STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495260	A. BUILDING _____ B. WING _____	C 02/01/2021

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BEAUFONT HEALTH AND REHABILITATION CENTER	200 HIOAKS ROAD RICHMOND, VA 23225

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted was conducted 1/26/2021 through 2/1/2021. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 120 certified bed facility was 63 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control and Abbreviated Survey was conducted 1/26/2021 through 2/1/2021. The facility was in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. However, corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The census in this 120 certified bed facility was 63 at the time of the survey. The survey sample consisted of 15 resident reviews and 3 staff reviews.	F 000		
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-	F 657		3/2/21

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

Electronically Signed | 02/18/2021

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F 657	Continued From page 1 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, the facility staff failed to review and revise care plans for 2 Residents (# 7 and #15) in a survey sample of 15 Residents. The findings included: 1. For Resident # 7, the facility staff failed to revise the care plan to include a diagnosis of COVID 19 positive. Resident # 7 was a 62 year old who was admitted	F 657	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged	

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F 657	Continued From page 2 to the facility on 02/27/2020. Resident # 7's diagnoses included but were not limited to COVID-19, Orthostatic Hypotension Hypopituitarism, Crohn's Disease, Gastroesophageal Reflux Disease, Dementia, and Anticoagulant Therapy. The most recent Minimum Data Set (MDS) was an annual assessment with an Assessment Reference Date (ARD) of 12/10/2020. The MDS coded Resident # 15 with a BIMS (Brief Interview for Mental Status) of 14/15 indicating no cognitive impairment; the resident required assistance with activities of daily living. On 1/28/2021, review of the Resident # 7's clinical record was conducted. Review of the care plan revealed no documentation of the COVID 19 positive status. Review of the Physician's progress notes revealed documentation of the positive COVID 19 results dated 1/21/2021. Review of the care plan revealed no documentation of the positive COVID-19 diagnosis. Thorough review of the care plan revealed focus areas including: crushing medications, Activities of Daily Living, resistance to care, impaired cognitive function, Dementia, falls, Gastrointestinal status, Colostomy, Gastroesophageal Reflux disease, Psychotropic medications, anticoagulant therapy, arthritis and feelings of sadness regarding visitation restrictions at the facility and potential for skin impairment.	F 657	deficiencies cited have been or will be corrected by the date or dates indicated. F657 1-Resident # 15 was discharged on 1/20/21. The Care Plan for Resident #7 was reviewed and updated to reflect the resident□s current status. 2-Residents admitting into the facility have the potential to be affected. An audit of residents with COVID 19 positive Diagnosis or possible exposure of COVID 19 will be reviewed by the DON or designee to ensure that this is accurately reflected on the care plan. 3-Education will be provided to licensed nurses by the Staff Development Coordinator on appropriately including COVID 19 Diagnosis or possible COVID 19 exposure on the care plan. 4-The Director of Nursing or designee will complete audits of care plans for residents with positive COVID diagnosis or exposure to ensure that this is appropriately reflected on the care plan. This audit will be completed 3x week x 4weeks, weekly x2, and then monthly x1. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation. 5-Completion date 3/2/2021.	

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F 657	Continued From page 3	F 657		

2. For Resident # 15, the facility staff failed to revise the care plan to include the diagnosis of COVID-19 positive.

Resident # 15 was readmitted to the facility on 1/15/2021 with diagnoses of but not limited to: COVID-19, Osteoarthritis, Hypertension, Breast Cancer, Gastroesophageal Reflux Disease, and Deep Vein Thrombosis/Pulmonary Embolism.

The most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 10/29/2020. The MDS coded Resident # 15 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required assistance with activities of daily living.

Review of the electronic clinical record was conducted on 1/28/2021 and 1/29/2021.

Review of lab results and orders revealed documentation of a Positive COVID-19 test on 1/6/2021.

Review of the care plan revealed no documentation of the positive COVID-19 diagnosis.

The care plan included focus areas of concern to include: Breast cancer, Activities, Alteration of prior leisure activities, ADL self care deficits, resistant to care, discharge planning, impaired cognition, impaired circulation, Diabetes, potential for falls, risk for alteration in hematological status due to anticoagulant side effects, nutrition risk due to dementia, pain, feelings of isolation due to

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F 657	Continued From page 4 visitation restriction , skin impairment, and impaired vision. On 1/29/2021 at approximately 4:00 P.M. the facility Administrator (Administration A), the Corporate Consultant and Director of Nursing (Administration B) were notified of the findings. The Director of Nursing stated that the diagnosis of COVID-19 positive did not need to be documented on the care plan. The Corporate Nurse stated that the nurses should include the COVID-19 positive results on the care plan. When asked to describe the process that should be followed when a resident is found to be COVID 19 positive, the Corporate Nurse stated, "We should put it on the care plan." No further information was provided.	F 657		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review facility documentation, and in the course of an investigation, the facility staff failed to ensure Residents were free from significant medication errors for 1 Resident (#3) in a survey sample of 15 Residents. The findings included: For Resident #3 the facility staff failed to administer 1 dose of Levomir insulin on 11/4/20	F 760	F760 1- Resident #3 medications are available and he is receiving the medications as ordered. 2-Resident admitting into the facility have the potential to be affected. The DON or designee will complete an audit of current residents to ensure that medications are available for administration and that the medications are administered as ordered. 3-The Staff Development Coordinator will	3/2/21

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F 760	Continued From page 5 his Trulicity weekly dose on 12/15/20 and Coumadin on 12/4/20, 12/8/20 and. Resident # 1, a 63 year old man admitted to the facility on 11/28/17 with diagnoses of but not limited to stroke, atrial fibrillation, major depressive disorder, dysphagia, hypothyroidism, anxiety disorder, hemiplegia and hemiparesis, diabetes type 2, hypertension, seizure disorder, and bipolar disorder. Resident # 3's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/11/2020 coded Resident # 3 as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #3 as requiring extensive assistance with all aspects of ADL's to include bathing, dressing, personal hygiene, and locomotion on and off the unit. The resident is able to eat independently however and requires a wheelchair with assistance for mobility. On 1/27/21 during clinical record review it was discovered that Resident #3 had the following orders: "Levomir flex pen solution pen-injector 100 units/ml inject 40 units 2 times a day for DM type II. Check glucose and call if BS is <60 or >400." A review of the MAR (medication administration record) for November 2020, revealed that on 11/4/20 the MAR had been coded as 9 indicating that the medication had not been given. A review of the progress noted revealed that the nurse had not given it due to "Levomir not yet received from pharmacy."	F 760	educate licensed Nurses on ordering, re-ordering medications, medication STAT box content and utilizing the STAT box for medications as needed. 4-The Unit Manager or designee will complete audits of the resident medication administration records 3x week x 4 weeks, weekly x2, and then monthly x1 to ensure that medications are available and that the residents are receiving the medications as ordered. Results of the audits will be presented to the Quality Assurance Committee for review and recommendation. 5-Completion date 3/2/2021.	

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F 760	Continued From page 6	F 760		

A review of the MAR for December 2020 revealed that the Resident had an order for "Trulicity solution pen injector 1.5 mg /0.5 ml. Inject 1.5 ml subcutaneously one time a day every Tues. for diabetes type 2."

A review of the MAR (medication administration record) for December 2020 revealed that on 12/15/20 the MAR had been coded as 9 indicating that the medication had not been given. A review of the progress note revealed that this medication also was coded as a 9 and charted as not having arrived from the pharmacy.

The Resident also had orders for Coumadin as follows:
"Coumadin (Warfarin Sodium) tablet 7.5 mg give 1 tablet by mouth in the evening Mon Tues and Fri. for artificial valve."
"Warfarin Sodium (Coumadin) 5 mg tablets give 1 tablet by mouth in the evening on Wed. Thurs. Sat. Sun. for blood thinner."

A review of the MAR (medication administration record) for December 2020, revealed that on 12/4/20 and 12/8/20 and 12/16/20 MAR had been coded as 9 indicating that the medication had not been given. A review of the progress note revealed that this medication also was coded as a 9 and charted as not having arrived from the pharmacy.

On 1/27/21 at approximately 10:40 an interview was conducted with Employee C who was asked what happens if a medication runs out, and she stated that if a Resident is out of a medication the nurse should first call the pharmacy to get it sent out on the next run, then check the stat box to see if the medication can be pulled from there,

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F 760	Continued From page 7 and if the medication is not in the stat box she would notify the unit manager, and the physician to see they would like to prescribe an alternate medication until the ordered medication arrives. On 2/1/21 at approximately 1:00 PM an interview was conducted with the DON who stated "It is my expectation that if a medication is not available they first call the pharmacy and get ordered stat, then check the stat box and notify the physician to see if an alternative med can be given from the stat box. We do not routinely get hold orders for unavailable medications." When asked what is the expectation for documenting medication she stated that she expected her nurses to accurately document their med pass for meds given and meds unavailable. On 2/1/21 a review of the stat box contents revealed that Coumadin was available in 1mg, 2mg, and 5 mg. On 2/1/21 at 4:30 PM during the end of day meeting the DON and Administrator were made aware of the concerns with medication administration. The DON stated that she spoke with the nurse and she said she gave the medications when they arrived from the pharmacy. When asked where the documentation that it was given is, she stated they didn't document it. No further information was provided	F 760		
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	F 842		3/2/21

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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 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

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F 842	Continued From page 9 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. §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, facility documentation and clinical record review and in the course of a complaint investigation, the facility staff failed to maintain accurate clinical records for 3 Residents (#2, #6, and #15) in a survey sample of 15 Residents and failed to document narcotic counts. The findings included: 1. For Resident #2 the facility failed to accurately document the code blue on 7/16/19. Resident #2, a 69 year old man admitted to the	F 842	F842 1-Resident #2 was discharged from the facility on 7/16/19. The Code status is now accurately recorded and documented by the Provider on the medical record for Resident #6. Resident #15 was discharged from the facility on 1/20/21. The Nursing Staff are documenting completion of Narcotic count on the provided Narcotic count sheet. 2-Residents admitting into the facility have the potential to be affected. The DON or designee will review any residents that coded in the facility since 2/1/21 to ensure	

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F 842	Continued From page 10 facility on 7/10/19 with diagnoses of but not limited to paranoid schizophrenia, anxiety disorder, major depressive disorder, diabetes type II, fracture of right femur, chronic obstructive pulmonary disorder, and lung cancer.. Resident #2 did not have an MDS that was completed while he was in the facility and that accurately assessed the Resident as he was only in the facility 6 days. His chart did contain a physician's note stating the Resident was unable to make decisions due to his mental status and that in the absence of any family, Resident #2's Rabbi had signed his POA. On 1/27/21 a review of the clinical record was conducted and it was found that Resident #2, had the status of full code and was found unresponsive on 7/16/20. The progress note read as follows: "7/16/19 at 8:19 AM - Pt found unresponsive with no pulse at 0730. CPR performed and EMT called. Pt. was pronounced dead at 0803 by [RN name redacted] MD/RP notified. [LPN signature redacted]." The current DON and Administrator were not working at the facility at the time of the incident, however, they were interviewed at 10:45 on 1/27/21. The Administrator was asked about the incident and she stated that she would try to obtain more information on the incident. A review of the clinical record revealed that the E -Transfer sheet had been completed excerpts are as follows: "Sent to (name of hospital) [Hospital Name Redacted] Date of Transfer -7/17/19 at 07:00	F 842	that the Code Blue was appropriately documented. The DON or designee will review current residents to ensure that the Code Status is accurately recorded and documented in the Provider progress notes on the medical record. The DON or designee will review the Narcotic count sheets on each unit to ensure that the Nurses are completing the forms accurately. 3-The Staff Development Coordinator or designee will educate licensed Nurses on accurately documenting actions taken or provided during a Code Blue; obtaining an order to update the medical record with the Code Status of a resident; Ordering, re-ordering medications, STAT box content and utilizing the STAT box for use; accurately documenting narcotic count verification on the Narcotic count sheet. The Administrator educated the Nurse Practitioner on ensuring accurate documentation is provided for the resident□s code status. 4-The DON or designee will complete audits of residents that coded in the facility to ensure that the Code Blue was appropriately documented. The DON or designee will review current residents to ensure that the Code Status is accurately recorded and documented on the medical record. The Unit Manager or designee will review the Narcotic count sheets on each unit to ensure that the Nurses are completing the forms accurately 3x week x 4 weeks, weekly x2, and monthly x1 to. Results of the audits will be presented to the Quality Assurance Committee for review and recommendation.	

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F 842	Continued From page 11 am Sent From: [Facility name redacted]" "Resident Representative: [Resident Name Redacted] Relationship SELF" "Notified of transfer? Yes" "Aware of clinical situation? Yes" "Usual mental status: Alert oriented and follows instructions" "Completed and reviewed by [LPN name redacted]" "Report called in by [LPN name redacted]" "Report called in to Emergency Room staff Date and time 7/16/19 at 08:00 am" "On 1/27/21 at approximately 2:00 PM an interview was conducted with the Administrator who was asked if the RN called the time of death at 8:03 AM how come the transfer summary has been completed. She stated that she believed it was because they had someone working on his paperwork while they were doing CPR. The Administrator offered to attempt to obtain the EMT record. She provided fax confirmation of request dated 1/27/21 at 2:47 PM. On 1/29/21 the EMS responded with a copy of the report of the code involving Resident #2 on 7/16/19. The EMS report indicated that EMS arrived on the scene at 7:44 AM and took over the code from the nursing staff, EMS attempted resuscitation, started an IV and gave emergency medications for advanced life support, applied Oxygen, and used the auto pulse vest with no success. The report indicates the EMS "Contacted hospital, cease resuscitation orders per [MD name redacted] confirmed time 8:03." The facility submitted a copy of the Emergency	F 842	5-Completion date 3/2/2021.	

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(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
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Care Policy #1102 dated 8/16/17 excerpts are as follows:
"1. Validate code status"
"2. Establish responsiveness"
"6. A licensed nurse will document in Nurses Notes the condition and circumstance of initiating CPR, the duration and events of the procedure, and outcome of the situation"
On 2/1/21 during the end of day meeting the Administrator was made aware of the inaccuracies in the record and no further information was provided.

2. For Resident #6 the facility failed to maintain an accurate record of code status.

Resident #6 a, 64 year old man admitted to the facility on 1/12/21 with diagnoses of but not limited to, hypertension, contracture, major depressive disorder, peripheral vascular disease, non-traumatic Intracerebral hemorrhage hemiplegia and hemiparesis affecting left side, and Poly neuropathy.

Residents most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/31/20 coded the Resident as having a BIMS (brief interview of mental status) score of 15 out of a possible 15. This indicates no cognitive impairment. The MDS codes the Resident as being total assistance needing at least 1 person for all aspects of ADL care except for eating. The Resident is unable to ambulate and requires a wheelchair with physical assistance of 1 person.

On 2/1/21 a review of the clinical record revealed that Resident #6 had no code status written on

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	495260	A. BUILDING _____ B. WING _____	C 02/01/2021

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the face sheet. Further review of the clinical record, revealed that the Resident had a FULL CODE status written in his physician orders however it was discontinued on 1/10/21 when he was discharged to the hospital. The FULL CODE was not reinstated when he returned to the facility. He did not have a valid order for either Full Code or DNR.

On 2/1/21 at approximately 3:00 PM an interview was conducted with the Administrator who stated that the "Full Code must have been discontinued when he was discharged and did not get put back on when he returned on 1/12/21." When asked if he should have a valid order for code status she stated "Yes but if according to our CPR Policy if they do not have a DNR they it defaults to Full Code."

On 2/1/21 during the end of day conference the Administrator was made aware of the concern and no further information was provided.

3. The facility staff failed to document narcotic counts.

On 1/28/21 at approximately 11:30 AM an observation was made of the narcotics count book. When asked the procedure for counting narcotics she explained that the oncoming and off-going shifts count the narcotics together. They have a sheet entitled "Narcotic Book Sign ON/OFF"
in the front of the book where the oncoming and off-going shifts sign. (Note there is 5 columns to this sheet they are : Date, 7 am - 7 pm ON, 7 am - 7 pm OFF, and 7 pm - 7 am ON, 7 pm - 7 am OFF)

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F 842	Continued From page 14 A review of the January 2021 Narcotic Book Sign On off sheet revealed that on 1/26/21 the 7 pm-7 am nurse did not sign on or off during their shift, and the Off-going nurse on 7 pm-7 am on 1/27/21 did not sign off. On 1/29/21 during and interview with the Administrator and the DON as well as the Corporate Nurse Consultant, the administrator was asked about the narcotic sign off sheet and she stated that if they didn't sign off other sheet "It does not mean they did not complete the count it just means they did not sign the sheet." When the Administrator was asked for the policy for narcotics count she stated "We don't have a policy for just narcotic counting." 4. For Resident # 15, the facility staff failed to ensure accurate documentation of code status in numerous Physicians and Nurse Practitioners Progress Notes. Resident # 15 was readmitted to the facility on 1/15/2021 with diagnoses of but not limited to: COVID-19, Osteoarthritis, Hypertension, Breast Cancer, Gastroesophageal Reflux Disease, and Deep Vein Thrombosis/Pulmonary Embolism. The most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 10/29/2020. The MDS coded Resident # 15 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required assistance with activities of daily living.	F 842		

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Review of the electronic clinical record was conducted on 1/28/2021 and 1/29/2021.

Review of the clinical record revealed documentation of a signed "Do Not Resuscitate" Form dated 3/30/2018. Further review of the clinical record revealed no documentation of revocation of the Do Not Resuscitate Order.

Review of the Medical Note Progress Notes written by three different nurse practitioners revealed documentation in the section for "Code Status" of "Full Code" written over 27 (twenty seven) progress notes from 3/22/2018-3/20/2020. Further review revealed the Physicians Progress Notes had "Full Code" written several times: examples including 11/28/2018, 7/29/2019, 8/13/2019, 11/21/2019 and 3/28/2020. There were only 4 (four) dates with DNR documented in the Progress Notes: 3/31/2019, 5/21/2020, 7/18/2020 and 11/14/2020.

On 2/1/2021 at 1:00 PM, an interview was conducted with the Administrator and Director of Nursing via telephone. Both stated the Code Status should be written on the order sheets and the nurses should follow the Physicians Orders. The Administrator also stated there was no noted documentation of the Code Status being changed from Do Not Resuscitate to Full Code as noted in the progress notes.

On 2/1/2021 at 1:07 PM, an interview was conducted with the Nurse Practitioner who stated she documented using a template which always listed the code status as Full Code. The Nurse Practitioner stated Full Code was not accurate for Resident # 15 since there was a signed DNR

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F 842	Continued From page 16 form. When asked about the importance of proper documentation, the Administrator, Director of Nursing and Corporate Nurse Consultant stated the documentation should be accurate but the nurses would follow the Physicians Orders and not what was written in the Progress Notes. No further information was provided.	F 842		