STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTER	**2700 E 12TH STREET CHEYENNE, WY 82001**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 12/19/22 to 12/22/22. Also reviewed in the course of the survey were complaint intakes WY00003471, WY00003486, and WY00003510. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CMS: Centers for Medicare and Medicaid Services CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the MDS assessment information was an accurate reflection of resident status for 6 of 21 sample residents (#2, #5, #8, #22, #33, #58). The findings were: 1. Review of the 9/28/22 and 11/6/22 quarterly MDS assessments showed the cognitive and mood assessments for resident #2 had not been	F 641	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE	1/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/18/2023

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F 641	Continued From page 1 completed. 2. Review of the 10/29/22 quarterly MDS assessment showed the cognitive and mood assessments for resident #5 had not been completed. 3. Review of the 9/22/22 annual MDS assessment showed the cognitive and mood assessments for resident #8 had not been completed. 4. Review of the 11/13/22 annual MDS assessment showed the cognitive and mood assessments for resident #22 had not been completed. 5. Review of the 10/25/22 significant change MDS assessment and the 11/7/22 quarterly MDS assessment showed the cognitive and mood assessments for resident #33 had not been completed. 6. Review of the 11/14/22 quarterly MDS assessment showed the cognitive and mood assessments for resident #58 had not been completed. 7. Interview with the MDS coordinator on 12/21/22 at 2:25 PM confirmed the MDS assessments were incomplete.	F 641	IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. F641 Accuracy of Assessments I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #2 The BIMs and PHQ9 will be completed within the 7 day look back period on their next scheduled MDS. Resident #5 The BIMs and PHQ9 will be completed within the 7 day look back period on their next scheduled MDS. Resident #8 The BIMs and PHQ9 will be completed within the 7 day look back period on their next scheduled MDS. Resident # 22 The BIMs and PHQ9 will be completed within the 7 day look back period on their next scheduled MDS. Resident # 33 The BIMs and PHQ9 will be completed within the 7 day look back period on their next scheduled MDS. Resident # 58 The BIMs and PHQ9 will be completed within the 7 day look back period on their next scheduled MDS.	

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F 641	Continued From page 2	F 641	II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents audited for BIMS and PHQ9 in the last quarter, any residents identified with no assessments were completed and care plan reviewed and updated. The BIMs and PHQ9 will be completed within the 7 day look back period on their next scheduled MDS. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Each resident will have a BIMs and PHQ9 completed within the 7 day look back period on their next scheduled MDS. The MDS Coordinator was educated on 12/21/22 by the DON/Designee on completing. Each resident will have a BIMs and PHQ9 completed within the 7 day look back period on their next scheduled MDS. The MDS coordinator will schedule MDS assessments and notify IDT. The appropriate party will complete the PHQ9/BIMS assessment per the MDS schedule. The MDS/Designee will audit 10% of MDS assessments weekly X 4 weeks, then monthly X 2 months that BIMS/PHQ9	

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F 641	Continued From page 3	F 641	were completed during lookback period and coded in MDS. Any concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The MDS/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		1/17/23

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F 656	Continued From page 4 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to ensure care plans were developed with resident-specific interventions to reflect individual needs for pain management for 1 of 5 residents (#25) reviewed for pain. The findings were: 1. Review of the 9/10/22 quarterly MDS assessment for resident #25 showed the resident was cognitively intact with a BIMS score of 14 out of 15, and had diagnoses which included type 2	F 656	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS	

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F 656	Continued From page 5 diabetes mellitus, cerebral vascular accident, multiple sclerosis, seizure disorder, and a fractured lumbar vertebra. The resident was on a scheduled pain medication regimen along with medication for breakthrough pain. The resident did not receive non-pharmacological interventions for pain relief. Further, the resident had frequent pain which made it hard to sleep at night and interfered with day-to-day activities. Review of the MAR for December 2022 showed the resident received tramadol 50 milligrams (mg) (pain medication) twice daily, and baclofen 10 mg (muscle relaxant) every 8 hours as needed for pain. Review of the treatment administration record (TAR) for December 2022 showed an order to "...observe pain every shift and to document pain level and treat, trying non-pharmacologic interventions prior to medicating..." Review of the care plan last revised 11/11/22 showed a care area for chronic pain related to arthritis and diabetic neuropathy. The following concerns were identified: a. Interview on 12/20/22 at 10:43 AM with the resident stated s/he only received pain medication to alleviate his/her pain. b. Review of the care plan for chronic pain showed no goals were identified, and the interventions failed to show an acceptable pain level or non-pharmacological interventions to help alleviate pain. 2. Interview on 12/21/22 at 3:10 PM with the DON confirmed the care plan had not been developed to include non-pharmacological interventions.	F 656	OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. F656 Development of Care Plan I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #25 care plan was updated on 1/13/23 to reflect non-pharmacological interventions for pain. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Residents with complaints of pain care plans were reviewed and updated by 1/17/23. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: By 1/16/23 DON/designee provided	

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F 656	Continued From page 6	F 656	education to MDS Coordinator to ensure when completing a pain care plan that non pharm interventions are included. The MDS coordinator will complete a comprehensive care plan on admission, annually and with significant change. Pain review with non-pharm interventions will be included if needed in the care plan. The MDS/Designee will audit 10% of residents weekly X 4 weeks, then monthly X 2 months that pain non-pharm interventions are included in the care plan. Any concerns will be corrected. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The MDS/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		1/17/23

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F 657	Continued From page 7 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to revise the care plan to reflect the resident's needs for 1 of 21 (#2) sample residents reviewed. The findings were: 1. Review of the 11/6/22 quarterly MDS assessment showed resident #2 was readmitted to the facility from the hospital on 10/20/22 and had diagnoses which included pneumonia, respiratory failure, and obstructive sleep apnea. Observation on 12/19/22 at 2:28 PM showed a continuous positive airway pressure (CPAP) machine was at the resident's bedside. Review of a 10/21/22 progress note showed the resident's physician had been notified that the resident had	F 657	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF	

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F 657	Continued From page 8 chosen to begin using the CPAP machine s/he had previously refused. The following concerns were identified: a. Review of respiratory care plan, last revised on 7/5/22, showed the use of the CPAP had not been included. b. Interview with the DON on 12/21/22 at 1:59 PM revealed it was the facility's expectation the resident's care plan should reflect the use of the CPAP and confirmed the resident's care plan had not been revised.	F 657	PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. F657 Care Plan Timing and revision I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #2 care plan updated to included CPAP on 12/21/22. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All other residents were audited on 12/21/22 to ensure that all residents needs were included in the plan of care, no other concerns were identified. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education was provided to MDS Coordinator to ensure revision of care plans included CPAPs and all other needs are met and completed 1/16/23 by DON/designee. The MDS coordinator will complete a	

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F 657	Continued From page 9	F 657	revision of care plan quarterly, annually and with significant change. All needs will be included as part of the care plan as needed. The DON/Designee will audit residents Care Plans weekly X 4 weeks, then monthly X 2 months that the care plan includes CPAPs and any other needs. Any concerns will be corrected. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The ADON/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		1/17/23

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F 688	Continued From page 10 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to provide range of motion services for 1 of 2 sample residents (#61) with limited mobility. The findings were: 1. Review of the 10/20/22 quarterly MDS assessment showed resident #61 was cognitively intact with a BIMS score of 15 out of 15 and had diagnoses which included functional quadriplegia, generalized muscle weakness, right and left wrist and foot drop, and end stage renal disease which required dialysis. The resident required extensive assistance of one staff member for transfers, bed mobility, and dressing due to impaired range of motion in the upper and lower extremities. Further, the resident received occupational therapy and physical therapy from 8/23/22 to 10/20/22. The following concerns were identified: a. Interview on 12/20/22 at 10 AM with the resident revealed s/he only got out of bed to go to dialysis and the facility did not provide any range of motion exercises. b. Interview on 12/22/22 at 12:15 PM with the DON revealed the facility did not have a restorative nursing program, and confirmed the resident was not receiving services to maintain range of motion. She further stated implementing a restorative nursing program was one of her goals.	F 688	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. F688 Increase / Prevent Decrease in ROM/Mobility I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	

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F 688	Continued From page 11	F 688		

Resident # 61 was referred to therapy services on 1/2/23 for services r/t ROM.

II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:

All residents with flaccid or contractured extremities reviewed and referred to therapy services as indicated by 1/17/23. Therapy services will screen/evaluate as appropriate and review plans of care.

III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:

Education provided to clinical IDT by DON/designee on 1/16/23 to ensure that residents with ROM needs are referred to therapy services and have a plan in place for management as appropriate.

On admission, quarterly and significant change residents will be screened for ROM needs. A plan of care will be put in place for management as appropriate.

The DON/Designee will audit 10% of residents with flaccid or contractured extremities weekly X 4 weekly, then monthly X 2 months that plan of care is in place. Any concerns will be identified immediately.

IV. HOW THE FACILITY PLANS TO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 12	F 688	MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The DON/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		1/17/23

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F 690	Continued From page 13 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, professional reference review, and staff interview, the facility failed to ensure urinary catheter bags were kept below the level of the bladder for 2 of 2 sample residents (#322, #326) with catheters. The findings were: 1. Review of a nurse's progress note showed resident #322 entered the facility on 12/12/22. The physician progress notes showed the resident had diagnoses which included overactive bladder, history of extended-spectrum beta-lactomases (ESBL- antibiotic resistance), Klebsiella pneumoniae infection, neurogenic bladder, and urinary tract infection. Review of the care plan showed the resident required extensive assistance with 2 staff using a sit-to-stand lift to move between surfaces. Further review showed the resident "requires use of Catheter. The resident will be/remain free from catheter-related trauma through review date. The resident has 16 French, 5 milliliter (ml) indwelling Catheter. Position catheter bag and tubing below the level of the bladder and away from the entrance room door." The following concerns were identified: a. Observation on 12/19/22 at 2:38 PM	F 690	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. F690 Bowel/Bladder Incontinence, Catheter, UTI	

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F 690	Continued From page 14 showed CNA #2 and CNA #3 transferred the resident from the wheelchair to the bed using a sit-to-stand lift. The urinary drainage bag was lifted above the bladder with urine observed returning to the bladder. The CNAs then placed the urinary bag on the foot rest of the lift while moving the lift. b. Interview with CNA #3 on 12/19/22 at 5:18 PM revealed "we normally pick the Foley bag up to keep it out of the way, or sit it on the foot rest, there's nowhere to hook it on the lifts. So, just we lift it up". She denied having training on placement of the urinary bag. 2. Review of the 12/5/22 admission MDS assessment for resident #326 showed diagnoses which included quadriplegia, Methacillin-resistant Staphylococcles aureus, bacterial infections, septicemia, and obstructive uropathy which required an indwelling catheter. The assessment further showed the resident required extensive assistance with activities of daily living. The following concerns were identified: a. Observation on 12/19/22 at 2:09 PM showed CNA #3 and CNA #4 transferred the resident using a mechanical lift. The CNAs lifted the urinary drainage bag above the bladder and the urine in the tubing was observed flowing back into the bladder. The CNAs kept the urinary bag above the bladder until the resident was placed on the bed. b. Interview at that time with the CNAs revealed this was there normal procedure when transferring a resident with a urinary catheter. 3. Interview with the DON on 12/21/22 at 10:38 AM revealed the facility's expectation was for the urinary drainage bags to be at or below the level of the bladder.	F 690	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #322 and #326 foleys were placed at appropriate level on 12/21/22. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents with foley catheter bags have the potential to be affected. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: CNAs and Nurses educated starting on 12/21/22 that when transferring a resident with a foley catheter the bag remains below the level of the bladder. During transfers staff will place the foley catheter bag in a location that the bag remains below the level of the bladder. The DON/Designee will complete 3 observations of residents' transfers with foley catheters, that the catheter bag remains below the level of bladder during transfer. Observations / Audits will be completed weekly X 4 weeks, then monthly X 2 months. Any concerns will be addressed.	

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F 690	Continued From page 15 4. Review of the wound, Ostomy, and Continence Nurses Society "Care and Management of patients with Urinary Catheters: a clinical resource guide" found at https://cdn.ymaws.com/member.wocn.org/resource/resmgr/document_library/care_&_mgmt_pts_w_urinary_ca.pdf, retrieved on 1/4/23 showed "...Place the bag in a dependent position, about 12 inches (30 cm) below the level of the hips. Do not rest the bag on the floor. Keep the tubing above the level of the drainage bag and free of kinks. If the tubing must be raised for an extended period of time (e.g., transporting the patient), care should be taken to prevent backflow of urine from the bag..."	F 690	IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The DON/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		1/17/23

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F 755	Continued From page 16 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record, the facility failed to ensure the timely administration of physician-ordered medications for 1 of 2 sample residents (#323) who were receiving intravenous antibiotics. The findings were: 1. Review of the medical record for resident #323 showed physician diagnoses which included cellulitis, cellulitis of lower limb, sepsis, acute osteomyelitis, and type 2 diabetes mellitus. Further review showed the resident was admitted to the facility on Saturday,12/17/22. Review of the physician orders showed the resident was to receive cefazolin sodium solution (an antibiotic), 2 grams (gm) intravenously three times a day for acute osteomyelitis of the right ankle and foot. The following concerns were identified: a. Interview with the resident on 12/19/22 at 3 PM revealed s/he had not received the first two doses of the antibiotic and was concerned the missed doses would make the infection worse. b. Review of the MAR showed the facility failed to provide the first two doses of the antibiotic.	F 755	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. ¿488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. F755 Pharmacy	

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F 755	Continued From page 17 c. Review of a nurse's progress note dated 12/17/22 and timed 5:46 PM showed cefazolin sodium solution 2 gm administration "[his/her] meds are not yet in the medication cart". In addition, a nurse's progress note dated 12/18/22 and timed 10:57 AM showed "Spoke with pharmacy will bring in stat today." d. Interview with the DON on 12/21/22 at 5:29 PM confirmed the resident did not get the first 2 doses of the antibiotic. Further, she stated the facility received their medications from Denver, which did not deliver on Sunday. However, the facility could get medications from a local pharmacy, if needed. In addition, she revealed the facility had a Stat Save (medication Pyxis) the nurses could have used.	F 755	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 323 received IV medication on 12/18/22. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents with any Medications have the potential to be affected, all residents with medications were audited and have medication on hand completed on 12/21/22. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Nurses were educated by the DON starting 12/21/22 on the process of ordering medications from pharmacy. When a new order is received the nurses will place the order into PCC which is transferred to the pharmacy via PCC. If the medication does not arrive as expected the nurse will notify DON/nurse manager and contact the MD, pharmacy, resident and resident representative as indicated. The DON/designee will audit residents on	

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F 755	Continued From page 18	F 755	IV antibiotics and any other medications to ensure there are no missing doses weekly X 4 weeks, then monthly X 2 months. Any concerns identified will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The DON/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		1/17/23

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F 761	Continued From page 19 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policy and procedure and manufacturer's instructions, the facility failed to ensure medications available for use were not expired in 2 of 3 medication storage areas (northeast and northwest medication carts). The findings were: 1. Observation of the northwest station medication cart on 12/21/22 at 3:14 PM with LPN #1 showed the following concerns: a. An over-the-counter (OTC) bottle of calcium with vitamin D had an original manufacturer's expiration date of 11/2024 with a "save bottle" label on the container. Interview with LPN #1 revealed revealed the container was used to store medications; however, she was not aware how many times the bottle had been refilled, by whom, or where the OTC medication came from. b. One Victoza (non-insulin medication to treat diabetes) pen-injector had an open date of 10/30/22 (52 days from opening). c. One vial of Novolog (insulin) had an open date of 11/10/22 (41 days post opening). d. One vial of Novolog with an open date of 11/22. It could not be determined as to what date the vial was actually opened.	F 761	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. F761 Medication Storage I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN	

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F 761	Continued From page 20 2. Observation of the northeast medication cart on 12/21/22 at 3:25 PM with RN #1 showed the following concerns: a. An over-the-counter bottle of calcium with vitamin D had an original manufacturer's expiration date of 11/2024 with a "save bottle" label on the container. Interview with RN #1 revealed the container was used to store medications; however, she did not know how many times the bottle had been refilled, by whom, or where the OTC medication came from. 3. Interview with the DON on 12/21/22 at 2:45 PM revealed it was the facility's expectation that medications not be used after the expiration date. In addition, the DON confirmed multi-use insulin vials expired 28 days after being accessed. 4. Review of the Novolog manufacturer's instructions retrieved at https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/020986s082lbl.pdf on 1/3/23 showed after initial use vials may be kept for up to 28 days. 5. Review of the Vitroza manufacturer's instructions retrieved at https://www.novo-pi.com/victoza.pdf#patient on 1/3/23 showed the pen-injector must be discarded 30 days after being opened. 6. Review of the policy and procedure titled "Storage of Medications ", last revised 11/2020, showed "2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers....4. Drug containers that have missing, incomplete,	F 761	AFFECTED BY THE DEFICIENT PRACTICE: All identified medications were removed from the medication cart. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All medication storage areas were audited on 1/17/23. Any identified medications were disposed of. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Nurses were educated starting on 12/21/22 on medication storage by the DON. Nurses will dispose of any medications that are not stored properly, dated correctly or expired. The nursing management team will be responsible for auditing medication storage areas including med carts. The DON/Designee will audit medication storage weekly X 4, then monthly X 2 months. Any identified concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE	

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F 761	Continued From page 21 improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed."	F 761	SUSTAINED: The DON/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the 2017 US Food Code, the facility failed to ensure food was stored in a manner that was safe for consumption in 1 of 1 kitchen. The	F 812	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR	1/17/23

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F 812	Continued From page 22 census was 77. The findings were: 1. Observation on 12/19/22 at 1:40 PM of the kitchen refrigerator #1, #2, and #3 showed multiple items were labeled with a prepared date; however, were not marked with a "use-by" date. Multiple items were unlabeled or had exceeded their expiration date. The following concerns were identified: a. A container of relish had a prepared date of 11/17/22. b. A container of gravy had a prepared date of 10/10/22. c. A plastic container of ketchup had a prepared date of 10/19/22. d. A container of jalapeno salsa had a prepared date of 11/27/22. e. A container of pumpkin had a prepared date of 11/23/22 and was observed to have two small areas of what appeared to be mold on the surface. f. An undated container of lemon wedges. g. An undated plastic bag of whipped topping. h. A cucumber, an onion, and a stalk of celery were wrapped in plastic and not dated. i. A 14.2 ounce container of lingonberry preserves had an expiration date of 10/15/22. j. A container of sweet potatoes had a use-by date of 12/6/22. k. A container of diced ham had a use-by date of 12/15/22. 2. Interview on 12/19/22 at 1:40 PM with cook #1, revealed the food in the refrigerators were for resident use. Additionally he confirmed all foods which were prepared and held in the refrigerators should be labeled with an open/prepared date, a use by date, staff initials and the day of the week it was prepared/opened.	F 812	AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. F812 Food Storage I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All identified food items were discarded. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All food storage areas were audited on 12/22/22, unlabeled or outdated food was discarded. III. MEASURES OR SYSTEMIC	

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	535025	A. BUILDING _____ B. WING _____	C 12/22/2022

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F 812	Continued From page 23 3. Interview on 12/21/22 at 9:53 AM with the certified dietary manager confirmed the food in the refrigerator should be labeled with a prepared date and used within 7 days. 4. According to the US Food Code -2017 (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Pf commercially processed food open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: Pf (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; Pf and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer	F 812	CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Food and Nutrition (FN) staff were educated starting 12/22/22 by the FN Manager/designee about proper food labeling and storage. Food and Nutrition staff label/date open and prepared food as required. The FNM/Designee will complete food storage audit weekly X 4 weeks, then monthly X 2 months. Any identified concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The FNM/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	

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F 812	Continued From page 24 determined the use-by date based on FOOD safety. Pf (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first-prepared ingredient. Pf	F 812		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.	F 888		1/17/23

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F 888	Continued From page 25 §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely	F 888		

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F 888	Continued From page 26 documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to,	F 888		

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F 888	Continued From page 27 individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on review of policy and procedures and staff vaccination records, and staff interview, the facility failed to ensure the process to mitigate the transmission and spread of COVID-19 for all staff who were not fully vaccinated for COVID-19 was implemented. The census was 77. The findings were: 1. Review of the facility's vaccination records showed 14 staff members were granted exemptions to the COVID-19 vaccination requirements. 2. Interview with the NHA, DON, and clinical consultant on 12/22/22 at 10:45 AM revealed the facility had stopped requiring the use of N95 masks or additional testing for unvaccinated staff when CMS memo QSO-20-38-NH, revised 9/23/22, was released which stated "routine testing for asymptomatic staff was no longer	F 888	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH	

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F 888	Continued From page 28 recommended but may be performed at the discretion of the facility." In addition, the facility was using the CDC "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated September 23, 2022 which stated "Updated to note that vaccination status is no longer used to inform source control, screening testing, or post-exposure recommendations." The NHA, DON, and clinical consultant confirmed the facility's policy had not been revised. 3. Review of the policy and procedure titled "Polaris Healthcare Mandatory Covid-19 Vaccine Policy and Procedure" received from the facility upon entry showed "III. Additional Precautions to Mitigate the Transmission and Spread of Covid-19 For All Staff Not Fully Vaccinated for Covid-19: Staff who are not yet fully vaccinated, have a pending exemption request, have been granted an exemption, or who have a temporary delay in vaccination approval must adhere to additional precautions based on national infection prevention and control standards for unvaccinated health care personnel that are intended to mitigate the spread of COVID-19. The Facility will take or require the following precautions, as deemed appropriate or necessary: C. Requiring, at a minimum, weekly testing for exempted Staff...Weekly testing will be required regardless of whether the Facility is located in a county with low to moderate community transmission...D. Staff who have not completed their primary vaccination series will be required to use a NIOSH approved N95 or equivalent or higher-lever respirator (and may also be required to wear a face shield or goggles) at all times when in the Facility, regardless of	F 888	SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. F888 COVID-19 vaccination for facility staff I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 14 identified staff that are not fully vaccinated were required to complete additional measures to prevent the spread of Covid-19 within the facility per CMS and CDC recommendations. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: By 1/17/23 education was provided by the NHA/IPC/designee to any staff identified as not fully vaccinated or unvaccinated on the requirements of additional measures to prevent the spread of Covid-19. All staff that are not fully vaccinated or unvaccinated will be required to comply	

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F 888	Continued From page 29 whether they are providing direct care to or otherwise interacting with residents..."	F 888	with additional measures to prevent the spread of Covid-19 within the facility. The NHA/IPC/Designee will complete 3 observations on identified staff to ensure compliance with additional measures weekly X 4 weeks, then monthly X 2 months. Any identified concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The NHA/IPC/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and determine the effectiveness of the plan to ensure substantial compliance is achieved. Date of Compliance: 1/17/23	