

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Salem Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1945 Roanoke Blvd Salem, VA 24153	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to screen for a mental disorder or intellectual disability prior to admission for 1 of 38 sampled residents. Resident #154. The findings include: For Resident #154 (R154), the facility staff failed to obtain a Level I Screening for Mental Illness, Intellectual Disability (ID), or Related Conditions, to determine if the resident had or may have had a MD (Mental Disorder), ID, or related condition prior to admission. R154's diagnosis list indicated diagnoses, which included, but not limited to Multiple Sclerosis, Legal Blindness, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, and Parkinson's Disease. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/27/24, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. On 5/30/24, during the clinical record review, surveyor could not locate a PASARR (Preadmission Screening and Resident Review) on R154's clinical record. On 5/30/24, 5/31/24 and 6/3/24, surveyor requested evidence of a PASARR for R154 from the director of nursing. On 6/3/24 at 1:28 PM, surveyor interviewed Discharge Planning Director #1 (DPD#1) about R154's PASARR history. DPD#1 stated she could not locate the PASARR on R154. She stated it was done on paper and she had reached-out to the screeners. DPD#1 stated R154 had come from [name omitted] and she requested a medical record request to the hospital on 5/30/24 and again today (6/3/24). DPD#1 stated they (hospital) may find it (PASARR), or they may not, so she did a new PASARR and provided surveyor with a copy of R154's PASARR dated 6/3/24. On 6/3/24 at 4:15 PM, the survey team met with the Administrator #1, Director of Nursing, Regional Director of Clinical Services, Regional MDS and Administrator #2, and discussed the concern of the facility staff failing to obtain a PASARR for R154 prior to admission. (continued on next page)		

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received a facility policy titled, Level I PASRR(sic)-Virginia, which read in part, .Prior to arrival of a planned admission the Social Worker and Discharge Planner will collaborate with the Admissions Director to preview the .Level 1 PASRR (Level 1 Screening for Mental Illness, Intellectual Disability, or Related Conditions) and/or initiate completion of the Level 1 PASRR if not completed .to predetermine if the transferring patient meets SNF/NF (skilled nursing facility/nursing facility) criteria and to screen the patient for indicators of serious mental illness, mental retardation, developmental disabilities or related conditions prior to being admitted in the SNF/NF Center, as required by Federal Regulation .if the Level 1 PASRR is missing from the preadmission paperwork, collaborate with admissions .in order to initiate completion of the Level 1 PASRR internally . No further information regarding this concern was presented to the survey team prior to the exit conference on 6/4/24.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42353 Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to follow the medical provider orders for 2 of 38 sampled residents (Residents #84 and #160). The findings included: 1. For Resident #84, the facility staff failed to follow the recommendations of the orthopedic specialist for compression stockings. Resident #84's diagnosis list indicated diagnoses, which included, but not limited to Chronic Respiratory Failure, Asthma, Chronic Kidney Disease Stage 3, Heart Failure, Paroxysmal Atrial Fibrillation, and Displaced Bicondylar Fracture of Left Tibia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/24/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. On 5/30/24 at 3:20 PM, surveyor spoke with Resident #84 who complained of swelling in their feet stating it was painful while participating in physical therapy. The resident removed their left sock revealing a large amount of swelling in the left foot. The resident stated they have been requesting a fluid pill for the edema but there has been no follow up. Resident #84 was not wearing compression stockings, only regular grip socks. The resident stated they have not had any compression stockings while at the facility. Surveyor reviewed Resident #84's clinical record and was unable to locate documentation of the resident's lower extremity edema or request for a diuretic. During a meeting with the facility management team on 5/30/24 at 3:25 PM, surveyor discussed the resident's edema and their desire for a diuretic. Resident #84's clinical record included a nursing progress note dated 5/13/24 11:57 AM which read in part Patient returned from follow up ortho appointment with recommendations to start .Compression stockings and LE [lower extremity] elevation . On 6/03/24 at 8:15 AM, surveyor spoke with the Director of Nursing (DON) and requested the ortho consult report from 5/13/24. On 6/03/24 at 12:40 PM, surveyor spoke with Resident #84 who stated some improvement with swelling today and was wearing bilateral compression stockings. According to the clinical record, the provider order for compression stockings was entered on 6/03/24 at 12:00 PM. On 6/03/24 at 2:34 PM, surveyor spoke with the DON who stated they reviewed the ortho consult today and noted the recommendation for compression stockings and spoke with the provider and added them today. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/03/24 at 4:18 PM, the survey team met with the Administrator, DON, and Regional Nurse Consultant and discussed the concern of Resident #84 not receiving compression stockings until today when they were recommended by the orthopedic specialist on 5/13/24. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/04/24. 2. For Resident #160, the facility staff failed to follow the provider orders for the administration of Amlodipine Besylate and Metoprolol Tartrate used to treat high blood pressure. Resident #160's diagnosis list indicated diagnoses, which included, but not limited to Respiratory Failure, Vascular Dementia, Dysphagia, Cerebral Infarction, Heart Failure, Type 2 Diabetes Mellitus, and Essential Hypertension. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/16/24 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired. Resident #160's provider orders included an order dated 12/07/23 for Amlodipine Besylate 10 mg one time a day for hypertension hold if systolic blood pressure (SBP) less than 100 or diastolic blood pressure (DBP) less than 60. The resident's orders also included an order dated 12/07/23 for Metoprolol Tartrate 25 mg two times a day for hypertension hold if heart rate less than 60. Surveyor reviewed Resident #160's clinical record and was unable to locate evidence of staff checking the resident's blood pressure prior to the administration of Amlodipine Besylate or heart rate prior to the administration of Metoprolol Tartrate. Surveyor requested and received the facility policy titled General Guidelines for Medication Administration with a revision date of 8/2020 which read in part .II. Administration .2. Medications are administered in accordance with written orders of the prescriber . On 6/03/24 at 4:18 PM, the survey team met with the Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of staff failing to administer Amlodipine Besylate and Metoprolol Tartrate according to the provider orders. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/04/24.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42353 Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a resident who is fed by enteral means receives the appropriate provider ordered hydration for 1 of 4 sampled residents dependent on enteral feeding (Resident #160). The findings included: For Resident #160, the facility staff failed to provide water flushes as ordered on seven (7) separate occasions during the month of May 2024. Resident #160's diagnosis list indicated diagnoses, which included, but not limited to Respiratory Failure, Vascular Dementia, Dysphagia, Heart Failure, Cerebral Infarction, Type 2 Diabetes Mellitus, and Essential Hypertension. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/16/24 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired. Resident #160 was coded for the presence of a feeding tube in which they received 501 cc/day or more of average fluid intake. Resident #160's current comprehensive person-centered care plan included a focus area stating, the resident is at risk for complications related to the need for an enteral tube feeding with an intervention to administer tube feedings and flushes per order. On 5/30/24 at 9:15 AM, surveyor spoke with Resident #160 who stated they felt hungry at times and craved water. The resident's lips appeared dry with a white coating present. Resident #160's provider orders included an order dated 3/26/24 to flush feeding tube with 200 cc of water every 4 hours. A review of the resident's May 2024 Medication Administration Record (MAR) revealed omissions for the water flushes on the following occasions: 5/11/24 10:00 AM, 5/11/24 2:00 PM, 5/11/24 10:00 PM, 5/12/24 10:00 AM, 5/12/24 2:00 PM, 5/21/24 2:00 PM, and 5/28/24 10:00 PM. Resident #160 had a provider order present to have nothing by mouth. Surveyor requested and received the facility policy titled Enteral Feeding Tubes with an effective date of 1/29/24 which read in part .Care and Management .3. Provide irrigation after feeding and/or routinely per provider order to ensure patency, and document in medical record . On 6/03/24 at 4:18 PM, the survey team met with the Administrator, Director of Nursing, and Regional Nurse Consultant and discussed the concern of the water flush omissions for Resident #160. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/04/24.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 42353 Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a resident who is fed by enteral means receives the appropriate treatment to prevent complications for 1 of 4 sampled residents dependent on enteral feeding (Resident #384). The findings included: For Resident #384, the facility staff failed to follow the medical provider orders for enteral feeding. Resident #384's diagnosis list indicated diagnoses, which included, but not limited to Respiratory Failure, Malignant Neoplasm of Brain, Malignant Neoplasm of Lung, Pneumonitis, Dysphagia, Cerebral Edema, and Seizures. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/28/24 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #384 was coded for the presence of a feeding tube. Resident #384's current comprehensive person-centered care plan included a focus area stating, the resident is at risk for complications related to the need for an enteral tube feeding with an intervention to administer tube feedings and flushes per order. On 5/29/24 at 1:21 PM and 5/30/24 at 9:26 AM, surveyor observed Resident #384 receiving Osmolite 1.5 continuously via pump running at 55 ml/hour. The resident's current medical provider orders included an order dated 5/28/24 for Osmolite 1.5 at 250 ml via bolus five (5) times a day at 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM. On 5/30/24 at 3:25 PM, the survey team met with the Administrator, Assistant Administrator, Director of Nursing, and the Regional Nurse Consultant (RNC) and discussed the concern of Resident #384 not receiving enteral feedings as ordered. On the morning of 5/31/24, the RNC provided the surveyor a written statement indicating the tube feeding pump had been removed from Resident #384's room. On 5/31/24 at 1:20 PM, surveyor spoke with the Registered Dietitian (RD) who stated the enteral feeding was changed to bolus because Resident #384 was taking a medication which required the feeding to be held with administration. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/04/24.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42353 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to provide respiratory care consistent with the comprehensive person-centered care plan and the provider orders for 1 of 38 sampled residents (Resident #84). The findings included: For Resident #84, the facility staff failed to administer supplemental oxygen as ordered by the provider. Resident #84's diagnosis list indicated diagnoses, which included, but not limited to Chronic Respiratory Failure, Asthma, Chronic Kidney Disease Stage 3, Heart Failure, Paroxysmal Atrial Fibrillation, and Displaced Bicondylar Fracture of Left Tibia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/24/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #84's comprehensive person-centered care plan included a focus area stating, the resident is at risk for respiratory complications secondary to respiratory failure with an intervention to administer oxygen as ordered. On two separate occasions, 5/29/24 at 12:30 PM and 5/31/24 at 8:56 AM, surveyor observed Resident #84 in bed receiving oxygen via nasal cannula at the delivery rate of 3 liters per minute (l/m) per the oxygen concentrator setting. The oxygen concentrator was located on the left side of the bed out of the resident's reach at each observation. Resident #84's current medical provider orders included an order dated 3/29/24 for oxygen at 2 l/m via nasal cannula. On 5/31/24 at 9:00 AM, surveyor spoke with Licensed Practical Nurse (LPN) #10 who verified the resident's oxygen was ordered for 2 l/m. The Unit Manager (UM) accompanied the surveyor to Resident #84's room and acknowledged the oxygen concentrator was set at 3 l/m and changed the setting to 2 l/m. Surveyor requested and received the facility policy titled, Respiratory Care & Oxygen Equipment with an effective date of 1/29/24 which read in part Oxygen therapy will be administered per provider's order . On 6/03/24 at 4:18 PM, the survey team met with the Administrator, Director of Nursing, and Regional Nurse Consultant and discussed the concern of Resident #84 receiving oxygen at the incorrect delivery rate. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/04/24.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 21227 2. The facility staff failed to document detailed assessments: (a) when Resident #185 experienced a fall on 10/27/23 which resulted in a medical provider ordering left leg and left hip x-rays and (b) when Resident #185 was provided pain medications which were ordered to be administered as needed. Resident #185's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/17/23, was signed as completed on 10/18/23. Resident #185 was assessed as able to make self understood and as able to understand others. Resident #185's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact and/or borderline cognition. Resident #185's clinical record included a Fall Note with an effective date of 10/27/23 at 7:11 p.m. This Fall Note indicated a left hip x-ray and a left leg x-ray were ordered. No documentation was found to indicate what change in the resident's condition/assessment resulted in the medical provider ordering the left leg and left hip x-rays. Resident #185's clinical record indicated the resident was administered as needed pain medications at the following times: - 10/19/23 at 12:18 p.m., - 10/22/23 at 3:55 p.m., - 10/28/23 at 9:23 a.m., - 10/30/23 at 7:38 p.m., - 10/30/23 at 9:52 p.m., - 10/31/23 at 9:13 a.m., - 10/31/23 at 12:11 p.m., and - 10/31/23 at 1:18 p.m. The facility staff documented a pain scale for the aforementioned as needed pain medication administrations. The facility staff failed to complete and/or document a detailed pain assessment, when as needed pain medications were administered, to include: (a) pain characteristics, (b) the impact of pain on quality of life/movement, (c) any factors that worsens or decreases the resident's pain, and (d) a physical description of the location of the pain. The following information was found in a facility policy titled Significant Change of Condition (with an effective date of 1/29/24): A licensed nurse will assess the patient for signs and symptoms of change of condition [sic]. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following information was found in a facility policy titled Pain Management Assessments (with an effective date of 1/29/24): - Patient [sic] will be assessed for acute and chronic pain by a licensed nurse and a plan of care will be established. - Initiate a pain assessment any time thereafter should a patient experience pain that is not usual for the patient. On 6/4/24 at 11:10 a.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Nurse Consultant. During this meeting, the surveyor discussed the failure of facility staff to document detailed pain assessments when providing as needed pain medications. 47299 Based on resident interview, clinical record review, and staff interviews the facility staff failed to ensure pain management was provided for residents in accordance with professional standards and/or the resident's preferences for two of 38 residents in the survey sample, resident # 123 and resident # 185. The findings included: 1. For resident # 123, the facility staff failed to administer pain medications timely per the resident's preference to ensure an acceptable level of pain is maintained throughout the day. Resident # 123's diagnoses included but was not limited to major depressive disorder, muscle weakness, heart failure unspecified, epilepsy unspecified, hemiplegia and hemiparesis. Resident # 123's minimum data set (MDS) assessment with an assessment reference date of 5/17/24 assigned the resident a brief interview for mental status (BIMS) score of 13 out of 15 indicating mild cognitive loss. This surveyor interviewed resident #123 on 5/29/24 at 12:40 PM. They stated that they have pain daily. When asked if their pain medication was controlling the pain to a satisfactory level they stated, When I get it on time. When asked how often the medications were brought late, they stated, It seems like every day. I always feel like if I don't tell them and remind them they won't bring it, so everytime they come in here I tell them, don't forget my pain medication. It's due every 8 hours. They stated that their current pain level was a 4 and and rarely is less than that. They state a 3 is an acceptable level. Surveyor asked resident if they felt like their pain would be tolerable if the medications were given as ordered consistently. They stated, I'm not sure, they've never been consistent. The resident denied that their pain level interfered with being able to enjoy their normal activity pursuits. I've always had the pain; I know I always will but if I got my meds on time it might be some better. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This concerned was reviewed during an end of day meeting with the Administrator, Assistant Administrator, The DON, RDCS, the Regional MDS Consultant and the visiting Administrator on 6/3/24 at 4:19 PM. On 6/4/24 at 9:41 AM this surveyor had another conversation with the DON and Regional Director of Clinical Services (RDCS). The DON stated, Our social worker met with (resident) and (resident) said that it wasn't that (their) meds were late, it was that the 5 mg wasn't controlling the pain and the dose needed to be increased. They indicated that they were working with the provider to increase the dose of the Oxycodone. This surveyor stated that the Office of Licensure and Certification had received a complaint that stated that the pain medications were often late. The resident had told the surveyor on two occasions that the meds are often late, and that they always feel as though they have to remind the nurses to bring them, in fear they won't get them. Reminded them that the documentation clearly supports that the meds are often very late, even before the 14th, which is when the computer issues were first reported according to their own records. No further information was presented to the survey team prior to the exit conference.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 42353 2. For Resident #160, the facility staff failed to obtain a STAT CBC (complete blood count) and BMP (basic metabolic panel) and failed to perform flu and COVID-19 testing timely. Resident #160's diagnosis list indicated diagnoses, which included, but not limited to Respiratory Failure, Vascular Dementia, Dysphagia, Cerebral Infarction, Heart Failure, Type 2 Diabetes Mellitus, and Essential Hypertension. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/16/24 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired. A review of Resident #160's clinical record revealed a telehealth evaluation progress note dated 4/14/24 4:24 PM CT which read in part .resident seen at the request of nursing for T [temperature] +100.4 F .Currently on 4 L [liters] O2 [oxygen] (chronically) O2 sat [oxygen saturation] 86% .STAT BMP and CBC ordered .Suspect underlying developing aspiration pneumonia . A provider order dated 4/14/24 at 4:24 PM was received for a STAT BMP and CBC. Surveyor reviewed Resident #160's clinical record and was unable to locate the results or evidence of the BMP and CBC being obtained as ordered. On 6/03/24 at 2:35 PM, surveyor discussed the missing lab results with the Director of Nursing (DON). The DON stated they checked with the lab, and they had the requisition but did not have any results. Resident #160 was again seen by the telehealth provider on 5/21/24 at 7:57 PM CT, the progress note read in part .temp 101.5 and thick yellow productive cough .check for flu and covid . A nursing progress note dated 5/21/24 at 10:37 PM read in part resident swabbed and unable to process .np [nurse practitioner], nursing management and resident notified . According to the resident's clinical record, the COVID test was completed the following day on 5/22/24 at 7:00 PM and the flu swab was obtained on 5/23/24 at 10:14 PM, both tests were negative. On 6/03/24 at 11:05 AM, surveyor spoke with the Infection Preventionist (IP) who stated COVID testing was done using rapid antigen tests and the tests are stored in each medication room with overflow stock available in the Director of Nursing's (DON) office. IP stated they have an ample supply of COVID tests and testing supplies available in the facility. IP stated until approximately mid-April, the facility was using a machine to process rapid flu tests but now flu swabs are sent out to the lab for testing. On 6/03/24 at 3:03 PM, surveyor spoke with Registered Nurse (RN) #10, the writer of the 5/21/24 nursing progress note. RN #10 stated they obtained the flu and COVID sample and were unable to locate the machine to process the results. (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received the facility policy titled Laboratory/Diagnostic Testing with an effective date of 1/29/24 which read in part . 1. A licensed nurse will obtain laboratory, radiology, or other diagnostic services to meet the needs of its patients as ordered by the provider. 2. A licensed nurse will monitor and track all provider ordered laboratory, radiology, and other diagnostic tests; ensure that tests are completed as ordered . On 6/03/24 at 4:18 PM, the survey team met with the Administrator, DON, and Regional Nurse Consultant and discussed the concern of the staff failing to obtain the STAT CBC and BMP and failing to complete flu and COVID testing timely for Resident #160. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/04/24. 47299 Based staff interview, and clinical record review, the facility staff failed to provide timely laboratory services to meet the needs of its residents for two of 38 residents in the survey sample, resident # 123 and resident # 160 . This findings included: 1. For resident # 123 the facility staff failed to ensure a Complete Blood Count (CBC) and a Basic Metabolic Panel (BMP) was done per practitioner's order on 5/4/24. Resident # 123's diagnoses included but was not limited to major depressive disorder, muscle weakness, heart failure unspecified, epilepsy unspecified, hemiplegia and hemiparesis, and recurrent urinary tract infections. Resident # 123's minimum data set (MDS) assessment with an assessment reference date of 5/17/24 assigned the resident a brief interview for mental status (BIMS) score of 13 out of 15 indicating mild cognitive loss. During a review of the clinical record this surveyor observed a note written by the Nurse Practitioner (NP) on 5/4/24. The note read in part under the heading, History of present illness: Pt (patient) complaining of dysuria (discomfort, pain, or burning when urinating) occasionally. He/she stated he/she had a UTI (urinary tract infection) last month and was treated for it. Will obtain a CBC, BMP, and consider a U/A (urinalysis) if WBC (white blood cell count) is elevated and if he/she develops a fever, chills, or sweats. There was a physician's order entered on 5/4/24 for a CBC and a BMP to be done on 5/5/24. The lab results were reviewed and this surveyor noted that according to the lab results report, the CBC and BMP were not drawn until 5/8/24 at 6:00 AM. The WBC was within the normal range and a urinalysis was not indicated. On 6/3/24 at 11:27 AM this surveyor interviewed the Director of Nursing (DON). When asked if labs are ordered due to a specific symptom a resident was having, would they expect the labs to be done the same day they stated, Yes, or at least the next day depending on what the situation is with that patient. Surveyor reviewed the concern with resident # 123's labs ordered on 5/4/24. They stated they would see if they could find out what happened. (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This surveyor requested a copy of the policy entitled, Laboratory/Diagnostic Testing with an effective date of 1/29/24. The policy read in part, Laboratory, radiology, and other diagnostic services are provided to the center by way of written contractual agreements. The contracted service vendor is to provide services to the center that ensure safe and effective patient testing and timely delivery of results. 1. A licensed nurse will obtain laboratory , radiology, or other diagnostic services of its patients as ordered by the provider. 6/3/24 at 4:19 PM this concern was discussed during an end of day meeting with the Administrator, Assistant Administrator, DON, Regional Director of Clinical Services, Regional MDS Consultant and visiting Administrator. No further information was provided to the survey team prior to the exit conference.		

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 21227 2. The facility staff failed to timely obtain Resident #185's medical provider ordered left leg x-ray and left hip x-ray. Resident #185's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/17/23, was signed as completed on 10/18/23. Resident #185 was assessed as able to make self understood and as able to understand others. Resident #185's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact and/or borderline cognition. Resident #185's clinical record included a Fall Note with an effective date of 10/27/23 at 7:11 p.m. This Fall Note indicated a left hip x-ray and a left leg x-ray were ordered. No documentation was found to indicate what change in the resident's condition/assessment resulted in the medical provider ordering the left leg and left hip x-rays. No evidence was found of Resident #185's x-rays being obtained until 10/30/23. On 6/3/24 at 12:08 p.m., the facility's Medical Director was interviewed via telephone. The Medical Director reported that ideally radiology reports would be available within 24 hours. The Medical Director stated they would estimate that they would be notified if the radiology report was not available in 48 hours; the Medical Director indicated decisions would be made at that time based on the resident's clinical presentation. (The medical provider, who ordered the 10/27/23 x-rays, was no longer employed by the facility therefore they were unable to be interviewed.) On 6/3/24 at 12:35 p.m., the surveyor interviewed an employee (Staff Member (SM) #14) with the company the facility had contracted with for radiological services. SM #14 reported someone from the contract radiology company had contacted the facility on the evening of 10/27/23 to inform the facility staff that the x-rays would not be completed on 10/27/23. SM #14 stated someone from the facility okayed not obtaining the x-rays ordered on 10/27/23 until 10/30/23; SM #14 reported the name of the facility staff member who was contacted about the delay in performing the x-rays was not documented by the staff of the contract radiology company. The following information was provided in the service agreement between the facility and the mobile imaging company: (The mobile imaging company's name omitted) shall: . make Radiology Services available for Facility patients seven days a week . On 6/4/24 at 11:10 a.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Nurse Consultant. During this meeting, the surveyor discussed the delay in obtaining Resident #135's 10/27/23 medical provider x-ray orders. 47299 Based on staff interview, facility document review and clinical record review, the facility staff failed to provide timely radiology services to meet the needs of its residents for two out of 38 residents in the survey sample, resident # 167 and resident # 185. (continued on next page)		

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings include: 1. For resident # 167 the facility staff failed to obtain timely x-rays of the left femur, tibia and fibula as ordered on 4/7/24 by the practitioner. The resident was diagnosed with a intertrochanteric femur fracture two days later. Resident # 167's diagnoses list included but was not limited to; displaced intertrochanteric fracture of the left leg, adult failure to thrive, peripheral vascular disease, anxiety, major depressive disorder, dementia, and arthritis. According to resident # 167's minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/22/24, the resident had a brief interview for mental status (BIMS) score of 8 out of 15 indicating moderate cognitive impairment. During record review this surveyor read a nurse's note documented 4/7/24 at 11:35 AM that read, Resident was yelling stating that pain this nurse and cna went in resident room to assess the resident, this nurse observed large bruise on left thigh 12cm length, and 8 cm wide bruises was black and purple, and leg was swelling, resident unable to state how bruise occur. Nurse calls the np (name omitted) got new order of x ray and ibuprofen 400mg every 4 PRN. and Resident is own responsible party. Another note on 4/7/24 by the Nurse Practitioner (NP) read in part, The patient is seen today per nursing concern of fall. Nursing and pt does not know how the patient had a fall. Patient in pain when moving extremities. He/she has L thigh bruising and on inner side and L thigh plus knee swelling. Per nursing his/her vitals are stable and neruo checks WNL. Fall precautions in place. Order X-Ray of L leg for fracture concerns. There were no other notes in the record that addressed the fall or the injury until 4/10/24 when another NP documented in part, Xrays were completed approx 2300 (11:00 PM) last night. Xray was POS for left trochanteric FX and, Left hip swollen and exquistely ttp. bruising to hip and thigh noted. I could not evaluate for leg shortening as he/she would not allow repositioning d/t pain and Closed fracture of trochanter of left femur with routine healing, subsequent encounter To ER for further evaluation and intervention. The clinical record included an x-ray report with an examination date 4/9/24 at 0500 and a reported date of 4/9/24 at 11:22 PM. the report read in part, IMPRESSION: Comminuted intertrochanteric fracture with shortening and lateral displacement. On 5/30/24 at 1:25 PM this surveyor interviewed resident and asked about the left leg fracture in April. They stated, It's not broke, that's my good leg I have arthritis in the other one. Surveyor asked why they had to have surgery on the leg if it wasn't broke and resident whispered, It was a mistake. There wasn't nothing wrong with it, these people messed up. Surveyor asked if the leg caused resident any pain or discomfort and they stated, no, there's nothing wrong with it, it ain't never hurt. 5/30/24 at 1:34 PM this surveyor asked the unit manager if they could check on why the x-ray for resident # 167 wasn't done for two days when they had an acute injury and also asked if they knew whether or not a Facility Reported Incident (FRI) was done. (continued on next page)		

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 1:50 PM this surveyor interviewed Registered Nurse (RN) # 8. They stated that resident # 167 was yelling in a way that was not normal and they and Certified Nursing Assistant C.N.A.) # 6 went to see what resident needed. He/she didn't say anything about pain at first so we decided to change him/her (perform incontinent care) and that is when I found the bruise and when I asked, he/she said it did hurt. RN # 8 stated that resident was in the bed at this time and they were not sure if resident had been up but didn't think so on that day. I called the NP and he/she ordered the Ibuprofen and to get x-rays. I called the x-ray in right away and they (the mobile imaging company) told me they had processed it and someone would come to do it. I don't know why they didn't come. I wasn't here the next day. RN # 8 stated that they administered the Ibuprofen as ordered and that it was effective. I asked RN # 8 why they documented that resident stated they didn't know what happened and then informed the NP that the resident fell . They stated, At first he/she told me he/she didn't know what happened but when I went back in to check on him/her, he/she said he/she fell . 5/30/24 at 3:05 PM the unit manager stated, The first x-ray was set up for the 7th but was canceled due to (resident being combative. They stated they got this information from a representative at the mobile imaging company and that this person was going to send something to show you that. They went on to say that there was no FRI done because resident told the nurse they felt. On 5/30/24 at 3:18 PM during an end of day meeting with the Administrator, Director of Nursing, and the Regional Director of Clinical Services (RDCS) this surveyor asked why an FRI was not done for resident # 167 related to the injury April 7, 2024. The DON stated, (resident) told the nurse that he/she fell so that's what we went with. There was no need for an FRI at that point because it wasn't an injury of unknown origin. This surveyor asked about the delay in obtaining the ordered x-rays and they stated, They came that same day but he/she was combative they said so they didn't do it and didn't tell anybody. 5/30/24 3:30 PM This surveyor requested a copy of the policy entitled, Laboratory/Diagnostic Testing with an effective date of 1/29/24. The policy read in part, Laboratory, radiology, and other diagnostic services are provided to the center by way of written contractual agreements. The contracted service vendor is to provide services to the center that ensure safe and effective patient testing and timely delivery of results. On 6/3/24 at 12:31 PM this surveyor spoke with a representative from the mobile imaging company. When asked if the x-rays were canceled on 4/7/24 due to the resident being combative, they stated, No, we couldn't get anyone over there. We called back around 3:00 PM to tell them it was scheduled for the next day on the 8th according to my notes, but couldn't get anyone on the phone to let the facility know that. When asked what happened on the 8th, they stated, we were short staffed and couldn't get it done we just had such a back log. On the 9th there is a note that the order was upgraded to a STAT order at 12:53 PM and we arrived at 2:00 PM to do it. Surveyor asked why the time on the report read 5:00 AM and they stated that is the time that their group puts it on the days schedule to be done. On 6/3/24 this surveyor received a copy of the contract with the mobile imaging company entitle, Services Agreement. On page 2 of the document it reads in part under Section II. Duties, 2.1 Provide radiology services for facility patients in accordance with: accepted standards of medical care, facility policies and procedures, requirements of all entities that accredit, regulate or license the facility and all applicable federal, state and local laws, regulations, guidelines and standards and 2.3.1 make radiology services available for facility patients seven days a week. (continued on next page)		

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24 at 12:44 PM this surveyor again met with the resident who again denied the fracture, the fall and any complaints of pain in the past or present. On 6/3/24 during the end of day meeting with the Administrator, Assistant Administrator, DON, Regional Director of Clinical Services and visiting Administrator, this concern was discussed. No further information was provided to the survey team prior to the exit conference.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 21227 Based on observations, interviews, and the review of documents, the facility staff failed to ensure menus were followed for two (2) of approximately 11 - 13 resident tray carts (each tray cart was used to transport multiple residents' trays to nursing units); this observation occurred for the lunch meal on 5/30/24. (The dietary staff members working on the food service line during the lunch meal on 5/30/24 indicated the last two (2) resident tray carts were the smallest carts to be sent out; the dietary staff members indicated each cart contained trays for approximately 20 residents.) The findings include: The facility staff failed to ensure all residents had the opportunity to receive the schedule menu items for the lunch meal on 5/30/24. The facility staff ran out of two (2) menu items prior to all the residents receiving their meals. The facility staff ran out of the pork loin with garlic and fresh herbs and the facility staff ran out of the roasted red potatoes. On the afternoon of 5/30/24, the facility's food service staff were observed to be preparing trays to be sent to residents who were having their midday meal on their nursing unit. On 5/30/24 at approximately 1:00 p.m., the Dietary Manager was observed to be cooking additional pork loin. On 5/30/24 at 1:10 p.m., the Dietary Manager was noted to place three (3) frozen pork tenderloin into the steam/oven to cook. The dietary staff had used all the pork loin that had initially been prepared for the 5/30/24 lunch. On 5/30/24, the Administrator reported the pork loin may have been used up due to residents asking for additional servings. On 5/30/24 at 1:30 p.m., the dietary staff were noted to be running out of the roasted potatoes. The Dietary Manager was noted to be preparing additional roasted potatoes. The facility's Region Director of Operations (Staff Member (SM) #17) with the dietary contract company stated they had contacted their dietitian and obtained approval for mashed potatoes to substitute for roasted potatoes. On 5/30/24 at 1:40 p.m., SM #17 stated they had obtained dietitian approval for use of pulled pork to substitute for pork loin. On 5/30/24 at 2:15 p.m., the cook (Staff Member (SM) #19), for the 5/30/24 lunch, reported they cooked the wrong size pork loin; SM #19 reported they felt they had cooked enough potatoes for the meal in question. On 5/30/24 at 2:25 p.m., SM #17 reviewed the facility's meal information for the 5/30/24 lunch. SM #17 reported six (6) pork loins should have been cooked but only four (4) were cooked. SM #17 reported that one too few bags of potatoes had been cooked. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 11:10 a.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Nurse Consultant. During this meeting, the surveyor discussed the facility staff running out of two (2) items on the menu for the 5/30/24 lunch meal.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 28169 3. For Resident #31, facility staff failed to accurately document medication administration for the 9:00 p.m. doses on 05/12/24 and 05/17/24. Resident #31's Admission Record listed diagnoses which included but were not limited to, metabolic encephalopathy (an underlying condition affecting metabolism), osteoarthritis, anxiety, depression, hypertension, chronic peripheral venous insufficiency, and congestive heart failure. The most recent annual minimum data set (MDS) with an assessment reference date of 05/01/24 assigned the resident a brief interview for mental status summary score a 15 out of 15. Resident #31's medication administration record for May 2024 was reviewed. There was no documentation for the 9:00 p.m. dose for seven medications on two dates, 05/12/24 and 05/17/24. The medications were: 1. Atorvastatin 20mg one tablet for hyperlipidemia, 2. Gabapentin 100mg two tablets for pain, 3. Melatonin 5mg for insomnia, 4. Mirtazapine 45mg one tablet for depression, 5. Carvedilol 25mg one tablet for hypertension, 6. Mycophenolate 500mg one tablet for DMARD (Disease-Modifying Antirheumatic Drugs - treatment of inflammatory arthritides), and 7. Hydroxyzine 10mg one tablet for anxiety. The controlled drug administration record tablet document for Resident #31's Gabapentin (an anticonvulsant medication also used for relief of nerve pain) was reviewed. For both dates, 05/12/24 and 05/17/24, facility staff had signed out the 9:00 p.m. dose, indicating that medication was removed from the resident's Gabapentin medication supply. Registered Nurse (RN #6) was interviewed in person on 06/03/24 at 3:00p.m. The nurse recalled administering Resident #31's 9:00 p.m. medications on 05/12/24 stating that although she was familiar with the resident, it had been a long time since she had provided his care until 05/12/24. When asked why she left the MAR's documentation blank for the 9:00p.m. doses, RN #6 stated it was completely an oversight. I promise I gave them; I remember giving them and talking with him and his roommate. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN #5) was interviewed in person on 06/03/24 at 12:26 p.m. The nurse recalled giving Resident #31 all his medications for 9:00p.m. on 05/17/24 and just forgot to sign off the MAR. LPN #5 reported she was supervising that day, and another nurse was having some issues with Resident #31, so LPN #5 helped by administering Resident #31's medications. LPN #5 stated Resident #31 can get frustrated and can be difficult but he did everything fine for me on the 17th. The regional nurse consultant provided the Pharmscript policy titled, General Guidelines for Medication Administration Policy #8.2 with an effective date 09-2018 and revision date of 08-2020. The policy read in part, IV. Documentation (including electronic) 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. On 06/03/24 at 4:17p.m. during an end of day meeting with the administrator, director of nursing, regional nurse consultant, regional MDS, and an administrator from a sister facility, the lack of medication administration documentation for both dates was discussed. No further information was provided prior to the exit conference. 42353 Based on observation, staff interview, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 3 of 38 sampled residents (Residents #384, #160, and #31). The findings included: 1. For Resident #384, the facility staff failed to document a medical provider order for an indwelling urinary catheter. Resident #384's diagnosis list indicated diagnoses, which included, but not limited to Respiratory Failure, Malignant Neoplasm of Brain, Malignant Neoplasm of Lung, Pneumonitis, Dysphagia, Cerebral Edema, and Seizures. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/28/24 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #384 was coded for the presence of an indwelling catheter. Resident #384's current comprehensive person-centered care plan included a focus area stating, the resident requires an [sic] urinary foley catheter 18 French 10 cc balloon. On 5/30/24 at 9:30 AM, surveyor observed Resident #384 with an indwelling urinary catheter in place and draining. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Salem Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1945 Roanoke Blvd Salem, VA 24153	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the clinical record and was unable to locate a medical provider order for an indwelling urinary catheter. However, the resident's clinical record included an Admission/Readmission Nursing Collection Tool V2-V13 dated 5/24/24 which indicated the resident was admitted with an indwelling catheter due to a neurogenic bladder. On 5/30/24 at 3:25 PM, the survey team met with the Administrator, Assistant Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of staff failing to enter an order for the use of an indwelling urinary catheter for Resident #384. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/04/24. 2. For Resident #160, the facility staff failed to maintain a provider order for the administration of supplemental oxygen. Resident #160's diagnosis list indicated diagnoses, which included, but not limited to Respiratory Failure, Vascular Dementia, Dysphagia, Cerebral Infarction, Heart Failure, Type 2 Diabetes Mellitus, and Essential Hypertension. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/16/24 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired. Resident #160's comprehensive person-centered care plan included an intervention to administer oxygen as ordered. On 5/29/24 at 12:48 PM, surveyor observed Resident #160 receiving oxygen via nasal cannula at the delivery rate of 3 liters per minute (l/m) per the oxygen concentrator setting. Surveyor reviewed Resident #160's clinical record and was unable to locate a current provider order for the use of supplemental oxygen. A previous order for oxygen at 2 l/m via nasal cannula was discontinued on 5/13/24. Surveyor was unable to locate additional documentation addressing the discontinuation of oxygen and the nurse who transcribed the discontinuation order was unavailable for interview. On 6/03/24 at 4:18 PM, the survey team met with the Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of Resident #160 receiving oxygen without a current provider order. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/04/24.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42353 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to maintain an infection prevention and control program designed to help prevent transmission of communicable diseases and infections for 1 of 38 sampled residents (Resident #90). The findings included: For Resident #90, facility staff failed to don the required personal protective equipment (PPE) prior to entering the resident's room. Resident #90 was on transmission-based precautions due to ESBL (extended spectrum beta-lactamase) present in the urine. Resident #90's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Borderline Personality Disorder, Chronic Kidney Disease, and Retention of Urine. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/08/24 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. On 5/29/24 at 3:15 PM, surveyor observed a posted contact precautions sign, and a caddy of PPE supplies located beside Resident #90's door. Surveyor donned PPE and entered the resident's room. While speaking with the resident, certified nursing assistant (CNA) #3 entered the resident's room without wearing a gown or gloves and picked up the resident's disposable cup and took the cup into the hall to refill with ice from an ice chest. CNA #3 stated Resident #90 was not on isolation and the contact precautions sign was left over from a previous resident. The Unit Manager (UM) approached the surveyor and CNA #3, and CNA #3 again stated the resident was not on isolation precautions. Surveyor accompanied the UM to the nurse's desk to check Resident #90's clinical record for clarification. UM reviewed the resident's clinical record and stated Resident #90 was on contact precautions for ESBL in the urine. Resident #90's medical provider orders included an order dated 5/24/24 for contact isolation precautions related to ESBL in urine. The resident's comprehensive person-centered care plan included a focus area stating the resident required contact isolation/precautions related to ESBL with interventions for appropriate PPE per policy and isolation precautions per order. Surveyor requested and received the facility policy titled Transmission Based Precautions-General Practice with an effective date of 12/01/21 which read in part The Center initiates transmission-based precautions (TBPs) to protect other patients, employees and visitors from the spread of a confirmed or suspected infection or contagious disease . On 5/30/24 at 3:25 PM, the survey team met with the Administrator, Assistant Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of CNA #3 failing to follow contact precautions with Resident #90. The Administrator stated they were aware, and the CNA had been re-educated and education had also been provided to additional staff present. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/03/24 at 11:00 AM, surveyor spoke with the Infection Preventionist (IP) who stated they provided one on one education with CNA #3 regarding isolation precautions. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/04/24.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer a pneumococcal immunization in accordance with nationally recognized standards for 1 of 5 sampled residents reviewed for immunizations, Resident #90. The findings included: For Resident #90, the facility staff failed to offer the resident a pneumococcal conjugate vaccine 20 (PCV20) or a pneumococcal polysaccharide vaccine (PPSV23) following admission to the facility. A review of the Centers for Disease Control and Prevention (CDC) guideline titled, Pneumococcal Vaccination: Summary of Who and When to Vaccinate last reviewed 9/22/23, read in part, that adults [AGE] years or older who have received a PCV13 (pneumococcal conjugate vaccine 13) at any age and a PPSV23 under [AGE] years old, should receive a PCV20 or PPSV23. Resident #90's diagnosis list indicated diagnoses, which included, but not limited to Type 2 (two) Diabetes Mellitus, Chronic Kidney Disease and Asthma. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/8/24 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Resident #90 was over the age of [AGE] years when admitted to the facility. Resident #90's clinical record included an Immunization Report that revealed Resident #90 received a PPSV23 on 9/18/2007 (under the age of 65) and a Prevnar 13 on 11/5/2018, prior to admission to the facility. Surveyor was unable to locate evidence of Resident #90 being offered a PCV20 or a PPSV23 following admission to the facility. On 6/03/24 at 1:15 PM, surveyor interviewed the IP (infection preventionist) regarding Resident #90's pneumococcal vaccine history. IP stated he did not have any evidence of offering a pneumococcal vaccine to Resident #90 after she was admitted and he could not remember if he asked her, so he offered the pneumococcal vaccine today (6/3/24) and Resident #90 declined. On 6/3/24 at 4:15 PM, the survey team met with the Administrator, Director of Nursing, Regional Director of Clinical Services, Regional MDS and an Administrator from another facility, and discussed the concern of the facility staff failing to offer Resident #90 a pneumococcal vaccine following admission. Surveyor requested and received the facility policy titled, Pneumococcal Vaccination which read in part, . Pneumococcal Vaccination .pneumococcal vaccine is offered in accordance with the CDC's (Centers for Disease Control) Pneumococcal Vaccination Algorithm .Prior to administering a pneumococcal vaccine to patients, complete the following: Screen for eligibility (.previous doses, etc.) .Patient pneumococcal vaccine tracking will be maintained by the Infection Preventionist using Immunization Tracking in the electronic medical records . (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit conference on 6/4/24.		

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22218 Based on observation facility staff failed to ensure hand rails were intact on 4 of 4 nursing units. During initial tour and throughout the course of the facility, surveyors observed residents utilizing hand rails for stabilization while ambulating and as an anchor to pull themselves down the halls while in wheelchairs. On 6/3/24, the surveyor checked handrails throughout the building and found a number of missing handrail segments or end caps which left sharp edges exposed posing a risk of injury: On the front hallway, there were no end caps between the elevator and dining room and no end cap or corner segment by the ladies' restroom. On Unit 1, a segment of the hand rail was missing near the door to the unit manager's office. End caps were missing by rooms 14, 17, 23, 25, and 26. On unit 2, the rail by the pantry was missing an end cap. On Unit 3, end caps were missing by the MDS office and room [ROOM NUMBER]. On 6/3/24, the administrator, director of nursing, MDS corporate consultant, regional nurse consultant, and a consulting administrator were notified of the concern during a summary meeting. No additional information was offered to surveyors prior to exit.		