STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295011	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Lyon Medical Center	213 Whitacre St Yerington, NV 89447

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 46301 Based on interview and document review, the facility failed to ensure pertinent State agencies and advocacy groups contact information posted in the facility were in a language understandable to residents. Findings include: On 07/16/2024 between 10:30 AM and 11:00 AM, during the Resident Council Interview, one of seven residents verbalized through a translator device, they were not aware of where the State agencies and advocacy groups contact information was located. This resident only read and spoke Spanish. On 07/16/2024 at 2:45 PM, the Director of Nursing verbalized none of the postings were understandable for the resident who read and spoke only Spanish. The DON confirmed the postings should be in a language understandable to the resident. The facility policy titled Resident Communication Rights, revised 07/2015, documented residents had the right to receive communication orally and in writing, including Braille or in a format and language the resident understands.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident was protected from resident-to-resident verbal abuse and harassment for 1 of 12 sampled residents (Resident #16). Findings include: Resident #16 Resident #16 was admitted to the facility on [DATE], with diagnoses including adjustment disorder with anxiety and chronic obstructive pulmonary disease. Resident #15 Resident #15 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and nutritional anemia, unspecified. On 07/16/2024 at 10:43 AM, Resident #16 verbalized a resident had been harassing them and calling them names. On 07/16/2024 at 11:04 AM, Resident #15 verbalized they believed Resident #16 had stolen a picture out of their room. The resident explained they believed Resident #16 must be gay because they took the picture. Resident #15 verbalized they called Resident #16 gay because they knew Resident #16 did not like it. Resident #15 laughed and verbalized they knew Resident #16 was having sex with male members of the surrounding community. On 07/16/2024 at 11:26 AM, Resident #16 verbalized Resident #15 had been harassing them. Resident #16 explained Resident #15 had started accusing Resident #16 of stealing a picture out of their room. Resident #16 had never seen the picture and did not think it existed. Resident #16 verbalized Resident #15 called Resident #16 slurs such as a whore, slut, thief. Resident#16 verbalized whenever they entered a room with Resident #15 present, Resident #15 would remark Oh, there Resident #16 is. The resident recalled Resident #15 would say it in an unwelcoming tone. Resident #16 recalled they informed the Director of Nursing (DON) of Resident #15's harassment. The DON told Resident #16 to try to get along with Resident #15 and to be the bigger person because of Resident #15's mental state and decline. Resident #16 verbalized they felt embarrassed when Resident #15 called them a thief and slut. Resident #15 often called Resident #16 names in front of other residents. Resident #16 felt it was very offensive when Resident #15 accused them of stealing. The resident did not want Resident #15 hounding them. Resident #15 would go 'on and on and Resident #16 just wanted it to stop. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #16 recalled Resident #15 would go into Resident #16's room to search for the picture and accuse Resident#16 of stealing. Resident #16 verbalized they felt tormented by Resident #15. Resident #16 explained they tried to avoid areas where Resident #15 frequented, however it was hard because they lived in a small area. On 07/16/2024 at 3:19 PM, an Observation Aide verbalized a few months ago they witnessed Resident #15 accuse Resident #16 of stealing a picture. The Observation Aide attempted to redirect Resident #15, but Resident #15 did not want to redirect. Resident #15 continued to insist Resident #16 had the picture, and then began to call Resident #16 a faggot and said they were gay. The Observation Aide told Resident #15 it was not nice to call Resident #16 names. Resident #15 continued to call Resident #16 gay slurs in the presence of the Observation Aide. The Observation Aide informed the nurse of Resident #15's verbal outbursts. The Observation Aide considered the name calling to be verbal abuse. On 07/16/2024 at 3:30 PM, an Activity Aide (AA1) verbalized Resident #15 did not get along with Resident #16. The AA1 witnessed a verbal altercation in the hallway a couple of months ago between Resident #15 and Resident #16. Resident #15 was accusing Resident #16 of stealing a picture. Resident #15 called Resident #16 a [NAME]. On 07/16/2024 at 3:36 PM, an AA2 verbalized when Resident #16 walked into a room where Resident #15 was present, Resident #15 would remark oh no, here they come. Resident #15 would often barge into whatever room Resident #16 was in to call them names. The AA2 explained they felt it was harassment because it happened often and Resident #15 was always instigating. One time, the AA2 heard Resident #15 saying leave me alone, I don't have your picture. The AA2 had to physically redirect Resident #15 away from Resident #16. On 07/16/2024 at 4:08 PM, an AA3 verbalized Resident #15 would go into Resident #16's room and instigate. The AA3 explained Resident #15 was sneaky and would wait for the opportunity to go into Resident #16's room. On 07/16/2024 at 4:24 PM, a Registered Nurse (RN) verbalized Resident #15 accused residents of taking items daily. The RN explained Resident #15 could be rude and nasty to other staff and residents. The RN had heard Resident #15 call Resident #16 the b-word. On 07/18/2024 at 10:44 AM, the DON defined abuse as any willingly harmful emotional, physical, or sexual abuse. The DON explained verbal abuse was abuse and all abuse needed to be reported to charge nurse or DON. The DON verbalized they were made aware of the interactions and name calling between Resident #15 and Resident #16. The DON explained Resident #15 had made accusations of theft against Resident #16. The DON spoke with Resident #15 and Resident #15 told the DON Resident #16 had stolen their picture because Resident #16 was in love with them. The DON explained Resident #15 was hard to redirect and was stuck on the topic. The DON spoke with Resident #16 and listened to their concerns. The DON did not initially think the harassment and verbal abuse was abuse because Resident #15 had dementia. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Communication Note for Resident #16, dated 06/15/2024, documented Resident #16 came out of their room to complain about another resident going into their room, threatened Resident #16 and made accusations the resident was sleeping with men over the weekend of Christmas. The other resident then accused Resident #16 of stealing a picture and refused to leave the room. The Certified Nursing Assistant (CNA) had to remove the resident from Resident #16's room. As the resident left Resident #16's room, the resident continued to call Resident #16 nasty names and insisted Resident #16 was sleeping with everyone in the facility. A Patient Grievance Form for Resident #16, dated 06/15/2024, documented Resident #15 went into Resident #16's room and made accusations the resident was sleeping with men over the weekend of Christmas. The resident then accused Resident #16 of stealing a picture and refused to leave the room. The CNA had to remove the resident from Resident #16's room. As the resident left Resident #16's room, the resident continued to call Resident #16 nasty names and insisted Resident #16 was sleeping with everyone in the facility. A Communication Note for Resident #16, dated 06/17/2024, documented the DON spoke with Resident #16 regarding their concerns and informed them the DON had spoken with Resident #15 and told Resident #15 they were not allowed to enter Resident #16's room. On 07/18/24 at 1:15 PM, the DON verbalized the DON became aware of the issues between Resident #15 and Resident #16 on 06/17/2024. The facility policy titled Abuse Prevention, revised 05/2023, documented residents would be free from abuse from other residents.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on interview, clinical record review, and document review, the facility failed to report and investigate an allegation of resident-to-resident verbal abuse and harassment for 1 of 12 sampled residents (Resident #16). This deficient practice could allow allegations of abuse to occur and not be reported for investigation. Findings include: Resident #16 Resident #16 was admitted to the facility on [DATE], with diagnoses including adjustment disorder with anxiety and chronic obstructive pulmonary disease. Resident #15 Resident #15 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and nutritional anemia, unspecified. On 07/16/2024 at 10:43 AM, Resident #16 verbalized a resident had been harassing them and calling them names. On 07/16/2024 at 11:04 AM, Resident #15 verbalized they believed Resident #16 had stolen a picture out of their room. The resident explained they believed Resident #16 must be gay because they took the picture. Resident #15 verbalized they call resident #16 gay because they knew Resident #15 did not like it. Resident #15 laughed and verbalized they knew Resident #16 was having sex with male members of the surrounding community. On 07/18/2024 at 10:44 AM, the DON defined abuse as any willingly harmful emotional, physical, or sexual abuse. The DON explained verbal abuse was abuse and all abuse needed to be reported to charge nurse or DON and all suspected abuse needed to be reported to the State Agency (SA) immediately or within two hours of the incident. The DON explained Resident #15 had made accusations of theft against Resident #16. The DON spoke with Resident #15 and Resident #15 told the DON Resident #16 had stolen their picture because Resident #16 was in love with them. The DON explained Resident #15 was hard to redirect and was stuck on the topic. The DON spoke with Resident #16 and listened to their concerns. The DON did not report the verbal abuse and harassment to the State Agency (SA) because Resident #15 had dementia. The DON confirmed the accusations and name calling were verbal abuse and harassment and should have been reported to the SA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Communication Note for Resident #16, dated 06/15/2024 documented Resident#16 came out of their room to complain about another resident going into their room, threatened Resident #16 and made accusations the resident was sleeping with men over the weekend of Christmas. The resident then accused Resident #16 of stealing a picture and refused to leave the room. The Certified Nursing Assistant (CNA) had to remove the resident from Resident #16's room. As the resident left Resident #16's room, the resident continued to call Resident #16 nasty names and insisted Resident #16 was sleeping with everyone in the facility. A Patient Grievance Form for Resident #16, dated 06/15/2024, documented Resident #15 went into their room and made accusations the resident was sleeping with men over the weekend of Christmas. The resident then accused Resident #16 of stealing a picture and refused to leave the room. The Certified Nursing Assistant (CNA) had to remove the resident from Resident #16's room. As the resident left Resident #16's room, the resident continued to call Resident #16 nasty names and insisted Resident #16 was sleeping with everyone in the facility. A Communication Note for Resident #16, dated 06/17/2024, documented the DON spoke with Resident #16 regarding their concerns and informed them the DON had spoken with Resident #15 and told Resident #15 they were not allowed to enter Resident #16's room. On 07/18/2024 at 1:15 PM, the DON verbalized the DON became aware of the issues between Resident #15 and Resident #16 on 06/17/2024. The facility policy titled Abuse Prevention, revised 05/2023, documented residents would be free from abuse from other residents. Alleged, suspected or observed abuse would reported immediately and an investigation begun.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301 Based on interview, clinical record review, and document review, the facility failed to ensure physician visits were completed timely for 3 of 12 sampled residents (Resident #26, #19, and #7). Findings include: Resident #26 Resident #26 was admitted to the facility on [DATE], with diagnoses including traumatic subarachnoid hemorrhage with loss of consciousness, fall on same level, and unspecified dementia with other behavioral disturbances. The clinical record for Resident #26 included documentation of the physician visits during the first 90 days were dated 05/11/2024, and 07/01/2024. The record lacked documented physician visits in June of 2024 by either a physician or a nurse practitioner. On 07/23/2024 at 10:24 AM, the Director of Nursing (DON) confirmed Resident #26 lacked a physician's visit in June of 2024. The DON explained a physician visit should had been completed as the resident was to be seen every 30 days for the first 90 days. 34524 Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus with diabetic chronic kidney disease, acquired absence of left leg below the knee, and retinal edema. The clinical record for Resident #19 included documentation of the physician visits dated 2/14/2024 and 3/6/2024. The record lacked a physician visit in April 2024. On 07/23/2024 at 10:25 AM, the DON confirmed Resident #19's clinical record lacked a physician's visit in April 2024. 43310 Resident #7 Resident #7 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified, type II diabetes mellitus without complications, and other specified hypothyroidism. The clinical record for Resident #7 included documentation of physician visits dated 01/17/2024 and 05/06/2024. The record lacked a documented evidence of a physician visit dated in March of 2024. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/23/2024 at 10:26 AM, the DON confirmed Resident #7's clinical record lacked a physician's visit in March of 2024. The DON verbalized the expectation was a physician's visit would be conducted every 60 days after the first 90 days of admission.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46301 Based on interview and personnel record review, the facility failed to ensure a Certified Nursing Assistant (CNA) had an annual performance evaluation completed timely for 1 of 2 CNAs employed greater than one year, sampled for personnel record review (Employee #7). Findings include: On 07/17/2024 at 11:04 AM, the Human Resources Supervisor participated in an interview to confirm the accuracy of the Personnel Records Checklist completed by the facility for 20 employees. Employee #7 Employee #7 was hired as a CNA with a start date of 04/01/2023. The CNA's personnel record lacked documented evidence of the completion of an annual performance evaluation. On 07/17/2024 at 1:53 PM, the Human Resources Supervisor confirmed the CNA's personnel record lacked documented evidence of the completion of an annual performance evaluation. The facility policy titled Performance Evaluation, revised 06/2019, documented employees would be evaluated by their supervisor annually in the month of their hire date.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure the label on a bottle of Morphine oral suspension (a liquid medication) included a measuring guide for 1 of 27 sampled residents (Resident #2). Due to this failure the facility was not able to determine if the medication was correctly reconciled in the facility's Narcotics Reconciliation log and/or if the medication had been diverted. Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, heart failure, unspecified, and unspecified atrial fibrillation. A physician's order dated 06/20/2024, documented Morphine Sulfate (concentrate) oral solution 20 milligrams/milliliters (mg/ml), give 0.1 ml by mouth every two hours as needed for pain related to chronic pain syndrome. A Controlled Drug Record for Resident #2 documented Morphine Sulfate 20 mg/5 ml. The starting quantity on 06/20/2024, was documented as 30 ml, an entry documented on 07/16/2024 at 1:30 PM, documented 25 of 30 ml remained in the bottle. On 07/17/2024 at 7:44 AM, during an inspection of a medication cart with the Director of Nursing (DON), a 30 ml bottle of Morphine oral suspension, 20 mg/ml was found. The bottle did not contain a measurement guide to be used by nurses when reconciling controlled substances at the end of each shift. The DON confirmed the bottle of Morphine oral suspension did not include a label with a measurement guide routinely used by nurses to determine the amount of the medication remaining in the bottle at the end of each shift. The DON confirmed the bottle was a 30 ml bottle and per the count in the Narcotics Reconciliation Log (NARC log) there should be 25 ml remaining. The DON confirmed the amount remaining in the bottle appeared to be a less than 25 ml and verbalized the bottle may have leaked. The DON confirmed the DON would expect to see approximately 5/6 of the morphine remaining in the bottle and there was approximately only 3/6 of the bottle remaining. On 07/18/2024 at 11:21 AM, the Pharmacist confirmed bottles of Morphine oral suspension should include a label with a measurement guide. The Pharmacist verbalized the DON sent a photograph of the bottle to the Pharmacist and the Pharmacist confirmed the bottle did not have a measuring guide. The Pharmacist declined to comment further or answer additional questions. The manufacturer's guide/instructions, titled Morphine Sulfate - Morphine Sulfate Solution, undated, documented Morphine Sulfate solution contained morphine, a schedule II controlled substance. Morphine Sulfate oral solution, like other opioidss, could be diverted for non-medical use into illicit channels of distribution. Careful record-keeping, including quantity, as required by state and federal laws was strongly advised.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on interview, clinical record review, and document review, the facility failed to ensure a psychotropic medication was prescribed to a resident with a diagnosed indication for use for 1 of 12 sampled residents (Resident #9). Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including vascular dementia, unspecified severity, with other behavioral disturbance and depression, unspecified. On 07/17/2024 at 3:17 PM, a Registered Nurse (RN) verbalized Resident #9 was administered Buspirone three times a day for behaviors such as yelling out, banging their fists, and throwing items. A physician's order dated 10/19/2023, documented Buspirone Hydrochloride (HCl) 15 milligram (mg) tablets. Give one tablet by mouth three times a day for anxiety as evidenced by outbursts and inconsolable crying. A physician's order dated 10/19/2023, documented antianxiety medication Buspar (Buspirone) - monitor for clinical side effects associated with the medication: appetite changes, memory impairment, muscle weakness, pronunciation difficulties, rash, respiratory depression, sedation, urinary retention, and weight loss/gain. Resident #9's July Medication Administration Record (MAR) documented Buspirone HCl 15 mg tablets was administered three times daily from 07/01/2024-07/16/2024. On 07/18/2024 at 9:16 AM, the Director of Nursing (DON) verbalized Resident #9 received Buspirone for anxiety three times daily. The DON confirmed Resident #9 did not have a diagnosis for anxiety and should have an indication for use prior to the administration of Buspirone. The facility policy titled Psychotropic Medication Use, revised 08/2018, documented psychotropic drugs were any drug which affected the brain activities associated with mental processes and behavior. The drugs included drugs such as anti-anxiety drugs. Psychotropic drugs may be ordered by a physician when medically necessary. Attending physicians must certify a psychotropic medication was necessary to treat a specific condition/behavior.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure medications were not repackaged for 1 of 27 sampled residents (Resident #3) Findings include: Resident #3 Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including nondisplaced oblique fracture of shaft of right tibia, subsequent encounter for closed fracture with routine healing, age related osteoporosis with current pathological fracture, unspecified site, subsequent encounter for fracture with routine healing, other muscle spasm, and localized edema. A physician's order date 05/10/2024, documented hydrocodone-acetaminophen (Norco) oral tablet 5-325 milligram (mg). Give one tablet by mouth every six hours for chronic arthritic pain. A Controlled Drug Record belonging to Resident #3, documented on 07/17/2024, the remaining count of Norco was 105. On 07/17/24 at 7:52 AM, during an inspection of the section one medication cart, conducted with the Director of Nursing (DON), a bottle of Norco belonging to Resident #3 was located. The bottle contained five tablets of Norco. The remaining 100 tablets had been separated into 10 packages of 10 each. The packages were created by using a plastic see through envelope used for crushing medications. The resident's last name and Norco 5/325 was written on the packets with a black marker and the packet was stapled with one staple. No additional information was written on the packets. The DON confirmed the medication was separated into the plastic packets by nursing staff and labeled with only the resident's last name, name and strength of the medication. No additional information was included on the labels. The facility policy titled Administration of Medications, dated 01/2021 documented medications should never be transferred from one container to another. The policy lacked guidance regarding what to include on a medication label including prescribed dose, strength, resident's name, route of administration, precautions such as take with meals or do not crush.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301 Based on observation, interview and document review, the facility failed to ensure a vegetable substitute of equal nutritive value was offered to 1 of 27 residents' trays observed during tray line (Resident #27). Findings include: Resident #27 Resident #27 was admitted to the facility on [DATE], with diagnoses including heart failure, chronic obstructive pulmonary disease and gastro-esophageal reflux disease without esophagitis. The lunch menu for 07/16/2024, documented roast turkey, Brussels sprouts, and corn pudding. Resident #27's Food Likes and Dislikes on the tray card, documented dislikes Brussels sprouts. On 07/16/2024 at 12:07 PM, during tray line observation, Resident #27's tray was plated with turkey, corn pudding and mashed potatoes were substituted for Brussels sprouts. On 07/16/2024 at 3:34 PM, the Registered Dietician (RD) verbalized when a resident had dislikes being served for the meal, the resident should be offered a substitute comparable in nutritional value. The RD confirmed mashed potatoes were not comparable in nutritional value for Brussels sprouts.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301 Based on interview, observation, clinical record review, and document review, the facility failed to provide meals based on resident's preferences for 1 of 12 sampled residents (Resident #27). Findings include: Resident #27 Resident #27 was admitted to the facility on [DATE], with diagnoses including heart failure, chronic obstructive pulmonary disease and gastro-esophageal reflux disease without esophagitis. Resident #27's Food Likes and Dislikes on the tray card, documented dislikes carrots. On 07/16/2024 at 11:32 AM, the Dietary Manager verbalized if a resident disliked what was being served, those items were to be marked on the tray card for the [NAME] to be aware of what was and was not to be on the resident's plate. The Dietary Aide was responsible for checking the tray card to make sure the plate did not contain resident dislikes. On 07/16/2024 at 3:34 PM, the Registered Dietician (RD) verbalized when a resident had dislikes being served for the main entree, the resident should not be served items the resident disliked. On 07/16/2024 a Dietician Note, documented the resident had requested no carrots or Brussels sprouts. The lunch menu for 07/17/2024 documented the vegetable served was broccoli and carrots. On 07/17/2024 at 12:33 PM, Resident #27 was eating lunch in their room. The plate contained carrots. On 07/17/2024 at 12:35 PM, Resident #27 verbalized not liking carrots and was not going to eat them. The facility policy titled Nutritional Assessment Program, undated, documented residents were screened at admission about their likes, dislikes and allergies to food or drinks.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, document review, and interview the facility failed to demonstrate effective administration by not ensuring the facility's influenza (flu) and pneumonia (PNA) vaccination program included 1) screening residents for eligibility to receive the vaccines, 2) the provision of education related to the risk and benefits of the vaccines to residents and/or the resident's representative preventing the resident or the resident's representative from making an informed decision regarding the vaccines, 3) a process for determining/selecting the correct PNA vaccine for each resident per the Centers for Disease Control and Prevention (CDC) guidance. This failure resulted in substandard quality of care. Findings include: Influenza Vaccine The facility lacked documented evidence 23 of 26 residents eligible or potentially eligible to receive a flu vaccine were screened for eligibility to receive a flu vaccine and lacked documented evidence education related to the 2023/2024 flu vaccines was provided to the resident or the resident's representative (Resident #4, #16, #10, #24, #11, #15, #19, #6, #13, #5, #23, #1, #3, #22, #21, #9, #7, #20, #18, #12, #26, #17 and #8). The facility administered Flu vaccines to the residents as follows: -8 of 26 residents eligible to receive a flu vaccine declined vaccination (Resident #11, #19, #13, #23, #3, #9, #18, and #12. The residents' clinical records lacked documented evidence the residents were screened for eligibility to receive a flu vaccine and the residents and/or residents' representatives were provided education regarding the 2023/2024 flu vaccines prior to declining vaccination resulting in the resident not having the opportunity to make an informed decision. -5 of 26 residents (Resident #24, #22, #7, #17 and #8) clinical records lacked documented evidence the residents were screened to determine eligibility to receive a flu vaccine and were provided education regarding the 2023/2024 flu vaccines prior to signing consents and prior to the administration of a 2023/2024 flu vaccine. This failure resulted in the residents not having the opportunity to make an informed decision prior to being administered a 2023/2024 flu vaccine and put residents at risk of having adverse reactions to the flu vaccine related to risk factors identified during the screening process. -3 of 26 residents (Resident #16, #20 and #26) clinical records lacked documented evidence the residents were screened for eligibility to receive a flu vaccine, education regarding the 2023/2024 flu vaccine was provided, and consent was given by the resident or the residents representative prior to administering a flu vaccine to the residents. This failure resulted in the residents not having the opportunity to make an informed decision and either consent to receive or decline to receive a flu vaccine prior to being administered a 2023/2024 flu vaccine. The lack of screening for eligibility put the residents at risk of having adverse reactions to the flu vaccine related to risk factors identified during the screening process. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6 of 26 residents (Resident #10, #15, #6, #5, #1 and #21) clinical records documented consents were signed to receive a flu vaccine during the 2022/2023 flu season. The residents' clinical records lacked documented evidence the residents were screened for eligibility to receive vaccination with a 2023/2024 flu vaccine, the resident or the resident's representative were provided education regarding the 2023/2024 flu vaccines, and consent for vaccination with the 2023/2024 flu vaccine was obtained prior to administering a 2023/2024 flu vaccine to the residents. This failure resulted in the residents not having the opportunity to make an informed decision and either consent to receive or decline to receive a flu vaccine prior to being administered a 2023/2024 flu vaccine. The lack of screening for eligibility put the residents at risk of having adverse reactions to the flu vaccine related to risk factors identified during the screening process. 1 of 26 residents (Resident #4) was screened for eligibility to receive a flu vaccine with a hospital consent form. The screening/consent form included a section with an acknowledgement of receipt of a Vaccination Information Sheet (VIS) and an acknowledgement the resident reviewed the information on the back of the form. The form documented the VIS provided to the resident was dated 08/06/2021. The form documented the vaccine administered to Resident #4, Fluad manufactured by Seqirus, was to be given to individuals 65 and older only !!!! and Resident #4 was 61 YOA. A Food and Drug Administration package insert titled Fluad Quadrivalent - Seqirus Incorporated, dated March 2023, documented the Fluad vaccine was approved for use in individuals [AGE] years of age or older and was not approved by the FDA for people under the age of 65. The facility policy titled Influenza Vaccination, revised 12/2023, documented influenza vaccination was the primary method for preventing influenza and it's severe complications. Therefore, vaccination against influenza was offered to residents. Upon admission residents were assessed for recent and past flu vaccination, and flu vaccines were administered to residents annually thereafter. The healthcare professional administering the vaccine obtained a signed consent from the resident or resident representative at the time of admission or prior to the next flu season. Residents were routinely vaccinated, unless contraindicated, at one time, annually, before the influenza season. Residents and/or the resident representatives were provided a copy of the most current VIS regarding the flu vaccine the resident was to be given. Residents were screened for history of Guillain-Barre Syndrome, and for severe allergic reaction to a previous dose, vaccine component, and egg protein. A flu vaccine was not to be administered to residents exhibiting signs and symptoms of moderate or severe acute illness, with or without fever. The facility referred to current Advisory Committee on Immunization Practices (ACIP) recommendations for special circumstances such as immunosuppression, immunodeficiencies, corticosteroid therapy and organ transplantation. Pneumonia Vaccine The facility lacked documented evidence 26 of 26 residents eligible or potentially eligible to receive a PNA vaccine were screened for eligibility to receive a PNA vaccine and lacked documented evidence education regarding the PNA vaccine the resident was eligible to receive was provided to the resident or the resident's representative (Resident #4, #27, #16, #10, #24, #11, #15, #14, #19, #6, #13, #5, #23, #2, #1, #3, #22, #21, #9, #7, #20, #18, #12, #26, #17, and #8). The facility administered PNA vaccines to the residents as follows: (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-13 of 26 residents (Resident #4, #16, #10, #24, #11, #15, #19, #6, #13, #5, #23, #1, #3, #22, #21, #9, #7, #20, #18, #12, #26, #17 and #8) eligible or potentially eligible to receive a PNA vaccine declined vaccination The residents' clinical records lacked documented evidence the residents were screened for eligibility to receive a PNA vaccine and the residents and/or residents' representatives were provided education regarding the PNA vaccines prior to declining vaccination resulting in the resident not having the opportunity to make an informed decision. -7 of 26 residents' clinical record included a signed consent requesting to receive vaccination with a PNA vaccine (Resident #2, #21, #8, #7, #22, #24, and #10). The residents' clinical record lacked documented evidence the resident was screened for eligibility to receive a PNA vaccine, education was provided related to the PNA vaccine the resident was eligible to receive, and the PNA vaccine was administered to the resident. The facility policy titled Pneumococcal Polysaccharide Vaccination, last revised 10/2017, documented because pneumococcal disease was known to lead to serious infections in the resident population and was proving to be resistant to antibiotics, the facility provided vaccination against pneumococcal disease to prevent the spread of infection. PPSV protected against multiple types of pneumococcal bacteria and was offered to the resident population. Residents were screened for severe allergic reactions after a previous dose of PPSV and consent was obtained from the resident or the resident's representative/guardian. Residents or the resident's representative/guardian were provided with information regarding potential reactions and a copy of the most current VIS. Copies of the VIS were obtained from the CDC website. Documentation in the residents clinical record included the date of administration, amount and dosage given, reactions to the vaccine. The policy was last revised in 2017, and documented the sole reference was titled CDC, Morbidity and Mortality Weekly Report (MMWR), Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP), volume 46/No. RR-8, dated 04/04/1997. The reference included a weblink, but the link indicated the page could no longer be found. The guidance in the policy was outdated and did not include the CDC's most recent guidance regarding the selection and administration of pneumococcal vaccines.

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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. 34524 Based on interview and document review the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify 1) the facility lacked screening and implementation for pneumococcal (PNA) and influenza vaccinations and education was not provided for declinations and consents were not obtained for vaccinations given 2) the Infection Preventionist (IP) had not completed a specialized IP training course 3) the Infection Control and Prevention Plan (IPCP) policy was reviewed annually and contained outdated information, and 4) the facility's Antibiotic Stewardship Program (ASP) policy was reviewed annually and contained outdated information. Findings include: Screening and Implementation for Pneumococcal (PNA) and Influenza vaccinations On 07/18/2024 at 8:29 AM, the Director of Nursing (DON) confirmed the facility did not have a process in place for screening residents for eligibility to receive a flu vaccine and did not provide education related to flu vaccines to the residents. The DON confirmed consents were signed at admit and new consents were not signed prior to each new flu vaccine administered. On 07/18/2024 at 8:36 AM, the DON confirmed the facility did not have a screening tool or an algorithm to assist in determining eligibility and/or the recommended PNA vaccine for a resident. The DON confirmed the facility was not using the Vaccine Information Sheet (VIS) educational documents to provide education related to flu and PNA vaccines to residents or the resident's representative/guardian. On 07/16/2024 at 4:22 PM, the DON confirmed the facility did not have a screening process in place related to PNA vaccines and did not provide education related to PNA vaccines to residents or the resident's representative. The DON confirmed none of the facility's 27 residents had been screened for vaccination with a PNA vaccine and education related to PNA vaccines was not provided to the residents. On 07/23/2024 at 3:20 PM, the Administrator verbalized the QAPI Committee was not aware of the lack of screening and implementation for PNA and influenza vaccinations. The Administrator explained the QAPI Committee would not have become aware of the lack of screening and implementation until the State Agency brought it to the attention of the facility. The Administrator verbalized the QAPI Committee was not aware education was not provided for declinations and consents were not obtained for vaccinations given. Cross reference with F883 Specialized Training (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/2024 at 11:45 AM, the IP verbalized the IP had completed the Centers for Disease Control and Prevention (CDC) training course and had completed and passed the courses final comprehensive test. The IP was not able to provide a certificate documenting the course was completed and provided a transcript which documented Modules 1-15 had been completed, an expiration date for each module was 10/01/2025. The end of training plan verification and continuing education (CE) information section was marked as completed but had an expiration date of 06/30/2024. The Completion for Nursing Home Infection Preventionist Training Course was marked as not started. On 07/16/2024 at 3:11 PM, the DON confirmed the Infection Preventionist Training Course Transcript provided by the IP lacked documented evidence the IP had completed the IP training course and confirmed the course needed to be completed in its entirety prior to being the facillity's IP. The DON confirmed the form did not include the IP's name. On 07/23/2024 at 3:33 PM, the Administrator verbalized the QAPI Committee was not aware the IP had not completed the Nursing Home Infection Preventionist Training Course. Cross reference with F882 Infection Control and Prevention Plan Policy The facility's IPCP policy documented the policy was last reviewed by the facility on 10/2022. The facility was not able to provide evidence the policy had been reviewed and/or revised after 10/2022. The policy referred to IPCP as the hospital's IPCP and the referenced duties for hospital staff did not include language indicating the policy included the Long-Term Care facility. The IPCP lacked the following elements: -a list of reportable communicable diseases and a process for reporting to the appropriate state agencies. -prohibition of employees with communicable diseases or infected skin lesions from direct contact with residents or their food if direct contact could transmit disease. -a process for communicating at time of a transfer to another care provider, to include diagnoses, infections, multi-drug resistant organisms (MDRO)status, special instructions or precautions including transmission-based precautions (TBP), medications, lab work, other diagnostics, test results, treatments, and discharge summary if applicable. -a process to ensure receipt of pertinent notes when transferred back from an acute care hospital or other facility type. The IPCP policy referenced an additional policy titled List of Nationally Notifiable Diseases, last revised 06/2020. The policy did not list the reportable diseases but provided two links to the most current nationally notifiable diseases. The links were dated 2020 and neither of the links were active. At the bottom of the policy, under references, an active link was provided. The policy did not include guidance for prohibition of employees with communicable diseases or a process for reporting to the appropriate agencies. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/18/24 at 8:45 AM, the Director of Nursing (DON) confirmed the IPCP provided was the policy used by the facility. On 07/18/24 at 8:00 AM, the DON confirmed the IPCP lacked the following elements: -a list of reportable communicable diseases and a process for reporting to the appropriate state agencies. -prohibition of employees with communicable diseases or infected skin lesions from direct contact with residents or their food if direct contact could transmit disease. -a process for communicating at time of a transfer to another care provider, to include diagnoses, infections, MDRO status, special instructions or precautions including TBPs, medications, lab work, other diagnostics, test results, treatments, and discharge summary if applicable. -a process to ensure receipt of pertinent notes when transferred back from an acute care hospital or other facility type. Cross reference with Tag F880 Antibiotic Stewardship Policy A facility policy titled Antimicrobial Stewardship Program, revised on 10/2023, lacked the following components: -Antibiotic use protocols related to prescribing antibiotics, including documentation of the indication, dosage, and duration of use of antibiotics -a process for periodic review of antibiotic use by prescribing practitioners. (such as review of labs and med orders, progress notes and medication administration records to determine if an infection or communicable disease was documented and whether an appropriate antibiotic was used for the recommended length of time). -a process for reviewing antibiotic use when a resident is newly admitted , returns, or is transferred from another facility/hospital -protocols to ensure the proper antibiotics are prescribed. -a system for the provision of feedback reports on antibiotic use, resistance patterns based on labs, and the prescribing practices of prescribing practitioners. The policy documented the ASP program included the following components, but failed to document how each element was accomplished and/or the guidelines used. -Formal programs for tracking, auditing, and reporting antimicrobial use. -Clinician and patient education on antimicrobial use. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Use of nationally recognized antimicrobial use guidelines. -A standardized process for outcome measurement. On 07/18/24 at 8:00 AM, the DON confirmed the facility's ASP policy lacked the following components: -Antibiotic use protocols related to prescribing antibiotics, including documentation of the indication, dosage, and duration of use of antibiotics -a process for periodic review of antibiotic use by prescribing practitioners. (such as review of labs and med orders, progress notes and medication administration records to determine if an infection or communicable disease was documented and whether an appropriate antibiotic was used for the recommended length of time). -a process for reviewing antibiotic use when a resident is newly admitted , returns, or is transferred from another facility/hospital -protocols to ensure the proper antibiotics are prescribed. -a system for the provision of feedback reports on antibiotic use, resistance patterns based on labs, and the prescribing practices of prescribing practitioners. On 07/23/2024 at 3:27 PM, the Administrator verbalized the Infection Control and Prevention Plan policy and the facility's Antibiotic Stewardship Program policy had been reviewed annually. The Administrator explained the IP was responsible to keep the policies updated. The Administrator confirmed the QAPI Committee was not aware the policies were not updated with the most current information. Cross reference with Tag F880 The facility policy titled Quality Management Program, last revised 11/2017, documented the QAPI committee, with the support and approval of the Governing Body, had the responsibility for monitoring every aspect of resident care and service from the time the resident entered the facility, through diagnosis, treatment, recovery, and discharge in order to identify and resolve any breakdowns with the potential to result in sub-optimal resident care and safety, while striving to continuously improve and facilitate positive resident outcomes.

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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** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure 1) the Infection Control and Prevention Plan (IPCP) policy was reviewed annually, and 2) enhance barrier precautions (EBP) were being implemented for 2 of 2 residents with indwelling medical devices (Resident #1 and #4). Findings include: Infection Control and Prevention Plan The facility's IPCP policy documented the policy was last reviewed by the facility on 10/2022. The facility was not able to provide evidence the policy had been reviewed and/or revised after 10/2022. The policy referred to IPCP as the hospital's IPCP, referenced duties for hospital staff, and did not include language indicating the policy included the Long Term Care facility. The IPCP lacked the following elements: -a list of reportable communicable diseases and a process for reporting to the appropriate state agencies. -prohibition of employees with communicable diseases or infected skin lesions from direct contact with residents or their food if direct contact could transmit disease. -a process for communicating at time of a transfer to another care provider, to include diagnoses, infections, multi-drug resistant organisms (MDRO)status, special instructions or precautions including transmission based precautions (TBP), medications, lab work, other diagnostics, test results, treatments, and discharge summary if applicable. -a process to ensure receipt of pertinent notes when transferred back from an acute care hospital or other facility type. The IPCP policy referenced an additional policy titled List of Nationally Notifiable Diseases, last revised 06/2020. The policy did not list the reportable diseases but provided two links to the most current nationally notifiable diseases. The links were dated 2020 and neither of the links were active. At the bottom of the policy, under references, an active link was provided. The policy did not include guidance for prohibition of employees with communicable diseases or a process for reporting to the appropriate agencies. On 07/18/24 at 8:00 AM, the DON confirmed the IPCP lacked the following elements: -a list of reportable communicable diseases and a process for reporting to the appropriate state agencies. -prohibition of employees with communicable diseases or infected skin lesions from direct contact with residents or their food if direct contact could transmit disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-a process for communicating at time of a transfer to another care provider, to include diagnoses, infections, MDRO status, special instructions or precautions including TBPs, medications, lab work, other diagnostics, test results, treatments, and discharge summary if applicable. -a process to ensure receipt of pertinent notes when transferred back from an acute care hospital or other facility type. On 07/18/2024 at 8:45 AM, the Director of Nursing (DON) confirmed the IPCP provided was the policy used by the facility. The facility policy titled Infection Prevention and Control Program, revised 10/2022, documented the IPCP was conducted in accordance with all applicable federal and state rules and regulations. The IPCP was evaluated annually and whenever risk had significantly changed. Revisions were made as appropriate. Enhanced Barrier Precautions Resident #1 Resident #1 was admitted to the facility on [DATE], and last readmitted to the facility on [DATE], with diagnoses including quadriplegia, unspecified, calculus of kidney, and other artificial openings of urinary tract status. Resident #1's Comprehensive Care Plan documented Resident #1 had a urostomy related to complications of quadriplegia. Resident #4 Resident #4 was admitted to the facility on [DATE], with a diagnosis of multiple sclerosis, neuromuscular dysfunction of bladder, retention of urine, unspecified, benign prostatic hyperplasia with lower urinary tract symptoms. Resident #4's Comprehensive Care Plan documented Resident #4 had a suprapubic catheter related to urinary retention, possibly related to the inhibition of the reflex arc, secondary to multiple sclerosis. On 07/15/2024 at 8:03 AM, the DON confirmed Resident #1 and #4 both had indwelling medical devices and should have had Enhanced Barrier Precautions (EBP) in place. The DON confirmed EBP had not been initiated and/or implemented for Resident #1 and #4. On 07/15/2024 at 9:48 AM, during an inspection of the facility, TBP including EBP, were not in place for any of the resident rooms, including Resident #1 and #4. On 07/18/2024 at 8:18 AM, the DON verbalized diagnostic testing and symptoms were used to determine if a resident needed to be placed in TBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled Enhanced Barrier Precautions, last revised 07/2024, with an effective date of 01/2024, documented the facility ensured staff used EBPs while caring for residents with wounds and indwelling medical devices. Effective implementation of EBP included staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene products at the point of care. Clear signage was to be posted outside of the resident room indicating the type of PPE required and to define the high risk patient care activities. Gowns, gloves and alcohol-based hand rub were available outside of the residents room. A trash can was made available for the disposal of PPE for each room. EBPs were continued for the duration of the resident's stay.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure 1) the facility's Antibiotic Stewardship Program (ASP) policy was reviewed annually, 2) education regarding the ASP/antibiotic use was provided to staff and residents, #3) a process was in place to ensure the Infection Preventionist (IP) was made aware when a resident had a new infection and an antimicrobial medication was prescribed, 4) an antibiotic time out was performed to ensure the best treatment was being provided to residents, and 5) the IP had a process in place related to communicating infection, treatment, and prescribing concerns to prescribing providers. Findings include: Antibiotic Stewardship Policy A facility policy titled Antimicrobial Stewardship Program, revised on 10/2023, lacked the following components: -Antibiotic use protocols related to prescribing antibiotics, including documentation of the indication, dosage, and duration of use of antibiotics -A process for periodic review of antibiotic use by prescribing practitioners such as: review of labs and med orders, progress notes and medication administration records to determine if an infection or communicable disease was documented and whether an appropriate antibiotic was used for the recommended length of time. -A process for reviewing antibiotic use when a resident is newly admitted , returns, or is transferred from another facility/hospital. -Protocols to ensure the proper antibiotics are prescribed. -A system for the provision of feedback reports on antibiotic use, resistance patterns based on labs, and the prescribing practices of prescribing practitioners. The policy documented the ASP program included the following components, but failed to document how each element was accomplished and/or the guidelines used. -Formal programs for tracking, auditing, and reporting antimicrobial use. -Clinician and patient education on antimicrobial use. -Use of nationally recognized antimicrobial use guidelines. -A standardized process for outcome measurement. On 07/18/2024 at 8:00 AM, the Director of Nursing (DON) confirmed the facility's ASP policy lacked the following components: (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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Antibiotic use protocols related to prescribing antibiotics, including documentation of the indication, dosage, and duration of use of antibiotics -A process for periodic review of antibiotic use by prescribing practitioners such as: review of labs and med orders, progress notes and medication administration records to determine if an infection or communicable disease was documented and whether an appropriate antibiotic was used for the recommended length of time. -A process for reviewing antibiotic use when a resident is newly admitted , returns, or is transferred from another facility/hospital. -Protocols to ensure the proper antibiotics are prescribed. -A system for the provision of feedback reports on antibiotic use, resistance patterns based on labs, and the prescribing practices of prescribing practitioners. Antibiotic Stewardship Education On 07/18/2024 at 9:20 AM, the facility was not able to provide documented evidence education related to the ASP was provided to staff and residents. On 07/18/2024 at 9:22 AM, the IP confirmed the facility had not provided education related to the ASP to staff or residents. On 07/18/24 at 10:17 AM, the IP confirmed the IP did not provide education related to the ASP to staff or residents because the IP was not clinical. A facility policy titled Antimicrobial Stewardship Program, revised on 10/2023, documented staff and residents were provided education related to antimicrobial medications. Antibiotic Stewardship Process On 07/18/2024 at 9:25 AM, the IP verbalized the IP did not review resident's antibiotic use upon admit and explained the review was completed by the pharmacist. The IP confirmed the pharmacist only came to the facility on e time per month. On 07/18/2024 at 9:30 AM, the IP explained a form titled The Four Moments of Antibiotic Decision Making as completed by nurses when a new onset of infection was suspected. The form was used to guide antibiotic selection, antibiotic duration, ensure cultures were completed, and ensure follow up after 24 hours. The IP verbalized the IP did not use the form and the form was not forwarded to the IP after it was completed by nursing. The IP verbalized when lab results were returned for a resident, the resident's nurse contacted the provider to confirm the resident was receiving the correct antibiotic. The IP explained when a resident had an infection, the IP was notified the resident had an infection when the resident's lab work result came back. After receiving the lab results, the IP looked to see if the correct antibiotic was being administered. Next the IP notified the pharmacist and documented the data onto a spreadsheet. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy titled Antimicrobial Stewardship Program, revised on 10/2023, documented the ASP proactively monitored the use of antimicrobial prescriptions with real time feedback and advised clinicians regarding the appropriate antimicrobial use in patients. The facility followed the Four Moments of Antibiotic Decision Making for every antibiotic order. Antibiotic Time Out On 07/18/2024 at 10:12 AM, the IP explained when nurses sent a culture to the lab, the nurse did not always tell the IP and most of the time the IP was not aware a culture had been sent until the results came back. The IP confirmed an antibiotic time out was not completed at any time during a resident's course of antibiotics. A Centers for Disease Control and Prevention document titled The Core Elements of Antibiotic Stewardship for Nursing Homes, dated 03/18/2024, documented broad interventions to improve antibiotic use and standardize the practices which should be applied during the care of any resident suspected of an infection. The practices included improving the evaluation and communication of clinical signs and symptoms when a resident was first suspected of having an infection. The use of diagnostic testing was optimized when an antibiotic review process known as an antibiotic time out was implemented for all antibiotics prescribed in the facility. Antibiotic reviews provided clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic when the clinical picture was clearer, and more information was available. A facility policy titled Antimicrobial Stewardship Program, revised on 10/2023, documented the resource for the policy was the Centers for Disease Control and Prvention (CDC) Core Elements of Antibiotic Stewardship Program. Communication with Prescribing Providers On 07/18/2024 at 10:17 AM, the IP verbalized the IP did not communicate with the physician regarding antibiotics including prescribing habits and antibiotic usage because the IP was not clinical. The IP confirmed the IP was not involved with the decision process for selecting the type of transmission based precautions (TBP) a resident may need and explained the decision was made and implemented by nursing staff. The IP confirmed the IP never communicated with the physician regarding any of the concerns of the ASP. A facility policy titled Antimicrobial Stewardship Program, revised on 10/2023, lacked guidance related to a system for the provision of feedback reports on antibiotic use, resistance patterns based on labs, and the prescribing practices of prescribing practitioners.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure the Infection Preventionist (IP) 1) completed a specialized IP training course, 2) provided education related to the Antibiotic Stewardship Program (ASP) to staff 3) understood and conducted an antibiotic time out (an active reassessment conducted of an antimicrobial prescription 48-72 hours after the first administration), 4) had a process in place to ensure residents and staff were offered vaccines (see tag F883 and F887), and 5) the IP communicated with providers regarding prescribing trends, needs, and outcomes, with the potential to effect the facility's entire census of 27 residents. Findings include: Specialized Training A facility document titled Payroll Status Form, dated 10/13/2022, documented the facility's IP had a hire and status (role) date of 10/13/2022. The role was documented as Infection Preventionist. On 07/16/2024 at 7:39 AM, the IP verbalized the IP had completed the Centers for Disease Control and Prevention (CDC) Infection Preventionist Training Course and provided a certificate documenting the IP had participated in an educational activity and was awarded two Continuing Education Units (CEUs). The certificate did not document the 19.75 CEU hours required for course completion. The IP provided a copy of the IP's Nursing Home Infection Preventionist Training Course transcript. The transcript documented the IP had completed 15 of the IP training course modules and one course was still required. The section of the transcript titled Completion for Nursing Home Infection Preventionist Training Course, was marked as not started. The IP confirmed the IP did not have any further documented evidence of course completion. On 07/16/2024 at 3:11 PM, the Director of Nursing (DON) confirmed the Infection Preventionist Training Course Transcript provided by the IP lacked documented evidence the IP had completed the IP training course. The DON verbalized the IP training course needed to be completed prior to an individual assuming the role of IP and confirmed the IP had been working in the role of IP without having completed an approved IP specialized training course. A facility document titled Infection Control Preventionist - Job Description, signed and dated by the IP on 04/04/2022, documented the IP was required to have knowledge of state and federal regulations regarding infection control. The Job Description failed to address the requirements related to the completion of specialized training in infection control. Antibiotic Stewardship Education On 07/18/2024 at 9:12 AM, the facility was not able to provide documented evidence the facility provided education related to the ASP to the facility's staff. The DON confirmed the facility did not have documented evidence education related to the ASP was provided to staff and confirmed the education was not provided. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy titled Antimicrobial Stewardship Program, revised on 10/2023, documented staff and residents were provided education related to antimicrobial medications. A facility policy titled Infection Prevention and Control Program, last revised 10/2022, documented the Infection Control Professional (IP) was responsible for providing education to residents, visitors, and staff. A facility document titled Infection Control Preventionist - Job Description, signed and dated by the IP on 04/04/2022, documented the IP was responsible for teaching principles and practical application on infection prevention and control to all levels of healthcare staff. The IP promoted the ASP. Cross reference with F881 Antibiotic Time Out A facility form titled Four Moments of Antibiotic Decision Making Form (Four Moments), undated, documented to review a residents length of time on antibiotics and determine if antibiotics could be stopped, therapy narrowed, or intravenous antibiotics changed to oral. On 07/18/2024 at 9:25 AM, the IP verbalized the IP did not review resident records for antibiotic use upon admit and explained the review was completed by the pharmacist. The IP confirmed the pharmacist only worked at the facility one time per month and was only available remotely if needed. On 07/18/2024 at 9:30 AM, the IP explained the Four Moments form was utilized by nurses when a new onset of infection was identified. Nurses communicated laboratory (lab) results to providers and confirmed if residents were being administered the correct antibiotics based on the lab results. The IP verbalized when a resident had an infection, the IP became aware when notified by the lab of lab results. The IP entered the information provided by the lab onto a spread sheet and notified the pharmacist. On 07/18/2024 at 9:34 AM, the IP verbalized the IP did not track isolation needs, timing of infections, and change in medications if indicated. The IP was not able to explain or describe a process related to an antibiotic time out and confirmed the IP did not use the Four Moments form at any time during a resident's course of treatment and was not aware of any other form used by the facility for the purpose of conducting and documenting an antibiotic time out. 07/18/2024 9:48 AM, the IP confirmed the IP did not use Four Moments Form and explained the form was filled out by nurses and confirmed the IP did not receive a copy of the form or utilize the form in any way. 07/18/2024 10:12 AM, the IP confirmed when nurses sent a culture to the lab, the IP was not always notified and confirmed most of the time the IP was not aware of an infection until culture results came back from the lab. The IP confirmed an antibiotic time out was not conducted. Nurses collected urine samples and sent them in and communicated with the doctor. The IP never communicated with the doctor. The nurses would tell the IP when they sent out a sample some of the time. The IP would ask nurses if there were any changes or anyone on anything new. If they had something new, the IP initiated on the flow sheet. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy titled Antimicrobial Stewardship Program, revised on 10/2023, documented the resource for the policy was the CDC's Core Elements of Antibiotic Stewardship Program. A Centers for Disease Control and Prevention document titled The Core Elements of Antibiotic Stewardship for Nursing Homes, dated 03/18/2024, documented broad interventions to improve antibiotic use and standardize the practices which should be applied during the care of any resident suspected of an infection. The practices included improving the evaluation and communication of clinical signs and symptoms when a resident was first suspected of having an infection. The use of diagnostic testing was optimized when an antibiotic review process known as an antibiotic time out was implemented for all antibiotics prescribed in the facility. Antibiotic reviews provided clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic when the clinical picture was clearer, and more information was available. A facility policy titled Antimicrobial Stewardship Program, revised on 10/2023, documented the resource for the policy was the CDC's Core Elements of Antibiotic Stewardship Program. Cross reference with F881 Resident Vaccines On 07/18/2024 at 8:29 AM, the DON confirmed the facility did not have a process in place for screening and providing education to residents and/or the residents' representatives regarding influenza (flu) vaccines and did not have residents sign new consents each year prior to administration of the vaccine. On 07/16/2024 at 4:22 PM, the DON confirmed the facility did not have a process in place for screening and providing education to residents and/or the residents' representatives regarding pneumonia (PNA) vaccines. The DON confirmed due to the lack of a process for screening residents for eligibility to receive a flu or PNA vaccine and the lack of provision of education related to the risk and benefits of receiving the vaccines to the resident and/or resident representative, none of the residents in the facility had been screened for eligibility to receive the vaccines and would not have been provided education related to the risk and benefits of the vaccines. On 07/18/2024 at 9:34 AM, the IP verbalized the IP only followed TB for vaccine type stuff and was not involved with the facility's flu and PNA vaccination process. The IP explained another staff member would provide the information regarding immunizations and the IP entered the data into the required data base, but was not otherwise involved. On 07/18/2024 at 9:48 AM, the IP verbalized the IP did not track immunizations because the IP was not clinical and immunizations were to be tracked by another staff member. Cross Reference with F883 Communication with Prescribing Providers On 07/18/2024 at 10:12 AM, the IP never communicated with physicians/providers and explained the IP was not clinical. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility policy titled Infection Prevention and Control Program, last revised 10/2022, documented the Infection Control Professional (IP), collaborated with all staff regarding infection prevention and control processes. The IP communicated to staff, including medical staff, concerns related to infection control processes. Cross reference with F881

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure 26 of 27 residents residing at the facility were screened for eligibility to receive immunization with an influenza (flu) vaccine and/or a pneumonia (PNA) vaccine and failed to ensure education related to the vaccines was provided resulting in substandard quality of care (Resident #4, #27, #16, #10, #24, #11, #15, #14, #19, #6, #13, #5, #23, #2, #1, #3, #22, #21, #9, #7, #20, #18, #12, #26, #17, and #8). Findings include: Resident #4 Resident #4 was admitted to the facility on [DATE], with a diagnosis of multiple sclerosis. The resident was [AGE] years of age (YOA). Resident #27 Resident #27 was admitted to the facility on [DATE], with diagnoses including heart failure, unspecified, chronic obstructive pulmonary disease (COPD), unspecified, and unspecified asthma, uncomplicated. The resident was 95 YOA. Resident #16 Resident #16 was admitted to the facility on [DATE], with diagnoses including COPD, chronic respiratory failure with hypoxia, fibromyalgia, and adult failure to thrive. The resident was 78 YOA. Resident #10 Resident #10 was admitted to the facility on [DATE], with diagnoses including vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and disease of pancreas, unspecified. The resident was 86 YOA. Resident #24 Resident #24 was admitted to the facility on [DATE], with diagnoses including alcoholic hepatic failure without coma, alcoholic cirrhosis of liver with ascites, and unspecified protein calorie malnutrition. The resident was 63 YOA. Resident #11 Resident #11 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations, adult failure to thrive, heart failure, unspecified, and hypothyroidism. The resident was 76 YOA. Resident #15 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #15 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and nutritional anemia, unspecified. The resident was 81 YOA. Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including cerebral infarction, unspecified, and hypertensive heart disease with heart failure. The resident was 79 YOA. Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus with diabetic chronic kidney disease and diabetic polyneuropathy, hypertensive chronic kidney disease with stage I through stage IV chronic kidney disease, or unspecified chronic kidney disease, and anemia in chronic kidney disease. The resident was 56 YOA. Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including cerebral infarction, unspecified, vascular dementia, moderate with agitation, and post COVID-19 condition, unspecified. The resident was 74 YOA. Resident #13 Resident #13 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, unspecified, post COVID-19 condition, unspecified, and acute kidney failure, unspecified. The resident was 88 YOA. Resident #5 Resident #5 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, unspecified, disease of pancreas, unspecified, and other nonspecific abnormal finding of lung field. The resident was 93 YOA. Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including COPD, adult failure to thrive, pulmonary hypertension, unspecified, and unspecified dementia, unspecified severity, with mood disturbance. The resident was 84 YOA. Resident #2 Resident #2 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance mood disturbance, and anxiety, heart failure, unspecified, and unspecified atrial fibrillation. The resident was 93 YOA. Resident #1 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #1 was admitted to the facility on [DATE], and last readmitted to the facility on [DATE], with diagnoses including quadriplegia, unspecified, hydrocephalus, epilepsy, unspecified, not intractable, without status epilepticus, unspecified asthma, uncomplicated, respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia, unspecified severe protein calorie malnutrition, calculus of kidney, other artificial openings of urinary tract status, other postprocedural cardiac functional disturbances following cardiac surgery, and adult failure to thrive. The resident was 41 YOA. Resident #3 Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type II diabetes mellitus with diabetic chronic kidney disease, hypertensive chronic kidney disease with stage I through stage IV chronic kidney disease, or unspecified chronic kidney disease, nonrheumatic aortic (valve) stenosis with insufficiency, chronic atrial fibrillation, unspecified, anemia in chronic kidney disease, coagulation defect, unspecified, and Guillain-Barre syndrome. The resident was 81 YOA. Resident #22 Resident #22 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations, unspecified severe protein-calorie malnutrition, and COPD. The resident was 84 YOA. Resident #21 Resident #21 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease with late onset, atherosclerotic heart disease of native coronary artery without angina pectoris, and personal history of pulmonary embolism. The resident was 73 YOA. Resident #9 Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia, unspecified affecting right dominant side, and vascular dementia, unspecified severity, with other behavioral disturbance. The resident was 86 YOA. Resident #7 Resident #7 was admitted to the facility on [DATE], with diagnoses including COPD, unspecified, type II diabetes mellitus without complications, and other specified hypothyroidism. The resident was 76 YOA. Resident #20 Resident #20 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with diagnosed including endocarditis, valve unspecified, primary pulmonary hypertension, nonrheumatic tricuspid (valve) insufficiency, hypothyroidism, and obstructive sleep apnea (adult) (pediatric). The resident was 86 YOA. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #18 Resident #18 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type II diabetes mellitus with diabetic polyneuropathy, long term (current) use of insulin, COPD, unspecified, and unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The resident was 80 YOA. Resident #12 Resident #12 was admitted to the hospital on 04/22/2024, with diagnoses including unspecified disorder of circulatory system, encephalopathy, unspecified, adult failure to thrive, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unspecified convulsions. The resident was 64 YOA. Resident #26 Resident #26 was admitted to the facility on [DATE], with diagnoses including traumatic subarachnoid hemorrhage with loss of consciousness, status unknown, subsequent encounter, and unspecified dementia, unspecified severity, with other behavioral disturbance. The resident was 79 YOA. Resident #17 Resident #17 was admitted to the facility on [DATE], with diagnoses including transient cerebral ischemic attack, unspecified, unspecified atrial fibrillation, and myasthenia gravis without (acute) exacerbation. The resident was 89 YOA. Resident #8 Resident #8 was admitted to the facility on [DATE], with diagnoses including COPD, unspecified, other forms of dyspnea, hypoxemia, and hypothyroidism, unspecified. The resident was 95 YOA. Influenza Vaccine The facility lacked documented evidence 23 of 26 residents eligible or potentially eligible to receive a flu vaccine were screened for eligibility to receive a flu vaccine and lacked documented evidence education related to the 2023/2024 flu vaccines was provided to the resident or the resident's representative (Resident #4, #16, #10, #24, #11, #15, #19, #6, #13, #5, #23, #1, #3, #22, #21, #9, #7, #20, #18, #12, #26, #17 and #8). The facility administered flu vaccines to the residents as follows: -8 of 26 residents eligible to receive a flu vaccine declined vaccination (Resident #11, #19, #13, #23, #3, #9, #18, and #12). The residents' clinical records lacked documented evidence the residents were screened for eligibility to receive a flu vaccine and the residents and/or residents' representatives were provided education regarding the 2023/2024 flu vaccines prior to declining vaccination resulting in the resident not having the opportunity to make an informed decision. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-5 of 26 residents' (Resident #24, #22, #7, #17 and #8) clinical records lacked documented evidence the residents were screened to determine eligibility to receive a flu vaccine and were provided education regarding the 2023/2024 flu vaccines prior to signing consents and prior to the administration of a 2023/2024 flu vaccine. This failure resulted in the residents not having the opportunity to make an informed decision prior to being administered a 2023/2024 flu vaccine and put residents at risk of having adverse reactions to the flu vaccine related to risk factors identified during the screening process. -3 of 26 residents' (Resident #16, #20 and #26) clinical records lacked documented evidence the residents were screened for eligibility to receive a flu vaccine, education regarding the 2023/2024 flu vaccine was provided, and consent was given by the resident or the residents representative prior to administering a flu vaccine to the residents. This failure resulted in the residents not having the opportunity to make an informed decision and either consent to receive or decline to receive a flu vaccine prior to being administered a 2023/2024 flu vaccine. The lack of screening for eligibility put the residents at risk of having adverse reactions to the flu vaccine related to risk factors identified during the screening process. -6 of 26 residents' (Resident #10, #15, #6, #5, #1 and #21) clinical records documented consents were signed to receive a flu vaccine during the 2022/2023 flu season. The residents' clinical records lacked documented evidence the residents were screened for eligibility to receive vaccination with a 2023/2024 flu vaccine, the resident or the resident's representative were provided education regarding the 2023/2024 flu vaccines, and consent for vaccination with the 2023/2024 flu vaccine was obtained prior to administering a 2023/2024 flu vaccine to the residents. This failure resulted in the residents not having the opportunity to make an informed decision and either consent to receive or decline to receive a flu vaccine prior to being administered a 2023/2024 flu vaccine. The lack of screening for eligibility put the residents at risk of having adverse reactions to the flu vaccine related to risk factors identified during the screening process. -1 of 26 residents (Resident #4) was screened for eligibility to receive a flu vaccine with a hospital consent form. The screening/consent form included a section with an acknowledgement of receipt of a Vaccination Information Sheet (VIS) and an acknowledgement the resident reviewed the information on the back of the form. The form documented the VIS provided to the resident was dated 08/06/2021. The form documented the vaccine administered to Resident #4, Fluad manufactured by Seqirus, was to be given to individuals 65 and older only !!!! and Resident #4 was 61 YOA. The hospital consent form instructed to initial on the line next to each acknowledgement and to sign the line below the acknowledgement to give consent for vaccination. A check mark was entered into the provided line in front of each acknowledgement and were not initialed by the resident or a resident representative. The signature line for consent documented verbal consent and did not document who gave the consent. This failure resulted in Resident #4 not having the opportunity to make an informed decision prior to being administered a 2023/2024 flu vaccine and put residents at risk of having adverse reactions to the flu vaccine related to risk factors identified during the screening process. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/18/24 at 8:29 AM, the Director of Nursing (DON) confirmed the facility did not have a process in place for screening residents for eligibility to receive a flu vaccine and did not provide education related to flu vaccines to the residents. The DON confirmed consents were signed at admit and new consents were not signed prior to each new flu vaccine administered. On 07/18/2024 at 8:36 AM, the DON confirmed the facility did not have a screening tool or an algorithm to assist in determining eligibility and/or the recommended PNA vaccine for a resident. The DON confirmed the facility was not using the VIS educational documents to provide education related to flu and PNA vaccines to residents or the resident's representative/guardian. A Food and Drug Administration (FDA) package insert titled Fluad Quadrivalent - Seqirus Incorporated, dated March 2023, documented the Fluad vaccine was approved for use in individuals [AGE] years of age or older and was not approved by the FDA for people under the age of 65. The facility policy titled Influenza Vaccination, revised 12/2023, documented influenza vaccination was the primary method for preventing influenza and it's severe complications. Therefore, vaccination against influenza was offered to residents. Upon admission residents were assessed for recent and past flu vaccination, and flu vaccines were administered to residents annually thereafter. The healthcare professional administering the vaccine obtained a signed consent from the resident or resident representative at the time of admission or prior to the next flu season. Residents were routinely vaccinated, unless contraindicated, at one time, annually, before the influenza season. Residents and/or the resident representatives were provided a copy of the most current VIS regarding the flu vaccine the resident was to be given. Residents were screened for history of Guillain-Barre Syndrome, and for severe allergic reaction to a previous dose, vaccine component, and egg protein. A flu vaccine was not to be administered to residents exhibiting signs and symptoms of moderate or severe acute illness, with or without fever. The facility referred to current Advisory Committee on Immunization Practices (ACIP) recommendations for special circumstances such as immunosuppression, immunodeficiencies, corticosteroid therapy and organ transplantation. The licensed nurse administered flu vaccines according to the manufacturer's instructions and followed the Six Rights of Drug Administration. Pneumonia Vaccine The facility lacked documented evidence 26 of 26 residents eligible or potentially eligible to receive a PNA vaccine were screened for eligibility to receive a PNA vaccine and lacked documented evidence education regarding the PNA vaccine the resident was eligible to receive was provided to the resident or the resident's representative (Resident #4, #27, #16, #10, #24, #11, #15, #14, #19, #6, #13, #5, #23, #2, #1, #3, #22, #21, #9, #7, #20, #18, #12, #26, #17, and #8). The facility administered PNA vaccines to the residents as follows: -13 of 26 residents (Resident #4, #16, #10, #24, #11, #15, #19, #6, #13, #5, #23, #1, #3, #22, #21, #9, #7, #20, #18, #12, #26, #17 and #8) eligible or potentially eligible to receive a PNA vaccine declined vaccination. The residents' clinical records lacked documented evidence the residents were screened for eligibility to receive a PNA vaccine and the residents and/or residents' representatives were provided education regarding the PNA vaccines prior to declining vaccination resulting in the resident not having the opportunity to make an informed decision. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-7 of 26 residents' clinical record included a signed consent requesting to receive vaccination with a PNA vaccine (Resident #2, #21, #8, #7, #22, #24, and #10). The residents' clinical record lacked documented evidence the resident was screened for eligibility to receive a PNA vaccine, education was provided related to the PNA vaccine the resident was eligible to receive, and the PNA vaccine was administered to the resident. Resident #14's clinical record lacked documented evidence the resident was screened for eligibility to received a PNA vaccine, education regarding PNA vaccines was provided, a consent or declination to receive a PNA vaccine was obtained, and the resident was provided with a PNA vaccine based on eligibility for the vaccine and the resident's desire to be vaccinated. The Centers for Disease Control and Prevention (CDC) app PneumoRecs VaxAdvisor (VaxAdvisor) recommendation for Resident #14 was to receive one dose of Pneumococcal conjugate vaccine (PCV)15 or PCV20. If PCV20 was administered, the resident's vaccinations were considered complete. If PCV15 was administered the recommendation was for Resident #14 to receive one dose of pneumococcal polysaccharide vaccine (PPSV) 23 after one year. Resident #4's clinical record included a consent signed by the resident on 10/11/2014, requesting to receive a PNA vaccine. Resident #4's clinical record documented the resident received one dose of PPSV23 on 11/07/2017, approximately three years after consenting/requesting to receive a PNA vaccine. Resident #4's clinical record lacked documented evidence the resident was screened for eligibility to receive a PNA vaccine and to determine the recommended dose to give the resident, and lacked documented evidence education regarding PNA vaccines was provided. The resident's clinical record lacked documented evidence the resident was screened for eligibility to receive any additional doses of a PNA vaccine. Resident #15's clinical record included a consent to receive a PNA vaccine signed by the resident's guardian on 02/10/2023. One dose of PPSV23 was administered to the resident on 02/13/2023. Resident #15's clinical record lacked documented evidence the resident was screened for eligibility to receive a PNA vaccine and to determine the recommended PNA vaccine to administer prior to administering a PNA vaccine. Resident #15's clinical record lacked documented evidence the resident and/or the resident's guardian were provided education related to the vaccine administered to Resident #15. Resident #6's clinical record included a consent to receive a PNA vaccine, the consent was verbal consent from the resident dated 09/09/2022. Resident #6's clinical record documented the resident received one dose of PPSV23 on 11/09/2022. Resident #6's clinical record lacked documented evidence the resident was screened for eligibility to receive a PNA vaccine and to determine the CDC recommended PNA vaccine to administer. The residents clinical record lacked documented evidence the resident was provided education related to PPSV23. Resident #6's clinical record lacked documented evidence the resident was screened for eligibility to receive any additional subsequent doses of a PNA vaccine. Resident #5's clinical record included a consent to receive a PNA vaccine signed by the residents guardian on 08/31/2011. Resident #5's clinical record documented the resident received one dose of PPSV23 on 12/04/2017, approximately six years after consenting/requesting to receive a PNA vaccine. Resident #4's clinical record lacked documented evidence the resident was screened for eligibility to receive a PNA vaccine and to determine the recommended dose to give the resident, and lacked documented evidence education regarding PNA vaccines was provided to the resident or the resident's guardian. The resident's clinical record lacked documented evidence the resident was screened for eligibility to receive any additional doses of a PNA vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #20's clinical record documented the resident was administered one dose of PPSV23 on 11/08/2022. Resident #20's clinical record did not include a signed consent to receive the vaccine, evidence the resident was screened for eligibility to receive a PNA vaccine and to determine which PNA vaccine to administer. Resident #20's clinical record lacked documented evidence the resident or the resident's representative were provided education regarding PNA vaccines. The CDC's VaxAdvisor recommended to administer one dose of PCV15 or PCV20 at least one year after the last dose of PPSV23 in order for the resident's PNA vaccinations to be complete. The failure to screen residents for eligibility to receive a PNA vaccine and determine the correct PNA vaccine to administer to each resident, placed residents at risk of being vaccinated with the wrong PNA vaccine for the resident, or not receiving additional needed doses of a PNA vaccine. The lack of education related to the PNA vaccine a resident was eligible to receive resulted in the residents not having the opportunity to make an informed decision and consent prior to being administered the vaccine. The failure to administer a PNA vaccine to eligible residents put the residents at risk of developing PNA with the potential to result in complications associated with PNA. On 07/16/24 at 4:22 PM, the DON confirmed the facility did not have a screening process in place related to PNA vaccines and did not provide education related to PNA vaccines to residents or the resident's representative. The DON confirmed none of the facility's 27 residents had been screened for vaccination with a PNA vaccine and education related to PNA vaccines was not provided to the residents. The facility policy titled Pneumococcal Polysaccharide Vaccination, last revised 10/2017, documented because pneumococcal disease was known to lead to serious infections in the resident population and was proving to be resistant to antibiotics, the facility provided vaccination against pneumococcal disease to prevent the spread of infection. PPSV protected against multiple types of pneumococcal bacteria and was offered to the resident population. Residents were screened for severe allergic reactions after a previous dose of PPSV and consent was obtained from the resident or the resident's representative/guardian. Residents or the resident's representative/guardian were provided with information regarding potential reactions and a copy of the most current VIS. Copies of the VIS were obtained from the CDC website. Documentation in the residents clinical record included the date of administration, amount and dosage given, reactions to the vaccine. The policy was last revised in 2017, and documented the sole reference was titled CDC, Morbidity and Mortality Weekly Report (MMWR), Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP), volume 46/No. RR-8, dated 04/04/1997. The reference included a weblink, but the link indicated the page could no longer be found. The guidance in the policy was outdated and did not include the CDC's most recent guidance regarding the selection and administration of pneumococcal vaccines.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure a Certified Nursing Assistant (CNA) was screened for eligibility to receive a COVID-19 (COVID) booster vaccine, education regarding the vaccine was provided and the CNA had an opportunity to make an informed decision to receive or decline the vaccination, and 2) 1 of 6 residents reviewed for immunization with a COVID booster vaccine were screened for eligibility to receive the vaccine, education regarding the vaccine was provided to the resident or the resident's representative, and the resident or the resident representative had the opportunity to make an informed decision to receive or decline the vaccine. Findings include: CNA The facility lacked documented evidence a CNA with the hire date of 10/25/2020, was screened for eligibility to receive a COVID booster vaccine, education regarding the vaccine was provided and the CNA had an opportunity to make an informed decision to receive or decline the vaccination. The CNAs state immunization record documented the CNA recieved a dose of a COVID vaccine on 10/13/2021 and 02/03/2021. On 07/16/2024 at 12:13 PM, the Director of Nursing (DON) confirmed the facility did not have documented evidence the CNA had been provided education regarding updated COVID vaccines, was screened for eligibility and had either been provided the vaccine or completed a declination for the vaccine. The facility was not able to provide documented evidence the vaccine was provided by a third party provider. The DON confirmed the facility was no longer tracking COVID vaccination status for staff. On 07/18/2024 at 9:10 AM, the DON verbalized education related to COVID vaccines was only provided when new vaccines were available or when a vaccination clinic was held. The DON confirmed education related to COVID vaccines was not being provided to residents or staff.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 46301 Based on personnel record review, interview and document review, the facility failed to ensure communications training was completed by staff for 1 of 20 sampled employees (Employee #4). Findings include: Employee #4 Employee #4 was hired as the Registered Dietician on 09/11/2003. Employee #4's personnel record lacked documented evidence of communication training. On 07/23/2024 at 9:42 AM, the Human Resources Supervisor verbalized all staff were required to complete Communication training within 30 days of hire and annually thereafter. The Human Resources Supervisor confirmed Employee #4 did not have Communication training. The facility policy titled Communication Training, effective 04/2022, documented employees were to complete Communication training at a minimum of annually.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 46301 Based on personnel record review, interview and document review, the facility failed to ensure resident rights training was completed by staff for 1 of 20 sampled employees (Employee #4). Findings include: Employee #4 Employee #4 was hired as the Registered Dietician on 09/11/2003. Employee #4's personnel record lacked documented evidence of resident rights training. On 07/23/2024 at 9:42 AM, the Human Resources Supervisor verbalized all staff were required to complete Resident Rights training within 30 days of hire and annually thereafter. The Human Resources Supervisor confirmed Employee #4 did not have Resident Rights training. The facility policy titled Resident Rights Training, effective 08/2022, documented employees were to complete Resident Rights education at a minimum of annually.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 46301 Based on personnel record review, interview and document review, the facility failed to ensure elder abuse training was completed timely for 7 of 20 sampled employees (Employee #4, #7, #10, #11, #17, #19, and #20). Findings include: Employee #4 Employee #4 was hired as the Registered Dietician on 09/11/2003. Employee #4's personnel record documented elder abuse training completed 10/06/2022, however lacked documented evidence elder abuse training was completed in 2023. Employee #7 Employee #7 was hired as a Certified Nursing Assistant (CNA) on 04/01/2023. Employee #7's personnel record documented elder abuse training completed 10/29/2023, however was completed more then 30 days after hire. Employee #10 Employee #10 was hired as a Licensed Practical Nurse on 06/06/2024. Employee #10's personnel record lacked initial elder abuse training completed prior to starting work on the floor. Employee #11 Employee #11 was hired as a Registered Nurse (RN) on 01/22/2024. Employee #11's personnel record documented elder abuse training completed 06/12/2024,however was completed more then 30 days after hire. Employee #17 Employee #17 was hired as a CNA on 11/13/2023. Employee #17s personnel record lacked initial elder abuse training completed prior to starting work on the floor. Employee #19 (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee #19 was hired as a Hospitality Aide on 04/19/2024. Employee #19's personnel record lacked initial elder abuse training completed prior to starting work on the floor. Employee #20 Employee #20 was hired as a Housekeeper on 11/09/2023. Employee #20's personnel record documented elder abuse training completed 12/27/2023, however was completed more then 30 days after hire. On 07/17/2024 at 11:04 AM, the Human Resources Supervisor verbalized all staff were required to complete elder abuse training within 30 days of hire and annually thereafter. The Human Resources Supervisor confirmed Employees #4, #7, #10, #11, #17, #19, and #20 lacked timely elder abuse training. The facility policy titled Abuse Prevention, revised 05/2023, documented all staff would be in serviced annually on the facility abuse prohibition policy. The facility abuse policy lacked the requirement to complete abuse training upon orientation.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 46301 Based on interview and document review, the facility failed to ensure Quality Assurance Performance Improvement (QAPI) training had been completed to include objectives of resident care needs for 1 of 20 sampled employees (Employee #4). Findings include: Employee #4 Employee #4 was hired as the Registered Dietician on 09/11/2003. Employee #4's personnel record lacked documented evidence of QAPI training. On 07/23/2024 at 9:42 AM, the Human Resources Supervisor verbalized all staff were required to complete QAPI training within 30 days of hire and annually thereafter. The Human Resources Supervisor confirmed Employee #4 did not have QAPI training. The facility policy titled Quality Management Program, revised 11/2017, documented all staff shall receive annual training on the facility's QAPI program.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 46301 Based on interview and document review, the facility failed to provide timely infection control training to all staff to ensure proper procedures and standards of the program for 1 of 20 sampled employees (#4). Findings include: Employee #4 Employee #4 was hired as the Registered Dietician on 09/11/2003. Employee #4's personnel record lacked documented evidence infection control training had been completed. On 07/23/2024 at 9:42 AM, the Human Resources Supervisor verbalized all staff were required to complete infection control training within 30 days of hire and annually thereafter. The Human Resources Supervisor confirmed Employee #4 did not have infection control training. The facility policy titled Infection Control Training, effective 01/2021, documented education and training would be provided to all healthcare personnel annually.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. 46301 Based on interview and document review, the facility failed to ensure compliance and ethics training was completed timely for 1 of 20 sampled employees (#4). Findings include: Employee #4 Employee #4 was hired as the Registered Dietician on 09/11/2003. Employee #4's personnel record lacked documented evidence of compliance and ethics training. On 07/23/2024 at 9:42 AM, the Human Resources Supervisor verbalized all staff were required to complete Compliance and Ethics training within 30 days of hire and annually thereafter. The Human Resources Supervisor confirmed Employee #4 did not have compliance and ethics training. The facility policy titled Compliance and Ethics Training, Effective 10/2022, documented all employees complete Compliance and Ethics continuing education. Education and training shall be provided to all staff annually.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 46301 Based on interview and document review, the facility failed to ensure behavioral health training was completed timely for 1 of 20 sampled employees (Employee #4). Findings include: Employee #4 Employee #4 was hired as the Registered Dietician on 09/11/2003. Employee #4's personnel record lacked documented evidence of behavioral health training. On 07/23/2024 at 9:42 AM, the Human Resources Supervisor verbalized all staff were required to complete Behavioral Health training within 30 days of hire and annually thereafter. The Human Resources Supervisor confirmed Employee #4 did not have Behavioral Health training. The facility policy titled Behavioral Health Care Training, effective 07/2022, documented employees were to complete Behavioral Health Care training at a minimum of annually.