STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155328	A. BUILDING 00 B. WING	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARK TERRACE VILLAGE	25 S BOEHNE CAMP RD EVANSVILLE, IN 47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00381871. Complaint IN00381871 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: September 19, 20, 21, 22, & 23, 2022 Facility number: 000221 Provider number: 155328 AIM number: 100267620 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 5 Medicaid: 41 Other: 20 Total: 66 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 28, 2022.	F 0000	Plan of Correction for Park Terrace Village F000 By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective October 23rd, 2022. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after October 23, 2022.	
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on interview and record review, the facility	F 0638	Resident 23 had no negative	10/23/2022

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

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	failed to ensure Quarterly MDS (MDS) assessments were completed timely for 2 of 22 residents reviewed. (Resident C, Resident 23) Findings include: 1. During record review on 9/21/22 at 1:15 P.M., Resident C's most recent Quarterly MDS assessment due 8/21/22 was still in progress. The last completed MDS assessment was a Significant Change assessment completed 5/21/22. 2. During record review on 9/23/22 at 10:40 A.M., Resident 23's most recent Quarterly MDS assessment due 9/14/22 was still in progress. Resident 23's last completed MDS assessment was a Significant Change assessment completed 6/14/22. During an interview on 9/23/22 at 11:32 A.M., the MDS Coordinator indicated they were new to the position and were trying to get caught up on the late assessments and that assessments should be completed every 3 months or during a significant change. On 9/23/22 at 11:50 A.M., the DON (Director of Nursing) supplied a facility policy titled, Resident Assessment (RAI) OBRA Required Assessments, dated 8/2019. The policy included, "It is the policy of [facility cooperation] to conduct an initial and periodic comprehensive as well as no less than quarterly... assessment of each resident's functional capacity..." 3.1-3(d)(3)		outcome due to this alleged deficiency. All Residents have the potential to be affected by the alleged deficient practice. A 100% audit to ensure that all of the past 90 day quarterly assessments are completed by MDS Coordinator/Desingee Re-education to be completed for MDS personnel on the timely completion of quarterly assessments by RAI Specialist. MDS schedule to be reviewed daily by RAI Specialist/Designee. RAI QAPI tool will be completed weekly times 4 weeks, monthly times 6 months, and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for responsible employee.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans			

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	§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 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			

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	the requirements set forth in paragraph (c) of this section. Based on observation, interview, and record review, the facility failed to implement the plan of care for 1 of 1 residents reviewed for pain and 1 of 4 residents reviewed for falls. A resident didn't receive a topical pain relieving gel as ordered by the physician and a resident's fall interventions were not in place. (Resident 49, Resident G) Findings include: 1. During an observation on 9/20/22 at 11:04 A.M., Resident 49 was lying in bed. A tube of ointment was lying on the bedside table next to the resident. Resident 49 indicated the tube on the bedside table was her Voltaren Gel (topical pain relieving gel), and that staff did not routinely apply the gel. Resident 49 indicated she had knee pain. During record review on 9/23/22 at 8:49 A.M., Resident 49's diagnoses included, but were not limited to, peripheral vascular disease, polyneuropathy, pain in right shoulder, and pain in left shoulder. Resident 49's most recent Quarterly MDS (Minimum Data Set) assessment dated, 7/24/22, indicated the resident had no cognitive impairment and received scheduled pain medications. Resident 49's physician orders included, but were not limited to: Voltaren gel (a topical pain medication) 1%, apply 2 grams topically for shoulder and knee pain three times a day. Resident 49's care plan included, but was not	F 0656	Resident 49 had no negative outcome due to this alleged deficiency. All Residents had the potential to be affected by the alleged deficient practice. A 100% IDT pain interview audit will be completed for all residents by DNS/Designee. A 100% fall intervention audit will be completed for all residents by DNS/Designee. DNS/Designee will round each shift to ensure fall interventions are in place per plan of care and to ensure residents who are to receive topical pain-relieving gel is administered as prescribed. All Nursing personnel will be in-serviced regarding fall interventions by DNS/Designee. All licensed Nursing personnel have been in-serviced on following physician orders for application of pain-relieving gel. Pain QAPI tool to be completed weekly times 4 weeks, monthly times 6 months, and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for	10/23/2022

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	limited to; Resident has pain or the potential for discomfort due to decreased mobility, osteoarthritis in multiple sites, diagnoses of chronic pain and low back pain, left and right shoulder pain. The interventions included, but were not limited to; Administer medications as ordered (initiated 4/20/21). During a review of Resident 49's medication administration record (MAR) from 9/1/22 through 9/22/22, the following order was not administered at the following dates and times: Voltaren Gel 1%, 2 grams topically for shoulder and/or knee pain three times a day 8:00 A.M., 2:00 P.M., and 8:00 P.M. 9/1/22 - did not receive at 8:00 P.M. 9/2/22 - did not receive at 2:00 P.M. 9/3/22 - did not receive at 8:00 P.M. 9/4/22 - did not receive at 8:00 P.M. 9/6/22 - did not receive at 8:00 P.M. 9/8/22 - did not receive at 2:00 P.M. 9/9/22 - did not receive at 8:00 A.M. and 8:00 P.M. 9/11/22 - did not receive at 8:00 P.M. 9/12/22 - did not receive at 8:00 P.M. 9/15/22 - did not receive at 8:00 A.M. 9/16/22 - did not receive at 8:00 P.M. 9/18/22 - did not receive at 8:00 P.M. 9/19/22 - did not receive at 8:00 A.M. 9/20/22 - did not receive at 8:00 P.M. 9/22/22 - did not receive at 8:00 A.M. During an interview on 9/23/22 at 9:30 A.M., LPN 40 indicated if a medication was not given as ordered, staff should document if the resident refused or was not available. 2. On 9/20/22 at 8:29 A.M., Resident G was sitting in his bed eating breakfast. The bed was not observed to be in low position, a fall mat was not observed on the floor, and the call light was not brightened.		responsible employee. A fall Management QAPI tool to be completed weekly times 4 weeks, monthly times 6 months, and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for responsible employee.	

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	On 09/22/22 at 10:10 A.M., Resident G was sitting in his bed with the bed. The bed was not in low position, no fall mat was present, and the call light was not brightened. On 9/23/22 at 10:48 A.M., Resident G was sitting in his bed. The bed was not observed to be in low position, a fall mat was not observed on the floor, and the call light was not brightened. During an interview on 9/20/22 at 8:29 A.M., Resident G indicated that he had fallen a couple times from his bed because he did not like using the call light to ask for help. During record review on 9/22/22 at 1:32 P.M., Resident G's most recent Quarterly MDS assessment, dated 8/8/22, indicated the resident required extensive assistance of 2 (two) staff for bed mobility and was moderately cognitively impaired. Resident G's diagnoses included, but were not limited to, cerebrovascular accident (CVA), Parkinson's disease, and hemiplegia (muscle weakness or partial paralysis) following cerebral infarction affecting left, non-dominant side. Resident G's care plan included, but was not limited to; Resident is at risk for falls (initiated on 5/3/22). The interventions included, but were not limited to, the resident's call light will be brightened to prompt resident to utilize the call light (initiated 6/30/22), fall mat to the left side of bed (initiated 5/17/22), and low bed (initiated 5/17/22). During an interview on 9/23/22 at 1:00 P.M., RN 12 indicated, Resident G should have a fall mat, the call light should have something on it to draw			

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	attention to it, and their bed should be in the lowest position. 3.1-35(g)(2)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §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 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. Based on interview and record review, the facility failed to ensure resident care conferences with residents and family members were held at least	F 0657	Residents 19, 21 and 50 had no negative outcome due to the alleged deficiency. All residents have the potential to	10/23/2022

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	quarterly for 4 of 6 residents reviewed for participation in care planning conferences. (Resident F, Resident 50, Resident 19, Resident 21) Findings include: 1. During an interview on 9/20/22 at 9:45 A.M., Resident F indicated they had not recently had a care planning conference. During record review on 9/22/22 at 12:00 P.M., Resident F's diagnoses included, but were not limited to, anxiety and dementia. Resident F's most recent Significant Change MDS (Minimal Data Set) assessment, dated 7/26/22, indicated the resident had no cognitive impairment. During an interview on 9/23/22 at 12:29 P.M., the Social Service Director (SSD) indicated Resident F had been scheduled to have a care planning conference and that their last care planning conference was held on 4/26/22. 2. During an interview on 9/19/22 at 12:50 P.M., Resident 50 indicated they had not had a care planning conference. During record review on 9/23/22 at 12:06 P.M., Resident 50's diagnoses included, but were not limited to, anxiety and dementia. Resident 50's most recent Quarterly MDS assessment, dated 7/26/22, indicated the resident had moderately impaired cognition. Resident 50's most recent care planning conference was dated 5/2/22.		be affected by the alleged deficient practice. A 100% IDT Care Plan conference audits will be completed to ensure that all Residents have been issued a care conference meeting. The schedule of the care conferences will be reviewed with IDT by Social Services to ensure Residents and families are aware of the scheduled conferences. A Comprehensive Care plan QA tool will be completed weekly times 4 weeks, monthly times 6 months, and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for responsible employee.	

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	During an interview on 9/23/22 at 12:29 P.M., the SSD indicated Resident 50's last care planning conference was on on 5/2/22. 3. On 9/22/22 at 1:59 P.M., Resident 19's clinical record was reviewed. Resident 19 was admitted to the facility on 6/22/22. The clinical record lacked documentation of a completed care planning conference since admission. During an interview on 9/23/22 at 11:41 A.M., the SSD indicated a care planning conference had not been completed for Resident 19 since admission. 4. During an interview on 9/20/22 at 10:55 A.M., Resident 21 indicated she was unaware of a care planning conference being done, and had not been invited to attend one. On 9/21/22 at 8:07 A.M., Resident 21's clinical record was reviewed. The most recent Quarterly MDS (minimum data set) assessment, dated 6/28/22, indicated a moderate cognitive impairment. A care planning conference form was completed on 5/26/22. The resident did not attend, and there was no indication that the resident was invited. The clinical record lacked any other care planning conferences. On 9/23/22 at 11:27 A.M., the Facility Administrator supplied a facility policy titled, IDT Comprehensive Care Plan Policy, dated 10/2019. The policy included, "...a comprehensive person-centered care plan developed based on comprehensive assessment... Resident, resident's representative, or others as designated by			

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	resident will be invited to care plan review." 3.1-35(c)(2)(C)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure residents who required assistance with ADL's received a shower for 7 of 9 residents reviewed. (Resident C, Resident F, Resident B, Resident D, Resident G, Resident J, Resident H) Findings include: 1. On 9/21/22 at 1:48 P.M., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, major depressive disorder, anxiety, and osteoarthritis. The Significant Change MDS (Minimum Data Set) assessment, dated 5/21/22, indicated the resident required the extensive assistance of two staff members for bed mobility, transfers, and was dependent on staff for bathing. Resident C was always incontinent of bowel and bladder. Resident C's care plan included, but was not limited to, resident will have ADL (Activities of Daily Living) needs med, initiated on 11/19/19. The interventions included, but were not limited to, morning and afternoon care including bathing.	F 0677	All Residents are receiving showers per their individual preference. All Residents have the potential to be affected by this alleged deficient practice. 100% of all Residents were interviewed to determine their individual shower preferences and Resident profiles were updated. Daily audits will be completed by DNS/Designee to ensure that Residents are receiving baths/showers per their individual shower preferences. A 100% staff in-service on shower/baths documentation and shower compliance by the DNS/Designee completed. The DNS/Designee will be responsible for the completion of a shower/bath compliance tool weekly times 4 weeks, monthly times 6 months, and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of	10/23/2022

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	Resident C's bathing schedule indicated he should receive a bath/shower on Wednesday's and Sunday's. Resident C's shower documentation from 8/21/22 through 9/21/22 indicated the following: 8/21/22 - (Sunday) Shower. Comments included, "was left with food trey [sic] ...bed totally wet, had to bath [sic] him just to get smell off ..." 8/24/22 - (Wednesday) no documentation 8/30/22 - (Tuesday) complete bed bath 9/2/22 - (Sunday) no documentation 9/6/22 - (Tuesday) complete bed bath 9/13/22 - (Tuesday) complete bed bath 9/17/22 - (Saturday) complete bed bath 9/18/22- (Sunday) complete bed bath 2. During an observation on 9/20/22 at 8:46 A.M., Resident F was sitting up in bed. The resident's hair appeared to be oily. At that time, Resident F indicated that staff do not wash her and she only received a shower once every 6 week. During record review on 9/22/22 at 12:00 P.M., Resident F's diagnoses included, but were not limited to, hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side and morbid obesity. Resident F's Significant Change MDS assessment, dated 7/26/22, indicated the resident had no cognitive impairment and required physical assistance of two staff for bathing. Resident F's bathing schedule indicated she should receive a bath/shower on Mondays and Fridays. During a review of Resident F's documented bathing record from 8/21/22 to 9/21/22, no		100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for responsible employee.	

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	complete bed baths or showers were documented. 3. On 9/19/22 at 9:09 A.M., Resident B was observed with greasy hair. On 9/21/22 at 1:19 P.M., Resident B was observed with greasy hair. At that time, she indicated she did not get enough showers to feel clean and had not had a shower in two weeks. On 9/21/22 at 6:40 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, end stage renal disease, Diabetes Mellitus, and heart disease. The Quarterly MDS assessment, dated 8/1/22, indicated the cognitive status was not assessed and Resident B required the assistance of two persons with bathing. A current ADL's care plan, dated 8/3/22, indicated "assist with bathing as needed per resident preference. Offer showers two times per week ..." Resident B's clinical record lacked a care plan for refusals of care. Resident B's clinical record lacked any documentation that a shower was given from 8/23/22 through 9/21/22. A bed bath was given on 8/22/22, 8/24/22, 8/29/22, 9/11/22, and 9/19/22. On 9/21/22 at 12:23 P.M., a shower sheet file was located at the nurse station that lacked any shower sheets for Resident B. At that time, RN 17 indicated when showers were given, a shower sheet was filled out, then given to a nurse to sign off on. After the forms were signed by the nurse			

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	and CNA, they were supposed to be placed into the shower sheet file at the nurse's station, then medical records came to clear out the file once a month. On 9/21/22 at 12:56 P.M., shower sheets were provided that indicated Resident B received a bed bath on 8/14/22, 8/22/22, 8/24/22, and 8/28/22. No other bathing was received. 4. On 9/202/22 at 8:53 A.M., Resident D was observed with messy uncombed hair. On 9/21/22 at 12:18 P.M., Resident D was observed with messy hair and a scruffy beard. At that time, he indicated he did not receive enough showers to stay clean and needed assistance to get into the shower. He also indicated he needed assistance with shaving and staff would not help him. Resident D indicated on shower days, staff would come ask what time he would like to take a shower that day and then not come back to assist with the shower. Resident D indicated he preferred showers for bathing. On 9/21/22 at 7:20 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, depression, anxiety, and COPD (chronic obstructive pulmonary disease). The Admission MDS assessment, dated 7/17/22, indicated Resident D was cognitively intact and required the assistance of one person for bathing. A current ADL's care plan, dated 7/12/22, indicated "Assist with bathing as needed per resident preference. Offer showers two times per week ..." Resident D's clinical record lacked a care plan for			

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	refusals of care. Resident D's clinical record indicated between 8/23/22 and 9/21/22 he received the following baths and showers: 9/2/22 - bed bath 9/13/22 - shower 9/16/22 - shower 5. On 9/20/22 at 8:29 A.M., Resident G was sitting in his bed eating breakfast. His hair was observed to be greasy and disheveled. On 9/22/22 at 10:10 A.M., Resident G was observed to be sitting in his bed. Resident G's hair was greasy and disheveled. On 9/22/22 at 1:32 P.M., Resident G's clinical record was reviewed. The diagnoses included, but were not limited to, CVA (cerebrovascular accident), Parkinson's disease, and hemiplegia. The Quarterly MDS assessment, dated 8/8/22, indicated the resident had moderate cognitive impairment and was dependent on staff for bathing. Resident G's care plan included, but was not limited to, resident requires assistance with ADL's, initiated 5/3/22. The interventions included, but were not limited to, assist with bathing as needed and offer showers two times per week, initiated 5/3/22. Resident G's shower records from 8/24/22 through 9/21/22 indicated Resident G received a shower on 9/10/22. 6. On 9/19/22 at 10:30 A.M., Resident J was observed sleeping in bed with greasy hair.			

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On 9/22/22 at 2:25 P.M., Resident J's clinical record was reviewed. The diagnoses included, but were not limited to, non-Hodgkin lymphoma, vascular dementia with behavioral disturbance, cerebral infarction, and muscle weakness.

The Quarterly MDS assessment, dated 6/10/22, indicated the resident had severe cognitive impairment and was dependent on staff for bathing.

The care plans included, but were not limited to, resident requires assistance with ADL's, initiated on 5/4/18. The interventions included, but were not limited to, assist with bathing as needed and offer showers two times per week, initiated 5/4/18.

Resident J's shower records from 8/24/22 through 9/21/22 indicated the resident received a shower on the following dates:
8/24/22
8/28/22
9/11/22
9/17/22
9/18/22

7. On 9/19/22 at 10:10 A.M., Resident H was sitting in his bed with greasy hair. Resident H indicated he did not regularly get showers and he was overdue for a shower.

On 9/22/22 at 9:46 A.M., Resident H was asleep in his bed. His hair was observed to be greasy and the room had a urine odor.

On 9/22/22 at 1:50 P.M., Resident H's clinical record was reviewed. The diagnoses included, but were not limited to, unspecified dementia and primary osteoarthritis.

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	The Quarterly MDS assessment, dated 7/7/22, indicated Resident H had severe cognitive impairment and was dependent on staff for bathing. Resident H's care plan included, but was not limited to, resident requires assistance with ADL's, initiated 5/4/18. The interventions included, but were not limited to, assist with bathing as needed and offer showers two times per week, initiated 5/4/18. Resident H's shower record from 8/24/22 through 9/21/22 indicated he received showers on the following dates: 8/25/22 9/8/22 9/15/22 During a review of the Resident Council Meeting minutes from September 2021 through April 2022, the following concerns were brought up: 6/9/22-Resident had concerns with getting showers on correct days and per their preference. This Federal tag relates to Complaint IN00381871. 3.1-38(b)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives			

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	adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide an environment free of accident hazards for 1 of 4 residents reviewed for accidents. (Resident 11) Finding includes: On 9/19/22 at 9:24 A.M., an empty box of cigarettes was observed lying on the resident's bed with a yellow lighter in it. On 9/22/22 at 9:52 A.M., 2 (two) cigarettes that had been lit and put out were observed in Resident 11's room. One on the bedside table and another one on the resident's nightstand. The room also smelled like smoke. During record review on 9/21/22 at 1:27 P.M., Resident 11's most recent quarterly MDS (Minimum Data Set) assessment, dated 8/21/22, indicated the resident had severe cognitive impairment. Resident 11's diagnoses included, but were not limited to, psychotic disorder (not schizophrenia), unspecified intellectual disabilities, unspecified psychosis not due to a substance or known physiological condition, and nicotine dependence. Resident 11's care plan included, but was not limited to, resident chooses to smoke (initiated on 3/18/22). It indicated the resident has a history of not following smoking policy and would become angry when staff explained she cannot keep smoking materials in her room. An intervention (initiated 3/18/22) indicated the resident was to be supervised during smoking times. Another	F 0689	Resident 11 had no negative outcome due to this alleged deficiency. Resident 11 has been discharged to another facility. All Residents have the potential to be affected by this alleged deficiency. Educate 100% of facility personnel and Residents on facility specific smoking policy by ED/SSD/Designee. All smoking residents' rooms assessed for smoking materials. Care Companions to ensure that residents' rooms do not have any smoking materials during daily rounds. All Residents who smoke will be informed of smoking policy. ED with permission will attend the Resident Council meeting to discuss the smoking policy. Smoking QA tool to be completed weekly times 4 weeks, monthly times 6 months, and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for responsible employee.	10/23/2022

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	intervention (initiated 3/18/22) indicated a smoking assessment would be completed upon admission, quarterly, and upon a significant change. The last Smoking Safety Assessment, dated 3/18/22, indicated that the following information was reviewed with the resident from the smoking policy: All residents are to be supervised when smoking... smoking materials are not permitted in the resident's room or on their person. All materials such as cigarettes, lighter, and matches are kept by the staff...informed resident that result of non compliance with smoking policy (which includes keeping cigarettes or lighters on their person, smoking outside of designated smoking times or smoking in the facility) will be a discharge plan will be immediately developed in conjunction with the physician. During an interview on 9/22/22 at 2:45 P.M., the SSD (social services director) indicated that smoking assessments were to be completed quarterly. A state reportable incident, dated 7/14/22, indicated there was an incident involving Resident 11 where cigarette lighters were found in the resident's room. A nurse's note, dated 2/11/22 at 2:03 P.M., indicated resident was seen in the courtyard smoking without staff present. A nurse's note, dated 2/11/22 at 2:15 P.M., (recorded as late entry on 2/12/22 at 7:05 A.M.) indicated staff was informed of resident smoking. Resident turned over cigarettes and lighter to staff.			

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A nurse's note dated 7/15/22 at 7:49 A.M., indicated resident came back from LOA (leave of absence) with family and was found to have a lighter in her room. The room was searched and several other lighters were found.

During an interview on 9/19/22 at 1:22 P.M., Resident 11 indicated that she keep a lighter in her room.

During an interview on 9/21/22 at 1:56 P.M., LPN 5 indicated cigarettes and lighters are kept in a box at the nurse's station. They further indicated residents should not have lighters or cigarettes in their rooms.

During an interview on 9/22/22 at 10:05 A.M., NAIT (nurse aide in training) verified that Resident 11's room smelt like smoke and that the 2 (two) cigarettes found had been lit. They further indicated that Resident 11 keeps cigarettes and lighters in her room.

During an interview on 9/23/22 at 9:21 A.M., SSD indicated that Resident 11's family wanted them to quit smoking because she started a fire in her house.

On 9/23/22 at 10:54 A.M., the DON (Director of Nursing) provided a facility smoking policy revised. The policy stated, "smoking shall be prohibited in all enclosed areas of the facility...all residents who smoke on facility grounds will be supervised... smoking materials are to to be kept in a safe location in the facility monitored by designated staff."

3.1-45(a)(1)

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F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			

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	Based on observation, interview, and record review, the facility failed to ensure accurately completed staffing sheets were posted daily for 5 of 5 days during the survey. Finding includes: During a review of the posted nurse staffing sheets on 9/23/22 at 12:00 P.M., the posted nurse staffing sheets indicated total hours worked by nursing staff, but lacked specific hours for the following days during the survey period: September 19, 2022 September 20, 2022 September 21, 2022 September 22, 2022 September 23, 2022 During an interview on 9/23/22 at 9:27 A.M., the Administrator indicated the correct form was behind the incorrect form, but was not visible for residents or guests to view. On 9/23/22 at 10:11 A.M., a current Posted Nurse Staffing Data and Retention Requirements policy, dated 7/2019, was provided and indicated "The facility must post the following information at the beginning of each shift...The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses, Certified nurse aides..."	F 0732	No Residents were affected by the alleged deficient practice. All Residents have the potential to be affected by the alleged deficient practice. Scheduler will be in-serviced on the accuracy of the posted nurse staffing information. Daily staffing hours are correct and will be updated as needed per DNS/Designee. Observational rounds will be completed by ED/Designee every day to ensure staffing is posted and is accurate. EE/Designee will complete QA tool weekly times 4 weeks, monthly times 6 months and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for responsible employee.	10/23/2022
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated			

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	with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic			

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	drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications. A resident received an antipsychotic medication every evening without having an adequate indication for its use. (Resident 19) Finding includes: During record review on 9/22/22 at 1:59 P.M., Resident 19's diagnosis included, but was not limited to, unspecified dementia without behavioral disturbance. Resident 19's most recent Admission Minimum Data Set (MDS) assessment, dated 6/28/22, indicated Resident 19 received antipsychotics on a routine basis. Resident 19's current physician orders included, but were not limited to, Seroquel (quetiapine) (antipsychotic medication) 25 milligrams (mg) oral at bedtime for a diagnosis of "unspecified dementia without behavioral disturbance." During an interview on 9/23/22 at 2:14 P.M., the Director of Nursing (DON) indicated that Resident 19 was admitted with the antipsychotic order and she does not have an appropriate diagnosis for the order. On 9/23/22 at 2:15 P.M., the DON provided an Evaluation for Gradual Dose Reduction of Psychotropic Medication form, dated 9/2/22 that	F 0758	Resident 19 had no negative outcome due to these alleged deficiencies. Resident 19 will be assessed and consult with physician regarding a GDR. All Residents have the potential to be affected by the alleged deficient practice. A 100% psychotropic medication audit will be completed to make sure they have the appropriate diagnosis and GDR review. Social Services and Licensed Nursing Personnel to be in-serviced on psychotropic medication and GDR requirements. IDT to review psychotropic medications upon initial admission review and with any other medication changes to ensure Resident has appropriate indication for the use of the psychotropic. Psychotropic QA tool to be completed by SSD/Designee weekly times 4 weeks, monthly times 6 months and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary	10/23/2022

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	indicated "Seroquel 25mg QHS [every night]...Admitted med [medication] on 6/22 No behaviors noted. No supporting Dx [diagnosis]...D/C [discontinue] meds." On 9/23/22 at 2:15 P.M., a Psychotropic Management policy, revised 7/2022, was provided and indicated "Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed... Each resident receiving psychotropic medication will have an adequate indication for use and supporting diagnosis for use." 3.1-48(a)(4)		action up to and including termination for the responsible employee.	
F 0803 SS=E Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition			

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	professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, interview, and record review, the facility failed to ensure kitchen staff followed recipes for 4 of 4 pureed meals observed. Kitchen staff failed to measure ingredients in accordance with the recipes. Finding includes: During an observation on 9/22/22 at 11:31 A.M., Dietary Manager prepared 4 (four) pureed meals. The Dietary Manager indicated he was preparing lasagna, Caesar salad, garlic bread, and peaches. The recipe binder was set on the table, closed. The meals were prepared as follows: Lasagna- The Dietary Manager added 4 (four) 6 (six) ounce scoops of lasagna and an undetermined amount of beef broth to the food processor. At that time, the Dietary Manager indicated it was probably about 1 (one) teaspoon of beef broth that was added. Caesar Salad- The Dietary Manager added an unknown amount of lettuce and salad dressing in the food processor, and 4 packets of parmesan cheese. At that time, the Dietary Manager indicated it was about 4 ounces of lettuce and about 1/3 cup of salad dressing. Garlic Bread- The Dietary Manager added 1 cup of pureed bread mix to a silver pan, added 1 cup of water, mixed it in the pan, added 0.5 cup of water, mixed it in the pan, added 0.5 cup of water.	F 0803	No Residents were affected by the alleged deficient practice. All Residents have the potential to be affected by the alleged deficient practice. DM/Designee will re-educate culinary employees on preparing puree meals and following recipe measurements. DM/Designee will ensure ingredients are being measured according to the recipes by utilizing the proper measuring tools. RD/Designee will monitor and complete QA tool on puree diet recipe measurements weekly times 4 weeks, monthly times 6 months, and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for responsible employee.	10/23/2022

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	Peaches- The Dietary Manager added an unknown amount of peaches and food thickener to the food processor. At that time, the Dietary Manager indicated it was about 4 of the 4 oz scoops of peaches and about a tablespoon of food thickener. The peaches were observed to be runny. During record review on 9/22/22 at 2:53 P.M., the recipes indicated the following measurements should be used to prepare the noted pureed meals (measurements calculated for 5 servings): Lasagna- 5 (five) 3 x 3.33" pieces, 1 and 3/8 teaspoon of low-sodium beef base, 1/2 cup and 2 tablespoons of hot water, and 1 tablespoon of food thickener. Caesar Salad- 1 and 1/4 quart of Caesar salad and 1/3 cup of food thickener. Garlic Bread- 2/3 cup and 1 tablespoon of pureed bread mix, 1/2 cup and 2 tablespoons of water, and 1/8 teaspoon of granulated garlic. Peaches- 2 and 1/2 cups of peaches and 1/3 cup of food thickener. During an interview on 9/23/22 at 9:19 A.M., the Dietary Manager indicated staff should follow the menu when preparing pureed meals. On 9/23/22 at 10:11 A.M., a Standardized Recipe policy, revised 10/2017, was provided and indicated "It is the policy of...to train the cooking staff to correctly follow menus by following the recipes..." 3.1-20(i)(4)			

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			

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	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were maintained for 1 of 7 residents observed during medication pass, 1 of 6 resident rooms on contact/droplet isolation precautions, and during 1 random observation. Staff was observed entering an isolation room with an N95 over the surgical mask,	F 0880	Residents 11 and 109 had no negative outcome due to this alleged deficiency. All residents have the potential to be affected by this alleged deficient practice. Education will be provided to CNA's 3, 4 and LPN 5.	10/23/2022

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	staff handled medications with their bare hands, and staff was observed eating in the hall without a mask on within arms length of a resident. (CNA 3, CNA 4, LPN 5, Resident 109, Resident 11) Findings include: 1. On 9/20/22 at 11:06 A.M., LPN 5 popped two tablets out of medication cards into his bare hand and then placed the tablets into a medication cup. LPN 5 then administered the medications to Resident 109. 2. On 9/21/22 at 7:41 A.M., Certified Nurse Aide (CNA) 3 entered a resident room on contact/droplet precautions and placed an N95 mask over her surgical mask. CNA 3 then exited the room wearing a gown, gloves, faceshield, N95 over the surgical mask, and proceeded to put the gown and gloves in a clear bag located on the PPE (personal protective equipment) cart, removed the N95, then walked the bag with the dirty gown and gloves down the hallway. 3. On 9/21/22 at 12:55 P.M., CNA 4 was observed to walk out of the conference room and into the hallway holding a box of food. CNA 4 was then observed to pull down her mask to eat while talking to Resident 11 within arms length of the resident. During an interview on 9/22/22 at 1:27 P.M., the Infection Preventionist (IP) indicated if a medication is touched with bare hands, the medication needs to be wasted, and the resident should not receive the touched medication. At that time, the IP indicated an N95 should not be put on over a surgical mask. During an interview on 9/22/22 at 2:00 P.M., RN 9		IP Consultant/Designee will provide re-education and training to IP/DNS/ED and IDT including providing all education, in-service materials, post-test, observation and QA tools. A root cause analysis will be conducted with a consultant Infection Preventionist, with input from facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause. All employees will be in-serviced on all Infection control pracitces to include medication administration and appropriate PPE specifically mask usage and donning and doffing of PPE> 100% employee in-service on all Infection control practices including proper PPE disposal. Daily observational rounds will be conducted on all shifts for 6 weeks until compliance is maintained by the IP/Designee using the infection control observational rounds tool to observe for proper medication handling, PPE use, and disposal. IP consultant will provide ongoing training, oversight, resources, and competencies as needed based on the observation rounds audit and QA tools identifying on-going areas of concern or not meeting threshold. The IP/Designee will monitor each	

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	indicated staff should be wearing masks at all times when within arms length of a resident. On 9/23/22 at 2:15 P.M., a current PPE Donning and Doffing policy, revised 10/2021, was provided and indicated "...Remove PPE at doorway prior to leaving resident room and perform hand hygiene. Dispose of gloves and gown prior to exiting resident room" The policy lacked information related to wearing an N95 mask with a surgical mask. On 9/23/22 at 2:15 P.M., a current Medication Pass Procedure policy, revised 12/2016, was provided and indicated "Medications are opened without contaminating..." 3.1-18(b)(1)		solution/systematic change identified in the RCA daily or more often as necessary for 6 weeks and until compliance is maintained. The IP/Designee will be responsible for the completion of Infection Control Observation QA tool weekly times 4 weeks, monthly times 6 months and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for responsible employee.	
F 0888 SS=D Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §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.			

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	§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. §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			

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	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 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			

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	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, 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; Based on interview and record review, the facility failed to ensure all staff received the COVID-19 vaccination and failed to follow the facility's	F 0888	No Residents were affected by the alleged deficiency. Employee #2 is no longer employed at the	10/23/2022

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	contingency plan for 1 of 1 partially vaccinated staff. (Staff 2) Finding includes: On 9/21/22 at 8:34 A.M., Staff 2's COVID-19 vaccination status was reviewed. Staff 2 was elgible for the second dose of a 2 (two) dose Covid-19 vaccination on 6/19/22. During an interview on 9/21/22 at 12:24 P.M, the Infection Preventionist (IP) indicated Staff 2 was currently working on getting a medical exemption. On 9/22/22 at 10:18 A.M., Staff 2's work schedule was reviewed. Staff 2 was actively working with residents in the facility. On 9/21/22 at 10:20 A.M., a current COVID-19 Employee Vaccination Requirement, dated July 8, 2022, was provided and indicated "All Current Employees, unless granted an exemption must, receive vaccines as per that below:...Received all shot doses...to be considered fully vaccinated by March 15, 2022 in order to meet the vaccine requirement...Please note that employees who are unvaccinated and whom do not have an approved vaccination exemption based on these deadlines will be removed from the schedule..." 3.1-18(b)		facility. All Residents have the potential to be affected by the alleged deficient practice. All employees were reviewed to ensure employees received COVID-19 vaccine per policy or had an approved exemption by the IP. IP will be educated on COVID-19 vaccines timelines and medical exemptions policy. All new employees will be reviewed prior to starting by ED to ensure staff have the appropriate vaccines or have an approved exemption. ED/DNS will complete COVID 19 vaccine QAPI tool weekly times 4 weeks, monthly times 6 months and quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination for responsible employee.	