STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE – PORTAGE CARE CENTER	3175 LANCER ST PORTAGE, IN 46368

(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 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00373293, IN00374125, IN00374441, and IN00375661. Complaint IN00373293 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F686, and F688. Complaint IN00374125 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F686, and F688. Complaint IN00374441 - Substantiated. Federal/State deficiencies related to the allegations are cited at F697. Complaint IN00375661 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F677, F684, and F686. Unrelated deficiency is cited at F888. Survey dates: March 30 and 31, 2022 Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census Bed Type: SNF/NF: 108 Total: 108 Census Payor Type: Medicare: 18 Medicaid: 77 Other: 13	F 0000	The facility respectfully requests desk review/paper compliance.	

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

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	Total: 108 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/4/22.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if			

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	any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure a resident's Responsible Party, as listed in the record, was notified of a hospital transfer for 1 of 3 residents reviewed for notification of change. (Resident D) Finding includes: The record for Resident D was reviewed on 3/30/22 at 10:38 a.m. Diagnoses included, but were not limited to, type 2 diabetes and abscess of left and right lower limb. The resident was discharged to the hospital on 2/26 and returned to the facility on 3/7/22. The resident's daughter was listed in his record as his Responsible Party, with two other names listed as Emergency Contacts.	F 0580	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident D was assessed and no adverse effects were noted related to the alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All other residents have the potential to be affected. An audit of all residents with transfers in the past 30 days was completed to	04/29/2022

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	The Quarterly Minimum Data Set (MDS) assessment, dated 3/14/22, indicated the resident was cognitively intact, had a surgical wound, and was receiving surgical wound care. Nurses' Notes, dated 2/25/22 at 11:29 p.m., indicated the Nurse Practitioner was contacted regarding the resident's cyst. The resident was scheduled to go to the emergency room the next day after dialysis to have the cyst lanced and drained. The cyst was causing the resident pain but he did not want to go to the emergency room until sometime after dialysis. The Physician was aware the resident would go to the emergency room after dialysis. Nurses' Notes, dated 2/26/22 at 4:40 p.m., indicated the resident returned from dialysis. Transport was called to take the resident to the emergency room to have his two cysts incised and drained. Report was given to the emergency room nurse, vitals were checked, and the resident left the facility with two transport staff. There was no documentation the resident's Responsible Party was notified of the transfer to the hospital. Interview with the Director of Nursing on 3/31/22 at 1:54 p.m., indicated there was no documentation indicating the resident's Responsible Party had been notified of him going to the hospital. This Federal tag relates to Complaint IN00375661. 3.1-5(a)(3)		ensure that responsible party notification had occurred. No other residents were identified as being affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The Director of Clinical Education (DCE)/designee educated all Licensed Nurses on the "Notification of Change" policy prior to 4.29.22. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: The Director of Nursing Services (DNS)/designee will audit 5 randomly selected resident's charts 5 times per week x 4 weeks, then 3 times per week x 4 weeks, then weekly x 4 months to ensure responsible party notification of transfer has occurred. Audits will include all shifts and units including weekends. Audits will be submitted to QAPI monthly for at least 6 months and will continue until 95% compliance is reached.	

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F 0677 SS=D 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, record review, and interview, the facility failed to ensure dependent residents received assistance with eating and nail care for 1 of 4 residents reviewed for activities of daily living (ADLs). (Resident G) Finding includes: On 3/30/22 at 11:57 a.m., Resident G was observed in his room in bed. The resident was feeding himself lunch using the fingers on his right hand. His left hand was closed in a fist. On 3/31/22 at 9:04 a.m., the resident was observed in his room in bed sleeping. His breakfast tray was on the over bed table uncovered. None of his food had been touched. At 12:16 p.m., the door to the resident's room was closed. Upon entering the room, the resident was feeding himself his lunch with his fingers. A utensil was observed in the resident's mashed potatoes. He was also slouched down in his bed at that time. On 3/31/22 at 1:15 p.m., the door to the resident's room remain closed. CNA 2 entered the resident's room. The resident was observed with food spillage on his gown and in his bed. He also had dried food spillage in his beard. The CNA indicated she was not assigned to the resident but she would get him cleaned up. At that time, the resident's left hand was closed in a fist. The CNA was able to extend the resident's	F 0677	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident G was assessed and no adverse effects were noted related to the alleged deficient practices. Resident G's fingernails were immediately trimmed and the resident is being assisted with meals. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All other dependent residents have the potential to be affected. An audit of all dependent residents to ensure assistance with all ADLs (Activities of Daily Living) including eating and nail care is being provided as needed was completed. No other residents were identified as being affected. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The DCE/designee educated all licensed nursing staff on the "Activities of Daily Living (ADL)" policy prior to 4.29.22. 4. How the	04/29/2022

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	fingers slightly. The fingernails on the resident's left hand were long. Interview with the resident at that time, indicated his nails could be trimmed. The record for Resident G was reviewed on 3/31/22 at 9:48 a.m. Diagnoses included, but were not limited to, stroke, lack of coordination, contracture of muscle, and hemiplegia (paralysis on one side of the body) following a stroke affecting the left non-dominant side. The Quarterly Minimum Data Set (MDS) assessment, dated 2/16/22, indicated the resident was cognitively intact and he needed extensive assistance with eating and personal hygiene. He also had functional limitation in range of motion on one side to the upper and lower extremities. The Care Plan, dated 3/30/22, indicated the resident had a physical functioning deficit related to mobility impairment due to a stroke with left sided hemiplegia and contractures. Interventions included, but were not limited to, encourage choices with care and provide assistance with eating as needed. Provide verbal cues and physical assistance as needed to complete the task. Open containers as needed, add condiments as desired, and cut up foods if needed. The March 2022 Physician's Order Summary (POS), indicated the resident received a regular diet, with mechanical soft texture, and fortified foods three times a day with meals. The shower sheets indicated the resident had received a shower on 3/21, 3/25, 3/28, and 3/30/22. Interview with the Director of Nursing on 3/31/22 at 1:40 p.m., indicated the resident		corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: The DNS/Unit Managers/designee will audit 5 randomly selected dependent residents 5 times per week x 4 weeks, then 3 times per week x 4 weeks, then weekly x 4 months to ensure ADL care is being provided as needed/per plan of care. Audits will include all shifts and units including weekends. Audits will be submitted to QAPI monthly for at least 6 months and will continue until 95% compliance is reached.	

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	should have been provided assistance with his meal and his nails would be trimmed. This Federal tag relates to Complaints IN00373293, IN00374125, and IN00375661. 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure treatments were completed as ordered for surgical and non-pressure wounds and dressings were in place for 2 of 3 residents reviewed for skin conditions, non-pressure related. (Residents D and H) Findings include: 1. Interview with Resident D on 3/30/22 at 3:15 p.m., indicated he had treatment orders for the surgical wounds on his thighs. He indicated his treatment had been completed this morning but not yesterday. He also indicated his treatment doesn't always get done on dialysis days. The record for Resident D was reviewed on 3/30/22 at 10:38 a.m. Diagnoses included, but were not limited to, type 2 diabetes and abscess of left and right lower limb. The resident was	F 0684	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident D was not consistently receiving treatments to his wounds on his dialysis days. The MD and wound nurse reviewed resident D's current treatment orders and revised them as needed to ensure treatments are completed per MD orders, no adverse effects were noted related to the deficient practice. Resident H no longer resides in the facility. Resident H's missing treatment was immediately put in place and signed out on the TAR (Treatment Administration	04/29/2022

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	discharged to the hospital on 2/26 and returned to the facility on 3/7/22. A Skin Evaluation, completed on 2/25/22 at 4:31 p.m., indicated the resident had a cyst to his left upper thigh that measured 1.5 centimeters (cm) x 0.5 cm and a cyst to the back of the right upper thigh that measured 1 cm x 0.2 cm. The resident was sent to the hospital for incision and drainage of the two areas on 2/26/22. The Quarterly Minimum Data Set (MDS) assessment, dated 3/14/22, indicated the resident was cognitively intact, had a surgical wound, and was receiving surgical wound care. The Care Plan, dated 3/14/22, indicated the resident had altered skin integrity, non-pressure, related to a surgical wound to the left and right thighs. Interventions included, but were not limited to, treatments as ordered. A Physician's Order, dated 3/8/22, indicated the area to the left and right thigh was to be cleansed with normal saline. The areas were to be packed with iodoform (an antiseptic dressing) and covered with an ABD pad and secured with a dressing every day shift. The March 2022 Treatment Administration Record (TAR), indicated the treatment had not been signed out as ordered on 3/12 and 3/14/22. A Physician's Order, dated 3/15/22, indicated the area to the left and right thighs was to be cleansed with normal saline, allow dry time, apply Calcium Alginate (a wound dressing) and cover with a border dressing daily on the day shift and as needed (prn).		Record). Resident H was assessed and no adverse effects were noted related to the deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. The Interim Wound Nurse assessed all residents with non-pressure wounds/areas to ensure treatment orders were completed as ordered and signed out as completed prior to 4.29.22. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The DCE/designee educated all licensed nursing staff on the “Wound Treatment Management” policy prior to 4.29.22. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: The DNS/Unit Managers/Wound Nurse will audit 6 randomly selected residents with non-pressure wounds to ensure treatments are completed as ordered and documented 3x/week	

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	The March 2022 TAR, indicated the treatment had not been signed out as ordered on 3/15, 3/17, 3/22, 3/24, 3/25, 3/26, 3/28, and 3/29/22. Interview with the Director of Nursing on 3/31/22 at 11:10 a.m., indicated the treatments should have been completed as ordered. She also indicated she was going to get the treatment changed from day to evening shift so his treatment wouldn't be missed on dialysis days. 2. On 3/31/22 10:10 a.m., Resident H was observed in bed. She was lying on her back with her bowl of cereal in her lap and her breakfast tray on the over bed table. RN 1 entered the room and was asked to perform a skin assessment. The RN left the room and came back with CNA 1. They rolled the resident on to her left side. At that time, the resident was observed with 2 bandages on her sacral area with a moderate amount of drainage. Both bandages were dated 3/31/22. They rolled the resident back onto her back. There was an open wound noted to her pubic area. The RN indicated it was an abscess. There was no bandage on the open wound. The record for Resident H was reviewed on 3/31/22 at 9:20 a.m. Diagnoses included, but were not limited to, cellulitis of the perineum, cancer, adult failure to thrive, peripheral vascular disease, and history of skin infections. The resident was admitted on 3/28/22. The Minimum Data Set (MDS) assessment was in progress and not completed. Nurses' Notes, dated 3/28/22 at 12:54 p.m., indicated a skin evaluation was completed. The resident had an open lesion "other than ulcers, rashes and cuts", located on the pubic area. The		x 4 weeks, then weekly x 2 months, then monthly x 3 months. Audits will include all shifts and units including weekends. Audits will be submitted to QAPI monthly for at least 6 months and will continue until 95% compliance is reached.	

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	lesion measured 1.5 centimeters (cm) by 1.5 cm by 0.4 cm. The wound bed was observed with slough (necrotic tissue). A Physician's Order, dated 3/28/22, indicated cleanse perianal wound with saline and cover with calcium alginate, cover with ABD pad and secure with tape. The order was discontinued on 3/29/22. A Physician's Order, dated 3/28/22, indicated cleanse peri-wound of perianal wound with normal saline, apply zinc paste and cover with ABD pad and secure with tape 2 times a day. A Physician's Order, dated 3/29/22, indicated to cleanse perianal wound with saline and cover with silver alginate, cover with ABD pads and secure with tape. The Treatment Administration Record (TAR) for 3/2022, indicated the order to apply the zinc paste to the peri wound was not signed on 3/30/22 at 8:00 a.m. The order to apply the silver alginate to the wound was not signed out on 3/30/22. Interview with the Director of Nursing on 3/31/22 at 12:45 p.m., indicated the resident had an open lesion on the pubic area. The treatment orders were for that area and not a perianal wound. The treatments were not signed out as being completed. This Federal tag relates to Complaint IN00375661. 3.1-37(a)			

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure pressure ulcer treatments were signed out as being completed to promote wound healing for 2 of 3 residents reviewed for pressure ulcers. (Residents B and H) Findings include: 1. The closed record for Resident B was reviewed on 3/30/22 10:32 a.m. Diagnoses included, but were not limited to, multiple sclerosis, sepsis, osteomyelitis of the right ankle, paraplegia, and contractures. The Quarterly Minimum Data Set (MDS) assessment, dated 1/25/22, indicated the resident was moderately impaired for decision making. The resident was totally dependent on staff with a 2 person physical assist for bed mobility and transfers. The resident had pressure ulcers.	F 0686	Please note: upon exit and in the body of this citation it is resident E, not resident H, who is identified. Resident H is identified on F684. This response is for resident B and E per the body of the citation and the exit conference resident listing. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident B no longer resides in the facility. Resident E was assessed by the Interim Wound nurse and no adverse effects were noted related to the deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	04/29/2022

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BRICKYARD HEALTHCARE – PORTAGE CARE CENTER	3175 LANCER ST PORTAGE, IN 46368

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	A Care Plan, dated 1/29/21, indicated the resident had actual pressure ulcers. The nursing approaches were to provide treatments as ordered. The resident was admitted to the hospital on 1/11/22 and returned on 1/17/22. A discharge summary from the hospital, dated 1/17/22, indicated the resident refused a below the knee amputation due to osteomyelitis. The patient wanted to continue antibiotic therapy and the risks were discussed with her if she did not undergo surgery. She will continue antibiotic intravenous therapy for the next 6 weeks. The patient refused palliative care as well as hospice. Nurses' Notes, dated 1/17/22 at 5:00 p.m., indicated the resident returned to the facility from the hospital. Nurses' Notes, dated 1/18/22 at 1:14 p.m., indicated a complete skin assessment was performed. The resident's current skin conditions were as follows: Left ischium pressure ulcer: unstageable, measuring 2 centimeters (cm) by 2 cm with slough (necrotic tissue). There was a moderate amount of purulent drainage. Right heel pressure ulcer: unstageable, measuring 6.2 cm by 7 cm with slough. The tissue was mushy with a moderate amount of purulent drainage. Coccyx pressure ulcer: stage 2, measuring 1.3 cm by 0.9 cm. with granulation tissue. Left ischium pressure ulcer: stage 2 measuring		action will be taken: All residents have the potential to be affected. The Interim Wound Nurse assessed all residents with pressure wounds/areas to ensure treatment orders were completed as ordered and signed out as completed prior to 4.29.22. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The DCE/designee educated all licensed nursing staff on the "Wound Treatment Management" policy prior to 4.29.22. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: The DNS/Unit Managers/Wound Nurse will audit 6 randomly selected residents with pressure wounds to ensure treatments are completed as ordered and documented 3x/week x 4 weeks, then weekly x 2 months, then monthly x 3 months. Audits will include all shifts and units including weekends. Audits will be submitted to QAPI monthly for at least 6 months and will continue until 95% compliance is reached.	

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	155187	A. BUILDING 00 B. WING	03/31/2022

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	0.5 cm by 0.5 cm with granulation tissue. Left heel pressure ulcer: unstageable, measuring 4 cm by 3 cm by less than 0.2 cm with granulation tissue noted. The wounds were cleaned and measured post hospital return. Physician's Orders, dated 1/19/22, indicated cleanse wound to right heel then apply calcium alginate and cover with foam dressing and wrap with gauze roll one time a day. Cleanse area to left ischium with normal saline apply calcium alginate and cover with foam dressing one time a day. Cleanse area to left heel apply calcium alginate cover with ABD pad and wrap in gauze roll one time a day. Cleanse area to coccyx and apply calazime two times a day. The Treatment Administration Record (TAR), for the month of 1/2022, indicated the right and left heel pressure ulcer treatments, and the left ischium ulcer treatment were not signed out as being completed on 1/19, 1/20, and 1/31/22. The coccyx treatment was not signed out as being completed on 1/20 and 1/31/22 at 8:00 a.m., and 1/25/22 at 4:00 p.m. The TAR for the month of 2/2022 indicated the right heel treatment was not signed out as being completed on 2/1, 2/3, and 2/5/22. The left heel treatment was not signed out as being completed on 2/3 and 2/5/22 and the left ischium treatment was not signed out as being completed on 2/1, 2/3, and 2/5/22. The coccyx pressure ulcer was not signed out as being completed on 2/1, 2/3, 2/5, 2/11, and 2/18 at 8:00 a.m. and 2/4, 2/8, and 2/10/22 at 4:00 p.m. Nurses' Notes, dated 2/15/22 at 2:00 p.m., indicated a complete skin evaluation was			

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	completed. The resident's current skin conditions were as follows: Left heel pressure ulcer: unstageable, measuring 4 cm by 2.5 cm with slough. Left ischium pressure ulcer: unstageable, measuring 2 cm by 2.5 cm with slough. Right heel pressure ulcer: unstageable, measuring 7 cm by 7.5 cm with slough. A Physician's Note (by the Infectious Disease Nurse Practitioner), dated 2/17/22 at 12:21 p.m., indicated the resident was seen today for follow-up of antibiotic therapy for osteomyelitis of the foot. The resident had a history of antibiotic therapy for the last 2 months for sepsis. Interview with the Director of Nursing (DON) on 3/31/22 at 12:20 p.m., indicated the pressure ulcer treatments were not signed out as being completed and/or initiated after being readmitted on 1/17/22. The DON felt the treatments were being completed, but just not signed out as such.2. Resident E was observed on 3/31/22 at 1:35 p.m., lying on her back in bed with wound dressings on bilateral lower legs. The record for Resident E was reviewed on 3/30/22 at 2:07 p.m. Diagnoses included, but were not limited to, cerebral palsy, seizure disorder, severe intellectual disabilities, and quadriplegia (unable to move upper and lower limbs). The Quarterly Minimum Data Set (MDS) assessment, dated 1/10/22, indicated the resident was severely cognitively impaired and was totally			

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	dependent on staff for all activities of daily living. The resident had a pressure reducing device for the bed, nutrition or hydration interventions to manage skin problems, and pressure ulcer or pressure injury care. There was no information provided if the resident had one or more unhealed pressure ulcers or injuries. A Skin Only Evaluation, dated 3/2/22, indicated the resident had multiple pressure ulcers as follows: - stage IV pressure ulcer to the sacrum/left buttock measuring 13 centimeters (cm) by 15 cm by 2.5 cm - stage IV pressure ulcer to the posterior head measuring 7 cm by 7 cm by 06 cm - unstageable pressure ulcer to the left malleolus measuring 7 cm by 3.2 cm - unstageable pressure ulcer to the right upper back measuring 3 cm by 4 cm - unstageable pressure ulcer to the right lateral malleolus measuring 2 cm by 2.5 cm - unstageable pressure ulcer to the right lateral malleolus measuring 3.2 cm by 3 cm - unstageable pressure ulcer to the right ischium measuring 5 cm x 6 cm - unstageable pressure ulcer to the right pinky toe measuring 1.2 cm by 1 cm - unstageable pressure ulcer to the right great toe measuring 2 cm by 1.5 cm - unstageable pressure ulcer to the left great toe measuring 1 cm by 1 cm A Physician's Order, dated 1/25/22 at 10:45 a.m., indicated an order to cleanse stage II pressure ulcer to right hand webbing between thumb and forefinger with normal saline (NS) or wound wash, pat dry, apply Medihoney (decreases bacterial growth within the wound) topically and cover with gauze dressing every day shift.			

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	The Treatment Administration Record (TAR), dated 3/2022, indicated the wound treatment to the right hand webbing had not been signed off as completed on 3/2/22, 3/12/22, 3/15/22, 3/17/22, 3/22/22, 3/27/22, and 3/29/22. A Physician's Order, dated 2/8/22 at 12:30 p.m., indicated an order to cleanse pressure area to right lateral malleolus with NS or wound wash, pat dry, apply honey, then collagen sheet topically, and cover with foam border gauze dressing every night shift. The TAR, dated 3/2022, indicated the wound treatment to the right lateral malleolus had not been signed off as completed on 3/4/22, 3/5/22, 3/8/22, 3/9/22, 3/11/22, 3/14/22, 3/17/22, 3/18/22, 3/19/22, 3/21/22, 3/22/22, and 3/26/22. A Physician's Order, dated 2/8/22 at 12:30 p.m., indicated an order to cleanse pressure area to sacrum/left buttock wound with NS or wound wash, pat dry, apply collagen and calcium alginate (helps to promote wound healing) to wound bed and into undermining. Fluff gauze or foam to fill space and over with absorbent dressing and secure every night shift. The TAR, dated 3/2022, indicated the wound treatment to the sacrum/left buttock had not been signed off as completed on 3/4/22, 3/5/22, 3/8/22, 3/9/22, 3/11/22, 3/14/22, 3/17/22, 3/18/22, 3/19/22, 3/21/22, 3/22/22, and 3/26/22. A Physician's Order, dated 2/8/22 at 12:30 p.m., indicated an order to cleanse pressure area to left ankle malleolus with NS or wound wash, pat dry.			

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	Apply calcium alginate topically and secure with bordered dressing every night shift. The TAR, dated 3/2022, indicated the wound treatment to the left ankle malleolus had not been signed off as completed on 3/4/22, 3/5/22, 3/8/22, 3/9/22, 3/11/22, 3/14/22, 3/17/22, 3/18/22, 3/19/22, 3/21/22, 3/22/22, and 3/26/22. A Physician's Order, dated 2/9/22 at 3:00 p.m., indicated an order to cleanse area to right little toe with NS. Apply calcium alginate and cover with foam dressing every evening shift and as needed. The TAR, dated 3/2022, indicated the wound treatment to the right little toe had not been signed off as completed on 3/4/22, 3/5/22, 3/6/22, 3/8/22, 3/10/22, 3/12/22, 3/19/22, 3/20/22, 3/21/22, and 3/26/22. A Physician's Order, dated 2/9/22 at 3:00 p.m., indicated an order to cleanse area to great toe on right foot with NS. Apply calcium alginate and cover with foam dressing every evening shift and as needed. The TAR, dated 3/2022, indicated the wound treatment to the great toe on right foot had not been signed off as completed on 3/4/22, 3/5/22, 3/6/22, 3/8/22, 3/10/22, 3/12/22, 3/19/22, 3/20/22, 3/21/22, and 3/26/22. A Physician's Order, dated 2/25/22 at 11:00 p.m., indicated an order to cleanse area to left great toe apply calcium alginate and cover every night shift. The TAR, dated 3/2022, indicated the wound			

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	treatment to the left great toe had not been signed off as completed on 3/4/22, 3/5/22, 3/8/22, 3/9/22, 3/11/22, 3/14/22, 3/17/22, 3/18/22, 3/19/22, 3/21/22, 3/22/22, and 3/26/22. A Physician's Order, dated 3/3/22 at 11:00 p.m., indicated an order to cleanse pressure wound to posterior head with NS or wound wash, pat dry, and apply skin prep outside of wound edges. Apply calcium alginate topically and cover with border dressing every night shift. The TAR, dated 3/2022, indicated the wound treatment to the posterior head had not been signed off as completed on 3/4/22, 3/5/22, 3/8/22, 3/9/22, 3/11/22, 3/14/22, 3/17/22, 3/18/22, 3/19/22, 3/21/22, 3/22/22, and 3/26/22. A Physician's Order, dated 3/3/22 at 11:00 p.m., indicated an order to apply Santyl Ointment 250 unit/gram topically every night shift for wound care. Cleanse right malleolus, left malleolus, right upper back and right ischium with NS, then apply a nickel thick layer edge to edge on wound bed, and cover with border dressing every night shift. The TAR, dated 3/2022, indicated the wound treatment to right malleolus, left malleolus, right upper back and right ischium with application of Santyl ointment had not been signed off as completed on 3/4/22, 3/5/22, 3/8/22, 3/9/22, 3/11/22, 3/13/22, 3/14/22, 3/17/22, 3/18/22, 3/19/22, 3/21/22, and 3/22/22. A Physician's Order, dated 3/27/22 at 8:00 a.m., indicated an order to apply Metronidazole Gel 1% to sacrum topically two times a day for			

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	wounds. The TAR, dated 3/2022, indicated the wound treatment to the sacrum with application of Metronidazole Gel 1% had not been signed off as completed on 3/8/22, 3/12/22, 3/16, 3/22/22, and 3/29/22. Interview with the Director of Nursing (DON) on 3/31/22 at 12:13 p.m., indicated hospice had been doing some of the wound care treatments and would search for those notes indicating the treatments were completed. Continued interview with the DON on 3/31/22 at 1:43 p.m., indicated hospice notes lacked documentation of completed wound care treatments. Wound care treatments should have been completed as ordered. This Federal tag relates to Complaints IN00373293, IN00374125, and IN00375661. 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §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			

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	motion. §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. Based on observation, record review, and interview, the facility failed to ensure a resident with a contracture received the necessary treatment and services to prevent further decline for 1 of 3 residents reviewed for limited range of motion (ROM). (Resident E) Finding includes: On 3/30/22 at 9:30 a.m., Resident E was observed lying in bed sleeping. The resident's hands were in a fist position. The resident was not wearing any palm protectors. On 3/31/22 at 1:35 p.m., Resident E was observed lying in bed. The resident's hands were in a fist position and was not wearing any palm protectors. Resident E's record was reviewed on 3/30/22 at 2:07 p.m. Diagnoses included, but were not limited to, cerebral palsy, seizure disorder, severe intellectual disabilities, and quadriplegia (unable to move upper and lower limbs). A Significant Change Minimum Data Set (MDS) assessment, dated 2/28/22, indicated the resident was severely cognitively impaired, was totally dependent on staff for all activities of daily living, and had an impairment in both upper and lower extremities for range of motion.	F 0688	1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident E was assessed and no adverse effects were noted related to the deficient practice. The MD reviewed Resident E's orders in conjunction with the hospice provider and orders were revised as appropriate. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents with contractures have the potential to be affected. All other residents with contractures were assessed prior to 4.29.22. No other residents were identified as being affected by the deficient practice. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The DCE/designee educated all	04/29/2022

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	A Physician's Order, dated 5/21/21, indicated bilateral palm protectors at all times except for during hand hygiene and showers. A Care Plan, initiated on 5/3/21, indicated the resident had a physical functioning deficit related to quadriplegia and cerebral palsy and had limited movement of extremities and contractures. Interventions included, to apply palm protectors to bilateral hands as tolerated. Interview with LPN 1 on 3/31/22 at 1:35 p.m., indicated she did not know if the resident was supposed to be wearing palm protectors. Interview with Director of Nursing (DON) on 3/31/22 at 1:43 p.m., indicated the resident should have been wearing palm protectors as ordered. This Federal tag relates to Complaint IN00373293 and IN00374125. 3.1-42(a)(2)		licensed nursing staff on the "Prevention of Decline in Range of Motion" policy prior to 4.29.22. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: The DNS/Unit Managers/designee will audit 5 randomly selected residents with contractures to ensure treatments for contractures are completed per MD orders 3x/week x 4 weeks, then weekly x 2 months, then monthly x 3 months. Audits will include all shifts and units including weekends. Audits will be submitted to QAPI monthly for at least 6 months and will continue until 95% compliance is reached.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident was free from pain related to not administrating scheduled and prn (as needed) pain medication for 3 of 4 residents reviewed for pain. (Residents H, C, and	F 0697	1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident H no longer resides in	04/29/2022

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	E) Findings include: 1. The record for Resident H was reviewed on 3/31/22 at 9:20 a.m. Diagnoses included, but were not limited to, cellulitis of the perineum, adult failure to thrive, peripheral vascular disease, and history of skin infections. The resident was admitted on 3/28/22. The Minimum Data Set (MDS) assessment was in progress and not completed. There was no Care Plan for pain. Physician's Orders, dated 3/28/22, indicated Norco Tablet 5-325 milligrams (mg) (Hydrocodone-Acetaminophen). Give 1 tablet by mouth every 6 hours as needed for pain. Physician's Orders, dated 3/28/22, indicated Tylenol Tablet 325 mg (Acetaminophen). Give 2 tablets by mouth every 6 hours as needed for pain. A Nurse Practitioner (NP) Note, dated 3/30/22 at 5:09 p.m., indicated the patient was seen and examined at the bedside. She was awake and alert, but oriented to herself and year. She had no specific complaints, however, she was a poor historian due to cognition. From the limited paperwork provided, she was previously treated for several weeks with Zosyn which finished on 3/24/22. She has several wounds and the Unit Manager had a concern today about the patient's pain. She indicated that during dressing changes or mobility the patient was screaming out in pain which, was hindering any care or progress with therapy.		the facility. Resident H was receiving her pain medications per MD orders prior to discharge, the resident was assessed and no adverse effects were noted. A pain care plan was immediately put in place. Resident C no longer resides in the facility. Resident E was assessed and no adverse effects were noted related to the deficient practice. Resident E's pain is being assessed and pain medications are being administered per MD orders. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. An audit of all residents was completed prior to 4.29.22 to ensure that residents are receiving pain medications per MD order, pain care plans are in place as appropriate, prescriptions for pain medications are received in a timely manner, pain is assessed to ensure pain is being managed effectively and all pain medications are stored in a consistent manner in the locked section of the medication cart as applicable.	

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	Nurses' Notes, dated 3/30/22 at 6:57 p.m., indicated the NP was in to see the resident this shift. The resident expressed pain issues to the NP who ordered Norco 7.5/325 mg three times a day and every 6 hours prn pain. This order has been noted and carried out by the writer. Physician's Orders, dated 3/30/22, indicated Norco Tablet 7.5-325 mg. Give 1 tablet by mouth three times a day. The order was obtained at 5:03 p.m. on 3/30/22, however, was not initiated until 3/31/22 at 6:00 a.m. The Medication Administration Record (MAR) for 3/2022, indicated the Norco was scheduled to be administered at 6:00 am, 2:00 p.m., and 10:00 p.m. The first dose was signed out as being administered was on 3/31/22 at 6:00 a.m. The prn Norco and Tylenol medications had not been signed out as being administered 3/28-3/31/22. Interview with the Director of Nursing on 3/31/22 at 12:45 p.m., indicated the pain medication was put in the computer to start on 3/31/22 at 6:00 a.m. The prn pain medication was not signed out as being administered. 2. The record for Resident C was reviewed on 3/30/22 at 9:21 a.m. Diagnoses included, but were not limited to, diabetes mellitus, muscle wasting, acute respiratory failure, and pressure ulcer of the sacral region. The Discharge Minimum Data Set (MDS) assessment, dated 12/9/21, indicated the resident was severely cognitively impaired for daily decision making. The resident was an extensive assistance for bed mobility and transfers. The		3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The DCE/designee educated all licensed nursing staff on the “Pain Management” and “Controlled Substance Administration and Accountability” policies prior to 4.29.22. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: The DNS/Unit Managers/designee will audit 5 randomly selected residents with pain/pain medications to ensure a pain care plan is in place, pain is being managed effectively, pain medications are being administered per MD orders, pain medications are being stored in a consistent area, prescriptions are received in a timely manner and medications are available and pain is being assessed 3x/week x 4 weeks, then weekly x 2 months, then monthly x 3 months. Audits will include all shifts and units including weekends. Audits will be submitted to QAPI monthly for at least 6 months and will continue until 95% compliance is reached.	

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	155187	A. BUILDING 00 B. WING	03/31/2022

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	resident was on a scheduled pain medication regimen, did not receive as needed (prn) pain medications, and had occasional pain that did not affect sleep or limit day-to-day activities in the last 5 days. The Care Plan, dated 1/24/22, indicated the resident needed pain management and monitoring related to wound. Interventions included, but were not limited to, administer pain medication as ordered. Evaluate need for routinely scheduled medications rather than prn pain medication administration. Evaluate need to provide medications prior to treatment or therapy. Notify the Physician as needed. A Physician's Order, dated 11/23/21, indicated Norco 325 mg every 6 hours as needed (prn) for pain - discontinued on 11/26/21. A Physician's Order, dated 11/26/21 at 8:00 p.m., indicated Norco (a pain medication) 325 milligrams (mg) scheduled every 6 hours for pain. The Medication Administration Record (MAR), dated 11/2021, indicated Norco was not administered and pain was not assessed on the following dates and times: - 11/30/21 at 8:00 a.m., 2 p.m., and 8:00 p.m. The Medication Administration Record (MAR), dated 12/2021, indicated Norco was not administered and pain was not assessed on the following dates and times: - 12/1/2021 at 2:00 a.m., 8:00 a.m., 2 p.m., and 8:00 p.m. - 12/2/2021 at 2:00 a.m., 2 p.m., and 8:00 p.m. - 12/3/2021 at 2:00 a.m., and 2 p.m.			

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	- 12/4/2021 at 2:00 a.m., 8:00 a.m., and 2 p.m. The Medication Administration Note, dated 11/30/21 at 1:52 p.m., indicated the resident needed a prescription for Norco and writer was notifying the Physician. The Medication Administration Note, dated 12/1/21 at 1:31 a.m., indicated the Norco prescription was not available. The Medication Administration Note, dated 12/1/21 at 3:13 p.m., indicated the Norco medication had been reordered. The Medication Administration Note, dated 12/2/21 at 4:32 a.m., indicated the Norco prescription was not available. The Medication Administration Note, dated 12/2/21 at 3:52 p.m., indicated the Norco medication had been ordered. The Medication Administration Note, dated 12/3/21 at 12:52 p.m., indicated the Norco was administered late. The Medication Administration Note, dated 12/4/21 at 10:48 a.m., indicated the Norco prescription was not available. The Controlled Substance Accountability Sheet for Resident C, indicated resident's Norco 325 mg every 6 hours as needed for pain was administered on 12/3/21 at 12:57 a.m. and 12/4/21 at 11:05 a.m. Interview with Director of Nursing on 3/30/22 at 2:06 p.m., indicated there was a delay obtaining			

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	the scheduled Norco 325 mg prescription. The pharmacy had an active prescription of prn Norco 325 mg pain medication still available for resident. The prn supply was used to manage pain on 12/3/21 and 12/4/21. The medication should have been administered at the scheduled times to manage pain until the new prescription arrived at the facility. 3. The record for Resident E was reviewed on 3/30/22 at 2:07 p.m. Diagnoses included, but were not limited to, cerebral palsy, seizure disorder, severe intellectual disabilities, and quadriplegia (unable to move upper and lower limbs). The Quarterly Minimum Data Set (MDS) assessment, dated 1/10/22, indicated the resident was severely cognitively impaired and was totally dependent on staff for all activities of daily living. The resident was on scheduled pain medications for the last 5 days. The Care Plan, initiated on 5/6/21, indicated the resident needed pain management and monitoring related to contractures. Interventions included, but were not limited to, administer pain medication as ordered. Evaluate need for routinely scheduled medications rather than as needed (prn) pain medication administration. Evaluate need to provide medications prior to treatment or therapy. Notify the Physician as needed. The Physician's Order, dated 2/8/22, indicated Norco (a pain medication) 10-325 milligrams (mg) every 6 hours for pain. The Medication Administration Record (MAR),			

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	dated 3/22, indicated Norco was not administered and pain was not assessed on the following dates and times: - 3/3/22 at 2 p.m. - 3/5/22 at 8 p.m. - 3/11/22 at 8 p.m. - 3/23/22 at 2 a.m. - 3/26/22 at 8 p.m. - 3/27/22 at 2:00 a.m., 8:00 a.m., 2 p.m., and 8:00 p.m. - 3/28/22 at 2:00 a.m., 8:00 a.m., and 2 p.m. - 3/29/22 at 2:00 a.m. and 8:00 a.m. The Medication Administration Note, dated 3/26/22 at 5:28 p.m., indicated the hospice facility was contacted to refill the Norco prescription. The Medication Administration Note, dated 3/27/22 at 10:45 a.m., indicated the Norco prescription was not available. The Medication Administration Note, dated 3/28/22 at 3:55 a.m., indicated the Norco prescription was not available and hospice was aware. The Medication Administration Note, dated 3/29/22 at 12:00 p.m., indicated the Norco prescription was not available. Interview with the Director of Nursing on 3/31/22 at 1:43 p.m., indicated the resident had an active prescription supply of Norco with a dispense date of 3/27/22. The staff did not retrieve and administer this medication because the medication was stored in a different location and they were not aware it was available. This Federal tag relates to Complaint			

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	IN00374441. 3.1-37(a)			
F 0888 SS=B 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. §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			

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	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 documenting the COVID-19 vaccination			

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	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			

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	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 record review and interview, the facility failed to ensure staff were fully vaccinated for COVID-19 and/or had an exemption in place for 2 of 126 employees who worked on 2 of 4 wings in the facility. This resulted in a 98.4% staff vaccination rate. (Employees 1 and 2, B and C Wings) Finding includes: The COVID-19 Staff Vaccination Matrix was reviewed on 3/31/22 at 10:30 a.m. The Matrix indicated Employees 1 and 2 were partially vaccinated and had no exemptions in place. The assigned work area for Employee 1 was listed as C Wing and the work areas for Employee 2 were listed as B/C Wings. Review of facility schedules indicated both employees had worked on 3/30/22 & 3/31/22.	F 0888	1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as being affected. All residents have the potential to be affected. Employee 1 and Employee 2 were immediately educated and removed from the schedule pending receipt of the 2 dose of vaccine. Employee 1 received the 2 dose of vaccine 4.1.22 and Employee 2 received the 2 dose of vaccine 3.31.22. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:	04/29/2022

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	Interview with the Director of Nursing (DON) on 3/31/22 at 1:17 p.m., indicated Employee 1 had not received a second dose of the vaccine and she was unsure why. She did not have a granted exemption on file. Employee 2 had not received a second dose of the vaccine and had attempted to get a medical exemption, but it was not approved. She did not have a granted exemption on file. A facility policy, titled "Employee COVID-19 Vaccinations Policy," indicated, "...1. The facility will ensure that all eligible employees are fully vaccinated against COVID-19, unless religious or medical exemptions are granted as per CMS guided timeframes ...5. The facility will ensure that all staff (except for staff who have been granted exemptions to the vaccination requirements, or those staff for whom COVID-19 must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) are fully vaccinated for COVID-19 ..." 3.1-18(b)		No residents were identified as being affected. All residents have the potential to be affected. Employee 1 and Employee 2 were immediately educated and removed from the schedule pending receipt of the 2 dose of vaccine. Employee 1 received the 2 dose of vaccine 4.1.22 and Employee 2 received the 2 dose of vaccine 3.31.22. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The DCE/designee in-serviced all staff who are not fully vaccinated on the “Employee COVID-19 Vaccination Policy” prior to 4.29.22. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: The Infection Preventionist/DCE/designee will audit all staff who are not fully vaccinated and do not have an exemption on file to ensure they receive the 1/2 dose of vaccine as applicable or have an exemption on file per the “Employee COVID-19 Vaccination Policy”. Audits will occur weekly for 6	

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			months. Audits will be submitted to QAPI monthly for at least 6 months and will continue until 95% compliance is reached.	