STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	C 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA 23225

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1-21-2020 through 1-23-2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/21/2020 through 01/23/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 174 certified bed facility was 127 at the time of the survey. The survey sample consisted of 40 resident reviews.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed	F 552		2/18/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/10/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Continued From page 1

care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review and clinical record review, the facility staff failed to ensure that one of 40 residents (Resident # 73) was fully informed of treatment options regarding smoking cessation.

The Findings included:

For Resident # 73, the facility staff (nurse practitioner) denied the resident's request for smoking cessation patch. The resident had a known diagnosis of "history of nicotine dependence with withdrawal." The facility had become a Smoke Free Facility on 9/1/2019.

Resident #73 was admitted in 2016 with diagnoses that included but were not limited to Schizophrenia, Heart Block, Hypertension and Nicotine Dependence with withdrawal.

Resident #73's most recent Minimum Data Set (MDS) Assessment was an Annual assessment with an Assessment Review Date (ARD) of 12/17/2019. The Brief Interview for Mental Status (BIMS) scored Resident #73 at 6 out of 15, indicating severe cognitive impairment. Resident #73 required setup assistance for eating, limited assistance of 1 person for transfers, dressing and bed mobility transfers, and extensive assistance of 1 person for toileting, personal hygiene, and bathing. Resident # 73 was frequently incontinent of bowel and bladder.

On 1/22/2020 at 2:15 p.m., a review of Resident

F 552

1. MD ordered nicotine patch for Resident #73 on 1/23/2020. Employee G was educated by the Medical Director on 1/23/2020 on nicotine replacement therapies.

2. Residents in the facility with a known history of smoking will be assessed by a licensed nurse to evaluate if they have the desire to smoke. Any identified residents will be offered smoking cessation assistance and those that do not desire alternative nicotine therapy will be assisted to finding placement in other facilities. Follow up based on findings.

3. Medical Director to provide education to his providers on nicotine replacement therapies for residents who have a history of smoking or a desire to quit smoking. Social Services/designee will interview residents with a known history of smoking weekly for 4 weeks to ensure that the residents desire to continue with smoking cessation.

4. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring scheduled modified based on findings.

5. Date of compliance is 2/18/2020.

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#73's electronic clinical record was conducted.

Review of the nurses notes revealed an entry dated 1/21/2020 which read: "md in to review residents request for smoking patch. md denied request at this time."

Review of the Education In-service Attendance Record revealed a list of residents who were inserviced on "Smoking Termination" and stated "All smoking residents were provided with a letter" stating that the facility was going to become a Smoke Free facility. Review of the letter dated July 30, 2019 provided to the residents revealed statements that the facility's focus was on the improvement of residents' health and quality of life." The letter also stated that as of September 1, 2019, the facility would be smoke free and "All patients will be offered and provided patches and/or gum to help them quit smoking, if so desired. Residents that do not want to quit smoking will be assisted with finding placement in other facilities." It also stated that if the residents wanted to be placed on a nicotine patch, "nursing will assist you in doing so." Review of the list of residents revealed Resident # 73's name and signature were listed.

On 1/22/2020 at 3:10 p.m., an interview was conducted with LPN (Licensed Practical Nurse) C who stated Resident # 73 had been seen by the nurse practitioner on 1/16/2020. LPN C stated Resident # 73 frequently asked about smoking.

On 1/23/2020 at 9:15 a.m., the Director of Nursing stated she was very familiar with Resident # 73 who often asked about cigarettes. The Director of Nursing stated she would redirect Resident # 73. The Director of Nursing stated

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F 552	Continued From page 3 she was not aware that any physician denied a request for a smoking cessation patch. The Director of Nursing stated she would have to see why a physician would deny a smoking patch. On 1/23/2020 at 10:25 a.m., a telephone interview was conducted with Resident # 73's medical doctor (Employee F) who stated he was unaware of Resident # 73 requesting a smoking cessation patch. Employee F stated he was a pulmonologist for over 21 years and would never deny a request for smoking cessation assistance. Employee F stated the facility had many residents who smoked for long periods of time and had been chain smokers. Employee F stated everything needed to be done to help the residents stop smoking. Employee F stated he would never deny a request for smoking cessation because of the damages to the body if smoking continues. Employee F stated he needed to review the records to see when his nurse practitioner last saw Resident # 73. Employee F checked the records while the surveyor was on the phone and stated the nurse practitioner last saw Resident # 73 "on 1/16/2020 and is now out of the country." Employee F stated he was going to call the nurse practitioner and call the surveyor back. On 1/23/2020 at 10:38 a.m., the medical doctor (Employee F) returned the call to the surveyor. Employee F stated he talked with the nurse practitioner and asked why she did not order a smoking cessation patch for Resident # 73. Employee F stated the nurse practitioner stated because Resident # 73 had not smoked for about 6 months, she determined that ordering a patch would be adding nicotine to Resident # 73's system and was not a good idea. Employee F	F 552		

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F 552	Continued From page 4	F 552		

stated he was going to call the facility to order the patch immediately.

On 1/23/2020 at 12:07 p.m., an interview was conducted with LPN (Licensed Practical Nurse) E who stated she did write the Nurses Note on 1/16/2020 at 2:00 p.m. after she asked the "doctor" for a patch but the request was denied. LPN E stated the person she asked was the doctor. When informed that the note was written by the nurse practitioner, LPN E stated that the nurse practitioner was who denied the request. LPN E stated she just wrote the MD because she meant the medical provider. LPN E stated she asked about the patch because she noticed that Resident # 73 had begun to ask for cigarettes regularly. LPN E stated she asked Resident # 73 to try the smoking patch instead and Resident # 73 agreed to try the patch.

On 1/23/2020 at 12:15 p.m., an interview was conducted with the nurse practitioner (Employee G) who stated she did "deny the request for a smoking cessation patch because he had not smoked in several months." Employee G stated she did not want to put nicotine in his system by starting a patch. Employee G stated she did receive a call from the medical doctor (Employee F) who told her that she should have ordered the patch and his reasons why. Employee G stated she did understand after Employee F gave the explanation.

During the end of day debriefing on 1/23/2020, the facility administrator and Director of Nursing were made aware of the findings that the facility staff failed to honor Resident # 73's choice of a smoking cessation patch. The nurse practitioner denied the request for a smoking cessation patch

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F 552	Continued From page 5 in a resident with a known diagnosis of "history of nicotine dependence with withdrawal." No further information was provided.	F 552		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §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 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	F 580		2/18/20

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F 580	Continued From page 6 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). This REQUIREMENT is not met as evidenced by: Based on interview, medical record and facility documentation the facility staff failed to follow up with the prescribing physician that Resident did not receive medications as ordered for 1 Resident (Resident #80) in a survey sample of 40 Residents. The findings included: For Resident #80 the facility staff failed to follow up with the prescribing physician that medications ordered were being held due to insurance denial. Resident #80 a 52 year old woman admitted to the facility on 10/14/19 with diagnosis of but not limited to Human Immunodeficiency Virus, Hemiplegia affecting dominant side, benign neoplasm of cerebral Meninges, seizures, cerebral infarction, poly neuropathy, and chronic pain.	F 580	1. Resident #80 did not suffer any adverse effects. The pre-authorization for Sandostatin LAR 30mg was signed by the facility administrator 1/23/2010. The medication was received and administered on 2/6/2020. 2. Residents in the facility have the potential to be affected. The Director of Nursing or designee will review medications requiring pre-authorization within the last 30 days to ensure that medications have been approved and administered as ordered. Follow up based on findings. 3. Nursing staff will be educated by the Director of Nursing or designee on medication availability, ordering medications and notifying the MD timely for medications that were not	

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F 580	Continued From page 7 The Residents most recent MDS a Quarterly dated 12/24/2019 coded the Resident as having a (Brief Interview of Mental Status) BIMS score of 99 indicating that the Resident was unable or unwilling to complete the test. On 1/21/2020 during clinical record review, it was noted that Resident #80 had a medication on hold for the months of November and December of 2019 and January 2020. The medication was ordered by her Oncology specialist on 11/7/2019. On 1/22/2019 at approximately 10:00 AM an interview was attempted with Resident #80 who stated "I don't know about no medicines or doctors leave me alone and ask them. Why you asking me?" On 1/23/2020 at 11:20AM an interview was conducted with acting DON who stated she thought the medication was not approved by Resident #80's health insurance. When asked if the prescribing physician was notified that the Resident did not receive this medication she provided progress notes. Excerpts from the progress notes are follows: "11/7/2019 6:58 PM - Resident has new orders from Oncology visit. NP verified new orders (1) Sandostatin LAR 30 MG [Milligrams] once every 30 days, (2) Afinitor 10 mg tablet PO daily" "11/13/2019 10:48 AM - Medication Afinitor prior auth denied. fnp/rp [family nurse practitioner/ responsible party] aware. Fnp to assess for alternate drug." "11/14/2019 2:26 PM - Writer spoke with Oncologist [Dr name redacted] office in regards	F 580	administered. The DON or designee to review pharmacy communication report during the daily clinical meeting for 4 weeks to ensure medications requiring prior-authorizations are addressed timely then weekly reviews for 4 weeks. 4. Follow up based on findings and reported to facility's monthly QAPI report meeting. Quality Monitoring schedule modified based on findings. 5. Date of compliance is 2/18/2020.	

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F 580	Continued From page 8 to Prior Auth denial for medication. Receptionist took information and writer's request for alternate medication if needed." On 1/23/2020 in an interview with the DON she stated that she was aware of the medication being from the Oncologist and that there should have been more follow up. The pharmacy sent a "Non-Covered Medication Notification" on 11/08/2019, the form was not signed for facility accepting financial responsibility for the medication until 1/23/2020. No further information was provided.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that 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 657		2/18/20

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F 657	Continued From page 9 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to review and revise the careplan for two Residents (Resident #60, #122) in a survey sample of 40 Residents. The findings included: 1. For Resident #60 the facility staff failed to revise the careplan to reflect a change in dates of dialysis treatment. Resident #60 was an active Resident of the facility at the time of survey/inspection. Resident #60's diagnoses included but were not limited to: chronic respiratory failure, chronic viral hepatitis C, end stage renal disease, and atherosclerotic heart disease. Resident #60's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 12/12/19 was coded as an admission assessment. Resident #60 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact. Resident #60 was also coded on this assessment as having required extensive assistance of staff for daily care needs (ADL's) except with bathing and	F 657	1. Resident #60 care plan has been updated to reflect treatment days as of 2/3/2020. Resident #122 care plan was revised to include her safe operation of an electric wheelchair on 2/8/2020. 2. Resident who reside in the facility have the potential to be affected due to inaccurate plan of care. MDS or designee will review care plans for residents receiving dialysis treatment and those who utilize electric wheelchairs to ensure that care plan is accurate. Follow up based on findings. 3. The Director of Nursing or designee will educate MDS staff on timely revision of care plans to reflect to accurately reflect resident's current status. The licensed nursing staff will be also educated on the importance of accurate care plans to guide resident care. The DCS/designees to review residents with changes to their plan of care during the daily clinical meeting weekly for 4 weeks to ensure that the care plan has been revised to accurately reflect changes. 4. Follow up based on findings and reported to the facilities monthly QAPI	

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eating.

On 1/22/2020 during a Resident interview, Resident #60 confirmed that he does go to dialysis on Monday, Wednesday and Fridays.

Review of the physician orders for Resident #60 revealed the following orders:
* 12/6/19 that read, "Hemodialysis (Tues, Thurs and Sat) [location address and phone number redacted]"
* 1/7/2020 that read, "Hemodialysis (M, W, F, [location address and phone number redacted] send bagged lunch".

Review of the current careplan for Resident #60 read, Focus area: "[Resident name redacted] needs dialysis r/t [related to] ESRD [end stage renal disease]" dated 12/9/19. The intervention dated 12/19/19 read, "hemodialysis (Tues, Thurs and Sat) [location address and phone number redacted]".

2. For Resident #122 the facility staff failed to timely revise the careplan to reflect safe operation of an electric wheelchair.

Resident #122 was an active Resident of the facility at the time of survey/inspection. Resident #122's diagnoses included but were not limited to: abnormal posture, muscle weakness, morbid obesity, chronic obstructive pulmonary disease and major depressive disorder.

Resident #122's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/8/2020 was

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meeting. Quality Monitoring scheduled modified based on findings.

5. Date of compliance 2/18/2020.

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coded as a quarterly assessment. Resident #122 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact. Resident #122 was also coded on this assessment as having required extensive assistance of staff for daily care needs (ADL's) except with bathing and toileting which the Resident was totally dependent upon staff.

On 1/21/2020 an interview was conducted with Resident #122. During this interview the Resident verbalized that she has had a few instances of hitting the door with her chair.

Review of the electronic clinical record revealed an entry dated 12/31/19 that read, "Resident was in motorized wheelchair when she notified nurse that she had hit her foot on the outside of the room door three times today while operating motorized wheelchair. Resident is complaining of right knee pain, and stated she heard knee pop when foot hit this door resident denies right foot pain".

Review of the careplan for Resident #122 revealed an intervention added with the date of 1/14/2020 that read, "Rehab to assess usage of wheelchair as needed".

This careplan revision was made 14 days following the date of the incident, made no mention of the x-rays completed in regards to the incident and complaints of pain, and was 12 days following the evaluation of Resident #122 for wheelchair management by occupational therapy.

On the afternoon of 1/23/2020 an interview was conducted with the MDS Coordinator (RN B). When asked who updates careplans, RN B

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ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA 23225

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F 657	Continued From page 12 stated, "the IDT [interdisciplinary team] and everybody". When asked how often they are updated RN B stated, "we update them quarterly and as things happen." RN B was then asked, when a change occurs when you can expect to see this update in the careplan, RN B stated, "immediately". On 1/23/2020 at 4:12 PM an interview was conducted with CNA C. CNA C was asked how CNA's use the careplan and the importance of it being accurate, CNA C stated, "they tell you what the Resident needs and requires. You need it if you are new or aren't familiar with the Resident to tell you what the Resident needs done". The facility Administrator and Director of Nursing were made aware of the facility staff's failure to review and revise the careplan for these two Residents during an end of day meeting held on the afternoon of 1/23/2020. No further information was received.	F 657		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		2/18/20

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professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 14 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on Staff Interview and Clinical Record Review, the facility failed to maintain an accurate clinical record for 1 Resident (Resident #73) in a sample of 40 Residents. The Findings included: 1. For Resident #73, A) a progress note for a different resident was found inside Resident #73's electronic clinical record. B) Another Progress Note for Resident # 73 had the incorrect age listed and C) one progress note for Resident # 73 had a different first name listed in the note. On 1/22/2020 at 2:15 p.m., a review of Resident #73's electronic clinical record was conducted. Review of the electronic clinical record revealed Physicians Progress Notes scanned in the electronic record. Review of the Physicians Progress notes from September 2019- January 2020 revealed errors with three Progress Notes documents. One document dated 9/20/2019 had	F 842	1. Resident # 73's medical record will be corrected to reflect the correct age and first name by the medical provider. The progress note for Resident #19 was removed from Resident #73's record on 1/22/2020. 2. Residents who reside in the facility have the potential to be affected. Medical records personnel will complete a review Physician visits within the last 2 weeks to ensure resident records accurately reflect resident demographics and that file is uploaded to correct resident. Follow up based on findings. 3. The Director of Nursing or designee will provide education to the Medical Director, Nurse Practitioners and medical records personnel on the accuracy of medical records, medical records integrity and scanning of medical records. The medical records clerk will review Physician visit notes weekly for 4 weeks to validate	

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F 842	Continued From page 15 another Resident's name (Resident # 19) and identifiable information. All of the information in that progress note indicated the information was about Resident # 19 and was scanned into the wrong clinical record. Further review of the progress notes revealed a progress note document dated 9/9/2019 had the incorrect age listed in the "history of Present Illness" section of the progress note. The form had Resident # 73's age listed as "a 31-year-old", however, Resident # 73 was 61 years old. Review of a third Progress Note dated 1/16/2020 revealed there was a different first name written in the "history of Present Illness" section of the progress note. The top of the form had Resident #73's name on it. Under "History of Present Illness" there was a different first name documented. On 1/22/2020 at 3:05 p.m., the Director of Nursing was in the conference room reviewing Physicians Progress Notes in Resident # 73's electronic record with the surveyor when errors were discovered in the documents. On 1/22/2020 at approximately 3:15 p.m., an interview was conducted with the Director of Nursing who stated the wrong Progress Note (actually for Resident # 19) should not be scanned in Resident # 73's record. The Director of Nursing stated the medical records staff was responsible for scanning documents in the electronic clinical record. The Director of Nursing stated the medical records staff was working extra time to complete the backlog of documents waiting to be scanned. The Director of Nursing stated the clinical record should be accurate.	F 842	accuracy of resident demographics prior to scanning into documents as well as ensuring correct document was scanned into the correct resident file. The DON or designee will review accuracy of these audits weekly for 4 weeks. 4. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring scheduled modified based on findings. 5. Date of compliance 2/18/20.	

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F 842	Continued From page 16 On 1/23/2020 at 9:45 a.m., an interview was conducted with the Medical Records staff (Employee H) who stated the records should be scanned in the correct records. Employee H stated it was important for records to be accurate. The Administrator and Director of Nursing were informed of the findings at the end of day meetings on 1/22/2020 and 1/23/2020. No further information was presented.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F 880		2/18/20

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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;
(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

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IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, Resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to follow contact precautions to prevent the spread of infection for one Resident (Resident #60) in a survey sample of 40 Residents.

The findings included:

1. Resident #60 was an active Resident of the facility at the time of survey/inspection. Resident #60's diagnoses included but were not limited to: chronic respiratory failure, chronic viral hepatitis C, end stage renal disease, and atherosclerotic heart disease.

Resident #60's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 12/12/19 was coded as an admission assessment. Resident #60 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact. Resident #60 was also coded on this assessment as having required extensive assistance of staff for daily care needs (ADL's) except with bathing and eating.

On 1/21/2020 at approximately 11:00 AM Resident #60's room was observed to have a sign on the door and an isolation cart outside the room.

On 01/21/2020 at 11:11 AM, Employee C was observed to enter the room of Resident #60 without doning any PPE (personal protective

Provider's Plan of Correction:

1. Resident #60's contact precautions were discontinued during survey on 01/21/2020.

2. Residents who reside in the facility have the potential to be affected. The facility does not have any residents on isolation.

3. Facility staff to be re-educated by Director of Nursing or designee on infection control practices to include guidelines for contact /isolation precautions. DON/designee to complete audit of staff compliance with procedures for those residents with contact precautions 5 times weekly for 4 weeks, then weekly for 4 weeks.

4. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring scheduled modified based on findings.

5. Date of compliance is 2/18/20.

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equipment) (masks, gowns, gloves). Employee C was asked why the Resident had a sign on the door and was on precautions, Employee C stated, "I'm not sure, I just saw his light on"

On 01/21/2020 at 11:46 AM this writer went to the nursing station and asked RN A, the assistant director of nursing why Resident #60 was on precautions and RN A stated, "I think shingles". She was asked what kind of precautions the Resident was on, RN A stated "contact".

On 01/22/20 at 08:30 AM, an observation was made of a housekeeper (Employee D) who was in the doorway of room putting a trash can liner in trash can and returned it to the room without doning any PPE, such as gloves or gowns.

On 01/22/20 at 08:36 AM CNA B was observed to enter the room to take Resident #60 a breakfast tray and exited, CNA B did not don PPE prior to entering the room.

On 1/21/2020 at 9:33 AM during an interview with Resident #60, the Resident reported he had shingles. During this interview, RN A came in and reported to the Resident that he was "done" and precautions were no longer required. The sign was removed from the door and the isolation cart was removed from outside the room.

On 1/21/20 a review of the clinical record for Resident #60 was conducted and revealed an active physician order dated 1/13/20 that read, "Place on contact precautions related to Shingles". This order was discontinued later on 1/21/20.

Review of the careplan for Resident #60 revealed

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a careplan initiated 1/13/2020 that read, "[Resident #60's name redacted] has shingles." An intervention on this same careplan read, "Contact precautions". This careplan was resolved on 1/21/20.

On 01/21/20 at 03:33 PM, an interview was conducted with LPN A. LPN A was asked why Resident #60 was on isolation, LPN A stated, "he has shingles". LPN A was asked what she expects staff to do prior to entering the room of Resident #60 and she stated, "put on gown and gloves". LPN A was asked the importance of this, LPN A stated, "he is on contact isolation," she was asked what the risks are if someone doesn't done PPE. LPN A said, "if you haven't had chicken pox or are pregnant, you risk getting it, you could potentially spread it". She was asked if she expects everyone to put on the gown, gloves and mask, LPN A stated, "yes, staff, visitors, any body".

On 01/22/20 at 01:34 PM an interview was conducted with LPN B. She was asked what it means when someone is on contact precautions, LPN B stated, "we have to don and doff when going in and out of room, gown, mask gloves. I check to see why they are on contact precautions so when I give report to my CNA's I am able to tell them why they are on precautions." LPN B was asked if she expects staff to put on the PPE before going in for anything; LPN B stated, "yes, if they need a straw, don't go in that room before putting it on". She was given the scenario if someone is taking in a meal tray in do they need to put a gown, gloves and mask on, LPN B said, "yes, because they are still going into that room". LPN B was asked what the risk is if someone doesn't follow this protocol, she said, "spreading

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the infection what ever it may be, it could be on a surface, there is the risk of spreading the infection". LPN B was asked, what if they are not nursing staff, LPN B said, "yes, everyone, housekeeping, maintenance, I remind them to put on their PPE". She was given the scenario of, what if they are going in to answer call bell but not provide any care? LPN B said, "yes, they should put on the PPE".

A review of the policy titled, "Isolation- Initiating Transmission-Based Precautions" with a review date of 9/1/17 read, "When transmission-based precautions are implemented, the Infection Preventionist shall: ensure that protective equipment is maintained near the resident's room so that everyone entering the room can access what they need; post the appropriate notice on the room entrance so that all staff will be aware of precautions, or be aware that they must first see a nurse to obtain additional information about the situation before entering the room".

On 1/22/2020 and again on 1/23/2020 during end of day meetings the facility Administrator and Director of Nursing were made aware of the facility staff not following contact precautions for Resident #60.

No further information was received.