and see if the resident was assigned to them. The surveyor observed RN #31 check their computer system, who then confirmed with the surveyor that they were assigned to the care of Resident #25. At this time, the surveyor shared their concern with RN #31 who observed and acknowledged the surveyor's concern, and the surveyor requested for the Director of Nursing (DON) to conduct a dual observation of the concern. On 11/19/24 at 12:30PM the surveyor conducted an interview with Licensed Practical Nurse #32 who confirmed with the surveyor that a fall mat should be in place and remain on the side of the bed that is not next to the wall, and that staff do not have to go retrieve a mat from anywhere when they put a resident who requires a fall mat into bed. On 11/19/24 at 12:33PM the surveyor conducted a dual observation with the facility's DON who observed the concern. The surveyor observed the DON look through the room to ensure there was no fall mat anywhere. At this time, the surveyor conducted an interview with the DON who acknowledged and confirmed understanding of the surveyor's concern and stated the following: There's no fall mat, it should be within the room and it's not. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hall Highway Crisfield, MD 21817	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 12:36PM the surveyor conducted an interview with Geriatric Nursing Assistant #33 who reported the following to the surveyor regarding fall mats: I don't usually deal with that, I think maintenance gets it for us, usually they're just on the floor. On 11/19/24 at 12:38PM the surveyor continued to observe there was no fall mat in place in the room of Resident #25. On 11/19/24 at 2:14PM, after surveyor intervention, review of the medical record revealed the pre-existing medical order dated as beginning on 10/24/24 for the fall mat was now discontinued, and a new order for a fall mat to be in place was ordered beginning 11/19/24. Additionally, a nursing note created on 11/19/24 at 12:54PM was observed documented by RN #31 which did not include information regarding intervention by the surveyor. Until surveyor intervention, sign off documentation was observed to be signed off on the October and November treatment administration records indicating the fall mat had been in place for the resident. The surveyor subsequently shared the concern with the facility's Administrator who acknowledged and confirmed understanding of the concern. On 11/20/24 at approximately 4:15PM during the exit conference, the surveyor again shared the concern.

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NAME OF PROVIDER OR SUPPLIER Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hall Highway Crisfield, MD 21817	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on observation, interview and record review it was determined the facility failed to ensure the implementation of a nutrition intervention for a resident to prevent further weight loss. This was evident for 1 (Resident #53) out of 3 residents reviewed for nutrition during the facility's recertification survey. The findings include: On 11/12/24 at 12:07PM the surveyor observed Resident #53 to be laying in bed awake, positioned at approximately a thirty degree angle with their lunch meal on the bedside tray table which was positioned over the bed. On 11/13/24 at 11:35AM the surveyor reviewed the medical record of Resident #53 which revealed that upon admission on 9/11/2024, they weighed 114.2 lbs. and on 11/07/2024, they weighed 103.9 lbs. indicating weight loss of the resident. Review of the physician's documentation revealed the resident had been losing weight prior to admission to the facility. On 11/15/24 at 9:31AM during review of the medical record of Resident #53 the surveyor reviewed section GG of the admission minimum data set (a standardized assessment tool used to evaluate residents) which revealed documentation dated 9/18/24 which coded the resident as needing partial/moderate assistance for eating upon admission to the facility. Review of a nutrition note dated 10/11/24 by Dietician #19 revealed they documented the following information: Nursing reports resident ate 100% when s/he was fed, Communicated with DON (Director of Nursing) and s/he will be continued to be fed by staff at mealtimes. Further review of the medical record revealed a quarterly nutrition assessment dated [DATE] which documented the following regarding the resident's feeding ability: Unable to feed self and must be assisted or supervised throughout the meal/snack. Review of the resident's care plan revealed the following intervention was documented on 9/11/24 upon their admission: S/he is dependent on staff for bathing and dressing, setup meals and assist to max intake as needed. On 11/18/24 at 12:15PM the surveyor conducted an observation of Resident #53 who was observed to be laying in bed repeatedly attempting to bring a cup and then a container (magic cup) to their mouth without eating or drinking the contents. Closer observation of the resident revealed the cup was empty and the container had a paper lid on it. Liquid was observed to be spilled adjacent to the bed. As the resident was picking up the magic cup container (nutritional supplement) they stated the following to the surveyor: Can't get it open, gosh, can't do that, I'll soon give up, it would be easier to try to get into this. The resident was observed raising their drink cup to show the surveyor and verbalized the following information: Can't get anything out of here. The surveyor observed that the resident had not yet consumed any of the lunch food items on their tray. On 11/18/24 at 12:23PM the surveyor conducted an interview with Registered Nurse (RN) #4. When the surveyor inquired as to the process of how staff ensure all residents receive feeding assistance at mealtime, they reported to the surveyor: The geriatric nursing assistants (gna's) are each assigned a group of residents, this group is heavy, they just figure it out amongst themselves, if I see somebody that needs to be fed I'll jump in today. RN #4 further reported that staff look and make sure the residents have been fed at clean up time. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 12:26PM the surveyor requested a dual observation of Resident #53 with RN #4. Upon entry to the room, RN #4 observed and verbalized that the resident's tea was spilled and was observed obtaining supplies and cleaning up the spill and retrieving another tea for the resident to drink. At 12:28PM Resident #53 was observed grabbing their magic cup and packaged cookies, however, they were unable to open the packaging. The surveyor shared their concerns with RN #4 who acknowledged and confirmed understanding of the concerns. On 11/18/24 at 12:32PM the surveyor observed Resident #53 accepting food while being provided with physical assistance for feeding by RN #4. On 11/18/24 at 12:37PM the surveyor reviewed the medical record for Resident #53 which revealed that documentation had not yet been recorded on the task list for either the breakfast or the lunch meal for 11/18/24. On 11/18/24 at 12:39PM the surveyor conducted an interview with Geriatric Nursing Assistant #28 who confirmed with the surveyor that the facility's expectation for documentation of amounts eaten and the resident's level of feeding assistance provided was expected to be documented at each meal, prior to the next meal occurring. On 11/18/24 at 12:53PM the surveyor conducted an interview of RN #4 who reported to the surveyor that Resident #53 had consumed all supplements including the ensure and magic cup, ate their cheeseburger, and some of their cookie. On 11/18/24 at 12:55PM the surveyor observed the resident's food tray in the food cart which confirmed the resident had eaten 100% of their supplements and 100% of their cheeseburger. On 11/18/24 at 12:58PM during an interview with the Director of Nursing (DON) they stated to the surveyor that the staff are provided with a paper cheat sheet that is updated by them after risk meetings are held. The DON observed the current cheat sheet and reported that it directed the staff to cue and feed as needed, but this was not the most current recommendation. The DON stated the following: I'm going to edit this right now. When the surveyor inquired as to the resident's care plan intervention which did not reflect the most current level of feeding assistance required, the DON reported the intervention should be updated on the care plan at the time of the change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hall Highway Crisfield, MD 21817	

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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. 51213 Based on observations, interviews and medical record reviews it was determined that the facility failed to 1) label the oxygen tubing and humidifier bottle and 2) failed to follow the physician's orders to label the oxygen tubing and humidifier when changed. This was evident for one (Resident #30) of one resident reviewed for respiratory care during the recertification survey. The findings include: A nasal canula is a plastic tube that delivers oxygen into a resident's nostrils. On 11/13/24 at 12:00 PM the surveyor observed Resident #30 with oxygen 2 Liters nasal cannula in her nose. It was observed that the oxygen tubing and the humidifier bottle had not been labeled with the date and time it was placed. On 11/14/24 at 11:32 AM the surveyor observed Resident #30 with oxygen 2 Liters nasal cannula in her nose. It was observed that the oxygen tubing and the humidifier bottle had not been labeled with the date or time it was placed. On 11/14/24 at 11:35 AM Staff #24, Licensed Practical Nurse (LPN), was interviewed regarding who changes the oxygen tubing and humidifier and when is it changed. LPN #24 replied that the night nurse changes the oxygen tubing and humidifier and stated, I am not sure how often the tubing is changed, but I think it is monthly. But you can ask a regular staff nurse. At the time of the interview LPN # 24 was shown that the oxygen tubing and humidifier bottle had not been labeled with the date and time. LPN #24 acknowledged that the oxygen tubing and humidifier bottle were not labeled. On 11/14/24 at 11:40 AM Staff #25, LPN Charge Nurse for the second and third floor, was interviewed about when oxygen tubing and humidifiers are changed. LPN #25 replied that the oxygen tubing gets changed every Sunday night by the night shift nurse along with the nebulizer or concentrator. When a resident is on oxygen there should be an order for the oxygen and when to change the oxygen tubing. When the tubing and humidifier have been changed by the night nurse, the nurse signs off that the oxygen tubing was changed on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). On 11/14/2024 01:00 PM the TAR was reviewed. The order on the TAR was to change oxygen tubing and humidifier every 2 weeks and PRN (as needed) on Sunday nights 7P-7A. Label O2 (oxygen) tubing and canister with the date and time. Start date of order was 8/26/24.

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NAME OF PROVIDER OR SUPPLIER Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hall Highway Crisfield, MD 21817	

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 47200 Based on observation and interview it was determined the facility failed to post required staffing information. This was evident for 3 out of 3 floors of the facility during the recertification survey. The findings include: On 11/12/24 at approximately 10:15AM surveyors entered the building for the facility's recertification survey and upon entering, no staffing information was observed posted on the first floor. On 11/12/24 at 11:47AM the surveyor conducted a tour of the facility's second floor nursing unit. Observation of a dry erase board on the unit revealed there was no facility name displayed, the following date was observed: November 1, 2024, there was no total number of staff displayed, and no actual hours worked listed by category for 7 out of 11 nursing staff. No other postings of staffing information were observed to be present on the unit. On 11/12/24 at 12:04PM the surveyor conducted a tour of the facility's third floor nursing unit. Observation of a dry erase board on the unit revealed there was no facility name displayed, there was no total number of staff displayed, and no actual hours worked listed by category for 10 out of 13 nursing staff. No other postings of staffing information were observed to be present on the unit. On 11/19/24 at 3:35PM the surveyor conducted an interview of the facility's Director of Nursing (DON) who stated the following information in response to the surveyor's sharing of the concern: We have a staffing binder on the second floor nursing station that is supposed to be on the counter. At this time, the DON confirmed with the surveyor that there were no postings of staffing information in the building occurring except on the dry erase board, and one was located on each unit (2nd and 3rd floors). On 11/19/24 at 3:36PM the surveyor conducted an interview of Front Desk Receptionist #26 who confirmed that there was no staffing information that was posted on the first floor. On 11/19/24 at 3:38PM the surveyor conducted an observation of the second floor nursing station and staffing schedule sheet binders were observed to be out of reach behind the nursing counter, in the office area. At the time of the observation, the surveyor again interviewed the DON who reported the following information to the surveyor: We have these binders and the staffing board on the units, no paper copies are posted anywhere, just the boards and binders. The surveyor subsequently shared the concern with the facility Administrator who acknowledged and confirmed understanding of the concern. On 11/20/24 at approximately 4:15PM during the exit conference, the surveyor again shared the concern.

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NAME OF PROVIDER OR SUPPLIER Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hall Highway Crisfield, MD 21817	

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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. 49304 Based on observation, record review, and interview with facility staff, it was determined that the facility 1) failed to ensure monthly Medication Regimen Reviews were completed by the pharmacist and 2) failed to respond to recommendations made by consulting pharmacists in a timely manner. This was evident for 1 (Resident #18) out of 5 residents reviewed for unnecessary medications during the recertification survey. The findings include: A Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen (plan) of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medications. The MRR includes review of the medical record to identify, report, and resolve medication-related problems, errors, and/or other irregularities. 1) On 11/14/24 at 9:49AM, the surveyor reviewed the medical record for Resident #18 which revealed on 8/29/24, Pharmacist #17 documented in the Chronological Record of MRR in the resident's paper chart, TSH low: decrease levothyroxine. On 11/14/24 at 10:56AM the surveyor requested copies of the last three months of medication regimen reviews and pharmacy recommendations for Resident #18 from the Director of Nursing (DON.) On 11/15/24 at 8:58AM the surveyor noted the above documentation requested was not received and made a second request to the Licensed Nursing Home Administrator (LNHA). On 11/15/24 at 9:35AM in an interview with the LNHA she stated she did not see a pharmacy recommendation for August for Resident #18. On 11/15/24 at 10:12AM in an interview with the LHNA she stated we have no formal recommendations (and she clarified formal recommendation to be the document titled Note to Attending Physician/Prescriber) for Resident #18 for August 2024 from Pharmacist #17. When showed the Chronological Record of MRR and asked why there is not a formal recommendation for Resident #18 from the month of August, she stated we do not have one because she [Pharmacist #17] never sent it to us. She [Pharmacist #17] comes to the facility, reviews all the residents' medications, makes recommendations (if necessary), inputs them into her software which generates a Note to Attending Physician/Prescriber, and then emails them to myself and the DON. On 11/15/24 at 11:02AM, the DON provided the surveyor with a screenshot she said she received from Pharmacist #17 showing her history of recommendations made and sent to the facility for Resident #18. There was no recommendation for the month of August 2024. On 11/18/24 at 12:33PM in an interview with Pharmacist #17 when asked if she made any recommendations for Resident #18 in August 2024, she stated she does not have an entry for Resident #18 for August 2024. During the interview when asked for an explanation, she stated she does not know why. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alice Byrd Tawes Nursing Home	201 Hall Highway Crisfield, MD 21817

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 3:29PM in an interview with the LNHA, when asked what process/system was in place to ensure the facility received all the pharmacy recommendations from the consulting pharmacist for a specific month, she stated there is not currently a system for knowing which pharmacy recommendations we should be receiving monthly. During the interview she stated, starting next month and moving forward Pharmacist #17 will send a monthly summary report to ensure we are aware of all the pharmacist's recommendations we should be receiving for a given month. 2) The medical record for Resident #18 was reviewed on 11/14/24 at 9:49AM. The review revealed on 9/29/24, Symbicort dose: increase puffs. On 11/14/24 at 10:37AM in an interview the DON when asked about the facility's MRR process, she stated, the pharmacy consultant, Pharmacist #17, comes to the facility monthly, reviews residents' medications and medical records, make any necessary recommendations, emails those recommendations to the LNHA and DON, and then we print them out. The Clinical Supervisor #3 gives the recommendations to the doctors and rounds with them. The doctors either agree or disagree with Pharmacist #17's recommendations and if they disagree, they must document their reason. During the interview, she stated it is the expectation that the provider checks one of the boxes (agree, disagrees, or other) and provides a rationale if they disagree with the pharmacist's recommendations. On 11/14/24 at 10:56AM the surveyor requested copies of the last three months of medication regimen reviews and pharmacy recommendations for Resident #18 from the Director of Nursing (DON.) On 11/15/24 at 8:58AM the surveyor noted the above documentation requested was not received and made a second request to the Licensed Nursing Home Administrator (LNHA). On 11/15/24 at 9:43AM in an interview with the LNHA she stated the September 2024 pharmacy recommendation was not addressed. The surveyor made a third request for the documentation. On 11/15/24 at 10:12 AM in an interview with the LHNA she provided a copy of the Note to Attending Physician/Prescriber, for Resident #18 with a documented MRR date of 9/29/24. The note stated, Dear Dr. [Physician #15], Resident is on Symbicort Inhalation Aerosol 160-4.5mcg- 1puff orally twice daily for bronchiectasis. Manufacturer recommends administration of 2 puffs not one for appropriate therapy in both asthma and COPD. Please change to Symbicort Inhalation Aerosol 160-4.5mcg- administer 2 puffs twice daily. Under the Physician/Prescriber Response heading, none of the 3 response boxes [agree, disagree, other] were checked and the Signature and Date fields were blank. The LNHA was interviewed on 11/18/24 at 12:21PM. When asked the facility's timeline for the physician/provider to respond to the pharmacist's recommendations she stated within 7-14 days. During the interview when asked why the 9/29/24 pharmacist's recommendation to increase Resident #17's Symbicort had not been responded to, she stated she could not say but could find out now if Physician #15 wanted to act upon that recommendation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hall Highway Crisfield, MD 21817	

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 1:11PM in an interview with the LNHA she stated there was no documentation anywhere else in Resident #18's medical record that the 9/29/24 pharmacist recommendation was addressed by Physician #15, so he did respond, sign, and date it today, 11/18/24. During the interview the LNHA provided a copy of the pharmacy recommendation with the disagree box checked, a rationale for the disagreement, and the doctor's signature and date (11/18/24). When asked if the 9/29/24 pharmacy recommendation was responded to within the facility's timeframe, she stated, no, it was not. The 9/29/24 pharmacy recommendation was not addressed until surveyor intervention, 82 days after the recommendation was made.

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NAME OF PROVIDER OR SUPPLIER Alice Byrd Tawes Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Hall Highway Crisfield, MD 21817	

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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. 51213 Based on observations and interviews, it was determined that the facility failed to properly store, date, and label food items to prevent food from being served that may be unsafe to eat and to prevent cross contamination. This was evident by the initial kitchen observations of the facility's dessert freezer during the recertification survey. The findings include: On 11/12/24 at 10:55 AM during the initial kitchen observation the surveyor entered the kitchen and spoke with the Food Service Supervisor (FSS) #22. Together a walkthrough of the refrigerator and freezers was conducted. During the inspection of the freezer, which had frozen desserts inside, the surveyor noticed a large full bag of brownies in a clear Ziplock bag and a large full bag of cookies in a clear Ziplock bag. This was brought to FSS #22's attention and they removed the bags of brownies and cookies and placed them on a stainless-steel counter in front of the dessert freezer. When asked how long the brownies and cookies had been in the freezer, FSS #22 said: I am not sure. FSS #22 then called over Dietary Aide #23 in charge of desserts, and asked Dietary Aide #23 about the Ziplock bags with brownies and cookies with no date and label. Dietary Aide #23 said the cookies and brownies were from yesterday and proceeded to label and date the Ziplock bags of brownies and cookies. During the initial kitchen observation, a blue rag in a clear Ziplock bag was also observed in the dessert freezer on the middle shelf. This blue rag in the clear Ziplock bag was shown to FSS #22 and the surveyor asked them what this was, and FSS #22 stated they were not sure. FSS #22 then asked Dietary Aide #23 what the blue rag in the Ziplock bag was doing in the dessert freezer. Dietary Aide #23 stated: I do not know. FSS #22 removed the blue rag in the clear Ziplock bag from the dessert freezer. On 11/19/24 at 12:00 PM the Food Receiving and Storage policy was received from the Food Service Director #30. Their facility policy stated that all foods stored in the refrigerator or freezer are covered, labeled and dated with a (use by date).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215058	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alice Byrd Tawes Nursing Home	201 Hall Highway Crisfield, MD 21817

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on record review and interview with facility staff, it was determined that the facility failed to ensure all employees' required immunizations and screenings were up to date, as it relates to infection prevention and control. This was evident for 2 (GNA #34 and LPN #35) of 5 employees reviewed during the recertification survey. The findings include: On 11/20/24 at 2:40PM, 5 employees' files were reviewed by the survey team. The review included TB screenings and immunizations and revealed Geriatric Nursing Assistant (GNA #34) did not have a documented TB screening on file and Licensed Practical Nurse (LPN #35) did not have a documented Tdap [tetanus, diphtheria, and pertussis (whooping cough)] immunization on file. The survey team requested documentation of these screenings and immunizations. On 11/20/24 at 3:25PM in an interview with the Licensed Nursing Home Administrator (LNHA), she stated employee health does not require Tdap for their employees, just for the pediatric unit, but she would change that now. During the interview, she stated any documentation for proof of TB screenings or immunizations we have not brought you, we do not have. On 11/20/24 at 3:58PM review of the Employee Health Procedures revealed, III. TUBERCULOSIS (TB) SURVEILLANCE AND PREVENTION Two-step TB testing is required of all new team members. Previously positive new team members must submit recent (within the last year) chest X-Ray results and symptoms questionnaire. TB assessment and/or testing is repeated annually for all team members. Team members are also re-tested after unprotected exposure to infectious TB. Further review of the facility's policy revealed, VII. TETANUS-DIPTHERIA-PERTUSSIS All new team members and those assigned to high risk areas (Mother Baby, SCN, Peds, Labor & Delivery, Child Care, ED, ICU, Respiratory, [NAME] Nursing Home) are required to have a single dose of Adult Tdap given at greater than or equal to [AGE] years of age AND after May 2005 (date of FDA licensure). Pediatric Tdap given less than [AGE] years of age or before May 2005 will not be accepted.