STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495237	A. BUILDING _____ B. WING _____	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA BEACH HEALTHCARE AND REHAB CENTER	1801 CAMELOT DRIVE VIRGINIA BEACH, VA 23454

(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 A COVID-19 Focused Emergency Preparedness Survey was conducted onsite on 03/23/2021, conducted offsite review on 03/24/2021 and continued with onsite review on 03/25/2021. 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 180 certified bed facility was 151 at the time of survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted onsite on 03/23/2021, conducted offsite review on 03/24/2021 and continued with onsite review on 03/25/2021. The facility was not 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. One (1) complaint was investigated during the survey. The census in the 180 certified bed facility was 151 at the time of survey. The survey sample consisted of 5 Resident reviews and 3 Employee reviews. 60 Residents had tested positive for COVID-19. 44 Staff had tested positive for COVID-19. 52 Residents recovered from COVID-19. 43 Staff had recovered from COVID-19. 8 Residents expired from COVID-19. Currently there are 0 Residents positive for COVID-19. Currently there is 1 Staff member positive for COVID-19.	F 000		

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

Electronically Signed | 04/13/2021

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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F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 5 residents (Resident #1) in the survey sample was provided a written Bed Hold Notice when discharged to the hospital on 12/29/2020. The findings included:	F 625	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	4/27/21

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F 625	Continued From page 2 Resident #1 was admitted to the facility on 09/14/2020 and discharged to the hospital on 12/29/2020. Diagnosis included but were not limited to, Diabetes Mellitus and Peripheral Vascular Disease. Resident #1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/21/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. A review of Resident #1's clinical record did not reveal documentation of a bed holb notice being sent when discharged to the hospital on 12/29/2020. An interview was conducted on 03/25/2021 at 10:35 a.m., when asked what information is sent to the hospital or with a resident when discharged to the hospital, Licensed Practical Nurse (LPN) #1 stated, "Send interact change in condition form and transfer discharge interact form, send face sheet, copy of order and reason why resident is going to the hospital, recent labs, medication list, if DNR (Do Not Resuscitate) send DNR with patient. Bed Hold Policy goes with resident, packet to hospital. Notify family, call the hospital and give report to the emergency room, send the care plan." When asked do you document that you sent the information, LPN #1 stated, "Yes, in PCC (Point Click Care)." An interview was conducted on 03/25/2021 at 10:45 a.m., when asked what information do you send out with the resident when transferring, discharging them to the hospital, LPN #2 stated, "I send copy of their orders, care plan, face sheet, Bed Hold Policy, medication list, transfer	F 625	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 deficiencies cited have been or will be corrected by the date or dates indicated. F625 1- Resident #1 was discharged from the facility on 12/29/20. 2-The DON or designee will review resident discharged since 3/26/21 to check for evidence of the bed hold notice being sent with the resident at the time of transfer. 3- The Staff Development Coordinator educated licensed Nursing staff on documenting that the bed hold notice was sent with the resident at the time of transfer. 4-The Unit Manager or designee will complete weekly audits of residents discharged to ensure that the bed hold notice was documented at the time of transfer 3x/week x 4, weekly x2, monthly x1. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation. 5-Completion date 4/27/21.	

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summary, SBAR." When asked do you document that you send the information, LPN #2 stated, "Usually document in the Progress Notes."

On 03/25/2021 at 11:10 a.m., an interview was conducted with LPN #3. When asked what information do you send with a resident when they are being discharged to the hospital, LPN #3 stated, "I send the face sheet, medication sheet, SBAR, reason for transfer sheet, medication administration sheet, medication list. I give information to med transport staff." When asked do you document that you send the information, LPN #3 stated, "Document in Health Status."

On 03/25/2021 at approximately 4:30 p.m., documentation was requested evidencing that the written Bed Hold Notice was sent with or provided to Resident #1 upon discharge to the hospital on 12/29/2020.

On 03/25/2021 at approximately 5:30 p.m., an interview was conducted with the Director of Nursing. The Director of Nursing provided the following forms for Resident #1. Review of the forms revealed and is documented in part, as follows - SNF (Skilled Nursing Facility) / NF (Nursing Facility) To Hospital Transfer Form - Interact Version 4.0 Tool; SBAR Communication Form and Progress Note for RN's (Registered Nurses)/LPN (Licensed Practical Nurse)/LVNs (Licensed Vocational Nurses) Interact Version 4.0 Tool. The Director of Nursing also provided an envelope which was labeled and read as follows: Acute Care Transfer Documents Envelope Note to Patient: Bed Reserve Policy. The Director of Nursing stated, "The nurses

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F 625	Continued From page 4	F 625		

place the SBAR Communication Form and Transfer Form in the envelope and it is sent with the patient and transport staff." The Director of Nursing stated, "The Bed Hold Policy is printed on the outside of the envelope." When asked is it documented in the medical record that the written Bed Hold Notice, envelope was sent with the resident, Director of Nursing stated, "It's protocol."

The Administrator, Assistant Administrator, Director of Nursing and Corporate Nurse was made aware of the findings at the pre-exit meeting on 03/25/2021 at approximately 6:00 p.m. The facility staff reported that they were unable to provide any documentation evidencing that the written Bed Hold Notice was sent with or provided to the resident upon discharge to the hospital. The facility staff did not present any further information about the finding.

On 03/25/2021, a copy of the facility's Hed Hold policy was requested and documents as follows:

Policy
Manual Name: Admissions Policies and Procedures
Manual Section: Bed Reserve
Policy Name: Policy
Policy Number: 601
Effective Date: 02/05/15

Policy: The Health & Rehabilitation Center charges the prevailing room rate for any bed reservation arrangement whenever a patient is not in the Health & Rehabilitation Center for the day or when reserving a bed for in-house transfer.

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F 880	Continued From page 5	F 880		
F 880 SS=E	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 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;	F 880		4/27/21

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F 880	Continued From page 6 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility documentation the facility staff failed to ensure infectious control measures were consistently implemented to prevent the development and / or transmission of a communicable disease (COVID-19). 1. Failed to observed staff being actively screened for COVID-19 when entering the facility	F 880	F880 1- 1.The screening log is provided and monitored by a designated facility staff member for staff to complete when entering the facility and to complete at the beginning of their shift to screen for fever and signs and symptoms of illness. The staff will be educated on what signs and	

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F 880	Continued From page 7 which resulted in discrepancies between what staff reported as the appropriate temperatures for reporting to work. The findings included: 1. During tour of facility on 03/23/2021 the following observations were made and interviews were conducted: On 03/23/2021 at 10:45 a.m., an interview was conducted with Housekeeping staff member, when asked are you screened when you come to work, Housekeeping staff member stated, "Yes, I enter the side entrance of Unit 1 at approximately 6:40 a.m." When asked who checks your temperature, Housekeeping staff member stated, "I do. I write my name and temperature down on a log at the nurses station." When asked are there questions on the log concerning COVID-19, Housekeeping staff member stated, "Yes." An interview was conducted on 03/23/2021 at approximately 11:00 a.m. with Activity Director. When asked to describe the screening process, Activity Director stated, "I enter on Unit 1 and I check my temperature, document and sign my name on the clipboard and answer questions." When asked at what temperature do you have to notify someone, Activity Director stated, "Not sure." An interview was conducted with Licensed Practical Nurse (LPN) #1 on 03/23/2021 at approximately 11:15 a.m. When asked to describe the screening process, LPN #1 stated, "I enter the side door on Unit 1 and check my temperature." When asked who checks your	F 880	symptoms and fever to report and who to report these signs to. 2. Screening logs are provided for staff to consistently document absence of symptoms consistent with COVID-19. 3. CNA #1 was educated on the appropriate personal protective equipment to wear to wear and proper hand hygiene after removing a mask when entering the resident room on Enhanced Droplet Precautions to prevent the spread of COVID-19 on 4/13/21. 2 □ 1. The screening log is provided and monitored by a designated facility staff member for staff to complete when entering the facility and to complete at the beginning of their shift to screen for fever and signs and symptoms of illness. The screening logs are monitored and maintained by the Infection Preventionist. The staff will be educated on what signs and symptoms and fever to report and who to report these signs to. 2. Screening logs are provided for staff to consistently document absence of symptoms consistent with COVID-19. The screening log clipboard will be monitored by the Infection Preventionist or Supervisors to ensure that a supply of screening logs are available and being completed appropriately. 3. 3.The Staff Development Coordinator or designee will conduct observations of staff entering resident rooms with Enhanced Droplet Precautions to ensure that they are wearing the appropriate personal protective equipment and completing proper hand hygiene when	

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F 880	Continued From page 8 temperature, LPN #1 stated, "I do it myself." LPN #1 stated, "I put my name down and temperature. If temperature is over 100.5 I notify my supervisor, I take Tylenol and recheck my temperature and if it does not come down I go home." LPN #1 stated, "I document on the employee temp log. Infection Control Nurse reviews the log every morning." On 03/23/2021 at approximately 11:30 a.m. an interview was conducted with Registered Nurse (RN) #1, Unit Manager, on Unit 2. When asked to describe the screening process, RN #1 stated, "We take our temperature and we have to sign in on our clip board." When asked where do you get your temperature checked, RN #1 stated, "Up here at the nurses station." When asked who checks your temperature, RN #1 stated, "Myself." When asked where do you enter the facility, RN #1 stated, "This is my unit, I always enter through the back door." When asked at what temperature do you have to notify someone, RN #1 stated, "Can't go over 100.5, I'm thinking. I can clarify for you." When asked how do you know everyone has checked their temperature, RN #1 stated, "Because they do it when they get their assignment." An interview was conducted on 03/23/2021 at approximately 11:45 a.m. with Licensed Practical Nurse (LPN) #4, Unit Manager, Unit 3. When asked to describe the screening process, LPN #4 stated, "I enter through Unit 4 side entrance with face mask on. I come to the unit and get the clipboard and answer the questions and check my temperature." When asked at what temperature do you have to notify someone, "LPN #4 stated, "If over 99.5 staff notify the Unit Manager and then the Unit Manager notifies the	F 880	entering the Enhanced Droplet Precautions rooms. 3- The Staff Development Coordinator or designee will educate all staff on the following: 1. Properly completing the Screening protocol when entering the facility. 2. The symptoms of COVID to report to the Supervisor or Infection Preventionist before reporting to work. 3. Licensed nursing staff will be educated on proper personal protective equipment to wear and proper hand hygiene when entering Enhanced Droplet Precaution Resident rooms to prevent the spread of COVID-19. 4- The DON or designee will complete weekly audits to ensure that the screening log is provided and monitored by a designated facility staff member for staff to complete when entering the facility and to complete at the beginning of their shift to screen for fever and signs and symptoms of illness. The DON or designee will complete weekly audits to ensure that the Screening logs are provided for staff to consistently document absence of symptoms consistent with COVID-19. The Staff Development Coordinator or designee will conduct observations of staff entering resident rooms with Enhanced Droplet Precautions to ensure that they are wearing the appropriate personal protective equipment when entering the rooms 3x/week x 4, weekly x2, monthly x1. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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F 880	Continued From page 9 DON (Director of Nursing) and SDC (Staff Development Coordinator)." On 03/23/2021 at approximately 12:00 p.m., an interview was conducted with LPN #5 on Unit 4. When asked to describe the screening process, LPN #5 stated, "I enter through the side door on Unit 1, I check my temperature and document on the clipboard at the nurses station, questionnaire." When asked at what temperature do you have to notify someone, LPN #5 stated, "If temperature is over 99.5 don't work." On 03/23/2021 at approximately 3:00 p.m., an interview was conducted with the Administrator and Director of Nursing. When asked what is the screening process of the staff, Director of Nursing stated, "The staff come on to shift and they fill out the form at the nurses stations." When asked who checks the staffs temperatures, Director of Nursing stated, "The staff have been educated on COVID and the temperature to report if over." When asked at what temperature are they to report, Director of Nursing stated, "If it is above 100." When asked who do they notify if over 100, Director of Nursing stated, "They are to notify the Director of Nursing." On 03/23/2021 requested copy of facility policy and procedure on staff screening process. On 03/25/2021 at 1:50 p.m., observed LPN #6 in shorts and shirt enter side door on Unit 1 and walk down the hallway pass several residents and entered into the In Service Education Room. At 1:52 p.m. LPN #6 exited the room When asked who he was, LPN #6 stated, "I am one of the nurses and I'm here to do swabs, tested on Tuesdays and Thursdays." When asked should	F 880	5-Completion date 04/27/21.	

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F 880	Continued From page 10 you be screened, have your temperature checked when you enter into the facility, LPN #6 stated, "Yes." When asked were you screened when you entered into the facility, LPN #6 stated, "No." When asked should you have been screened when you entered the facility, LPN #6 stated, "Yes." When asked who usually screens you, takes your temperature when you come to work, LPN #6 stated, "I do." On 03/25/2021 requested copy of facility policy and procedure on staff screening process, did not receive. The Administrator, Assistant Administrator, Director of Nursing and Corporate Nurse was made aware of the finding at the pre-exit meeting on 03/25/2021 at approximately 6:00 p.m. The facility staff did not present any further information about the finding. 2. The facility staff failed to consistently document absence of symptoms consistent with COVID-19. 2. On 03/23/2021 at approximately 10:30 a.m., facility staff report documenting their name and temperature on Employee Log form at nurse's station on Unit 1 after screening themselves. Review of form revealed and is documented in part, as follows: "Employee Log; Since the last time I worked I have not been in contact with any one who has confirmed COVID-19 or is under investigation for COVID-19.; Since the last time I worked, I have not worked in another healthcare facility that has a case of COVID-19.; I currently do not have the following symptoms: shortness of breath, new or change in cough, sore throat,	F 880		

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F 880	Continued From page 11	F 880		

chills, vomiting, diarrhea, muscle pain, headache, new loss of taste or smell.; If all of these statements are true please sign. Signature Date Temperature: ."Review of Employee Log revealed 9 available spaces for staff to document their signature, date and temperature after reviewing the statements.

On 03/23/2021 at approximately 2:30 p.m., an interview was conducted with Registered Nurse (RN) #2, Infection Control Nurse. Requested copies of Employee Logs for Unit 1 for 7-3 shift and received. During the process of the Infection Control Nurse going through Employee Logs on a table in her office several logs were observed to have employee signatures and temperatures documented on the blank back side. Also observed sheets of paper with only employee signatures, temperatures and a date documented on them. When asked why there were signatures and temperatures documented on the blank back side of the Employee Logs and on plain sheets of paper, Infection Control Nurse stated, "They ran out of space to document and documented on the back of the page." When asked should the staff document on the back of the form, Infection Control Nurse stated, "No, we have plenty of forms." Infection Control Nurse pointed to the plain pieces of paper with signatures and temperatures and stated, "Dietary documented on that page. Dietary Manager is over Dietary." Requested a few copies of the Employee Logs with documentation on the blank back side and documentation on blank sheets of paper and received. Review of Employee Logs and blank papers revealed the following: Employee Log dated 1/30/21 revealed documentation on the blank backside - date 2/23/2021, staff signatures and temperatures; Employee Log

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VIRGINIA BEACH HEALTHCARE AND REHAB CENTER	1801 CAMELOT DRIVE VIRGINIA BEACH, VA 23454

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F 880	Continued From page 12 dated 2/1/21 revealed documentation on the blank back side - date 2/25/2021, staff signatures and temperatures, one signature and temperature with a date of 2/26/2021; plain sheet of paper dated 2/27/21 and 2/28/21 revealed documentation of 8 signatures and 5 temperatures with Dietary documented on the back; plain sheet of paper dated 3/1/21 revealed documentation of signatures and temperatures; back side of the plain paper revealed dates of 3/2/21 and 3/3/21 revealed documentation of 11 signatures and 10 temperatures. An interview was conducted with the Administrator and Director of Nursing on 03/23/2021 at approximately 3:00 p.m. and reviewed Employee Logs. When asked should the staff be documenting their signatures and temperatures on the backs of the Employee Logs and on blank sheets of paper, Director of Nursing stated, "No." The Administrator, Assistant Administrator, Director of Nursing and Corporate Nurse was made aware of the finding at the pre-exit on 03/25/2021 at approximately 6:00 p.m. The facility did not present any further information about the finding. 3. Failed to wear personal protective euipment (googles or faceshield) and practice hand hygiene after removing face mask in a patient room on Enhanced Droplet Contact Precautions for 1 of 5 residents in the survey sample, Resident #2. 3. Resident #2 was originally admitted to the facility on 12/12/2020, discharged to the hospital	F 880		

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F 880	Continued From page 13	F 880		

on 03/07/2021 and readmitted to the facility on 03/22/2021. Diagnosis included but were not limited to, Multiple Sclerosis and Type 2 Diabetes Mellitus. Resident #1's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 02/03/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #2 as requiring total dependence of 1 for personal hygiene and dressing, total dependence of 2 for bed mobility, transfer, toilet use and bathing and supervision with setup help only with eating.

On 03/25/2021 at approximately 12:35 p.m., observed Certified Nursing Assistant (CNA) #1 standing outside of Room #1 wearing an isolation gown and surgical face mask. Observed CNA #1 remove N95 face mask from Isolation bin setup outside of room. CNA #1 removed surgical face mask touching the front of the face mask and crumpled it up with her bare hands. CNA #1 donned N95 face mask then picked up gloves from top of Isolation bin set up. CNA #1 then walked into Room #1. CNA #1 immediately came out of the room and was donning gloves. CNA #1 was handed a meal tray by another CNA and CNA #1 carried the tray back into Room #1. CNA #1 closed the room door. Signage observed on Room #1 door that read: Enhanced Droplet Contact Precautions Perform hand hygiene, N95 or surgical mask when entering room, Eye Protection when entering room (Goggles or Face Shield), Gown when entering room, gloves when entering room, Keep door closed, Remove PPE (Personal Protective Equipment) and perform hand hygiene before exiting room. At approximately 12:40 p.m., CNA #1 exited the room and went to hand sanitizer

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F 880	Continued From page 14 dispenser on wall in hall and sanitized her hands. Requested CNA #1 to review the signage on the door of Room #1. When asked did you wear goggles or a face shield when you went into Room #1, CNA #1 stated, "No." When asked if she should have worn goggles or a face shield into Room #1, CNA #1 stated, "Yes." When asked what she did with the surgical face mask after entering Room #1, CNA #1 stated, "I threw it in the trash can." When asked if she cleaned her hands after discarding the surgical face mask and prior to donning the clean gloves, CNA #1 stated, "No." When asked do you consider your face mask clean or dirty after you have worn it, CNA #1 stated, "Dirty." When asked should you have cleaned your hands, performed hand hygiene, after discarding the surgical face mask and prior to donning the clean gloves, CNA #1 stated, "Yes." On 03/25/2021 at approximately 4:00 p.m., an interview was conducted with the Director of Nursing, when asked what are her expectations of the nursing staff, Director of Nursing stated, "They should follow appropriate PPE as listed." Requested copy of Infection Prevention and Control Policy and received. The Administrator, Assistant Administrator, Director of Nursing and Corporate Nurse was made aware of the finding at the pre-exit meeting at approximately 6:00 p.m. on 03/25/2021. The facility did not present any further information about the finding. Policy Name: Enhanced Barrier Precautions (EBPs) Effective Date: 09/26/2019	F 880		

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F 880	Continued From page 15 Policy: Employees providing high-contact patient care activities will follow Enhanced Barrier Precautions (EBPs). This level of precaution is indicated during the implementation of a containment strategy to prevent the potential transfer of a novel or targeted multi-drug resistant organism (MDRO). Enhanced Barrier Precautions falls between Standard and Transmission - based Precautions and refers to the use of gown and gloves during high - contact patient care activities. Policy Name: Handwashing Requirements Effective Date: 02/06/20 Policy: All staff are trained in proper techniques upon hire, annually, and PRN (As Needed), and are monitored for proper handwashing practices. Employees will wash hands at appropriate times to reduce the risk of transmission and acquisition of infections."	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		4/27/21

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F 883	Continued From page 16 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883		

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F 883	Continued From page 17 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review the facility staff failed to provide documentation evidencing that the resident or resident representative was provided education regarding the benefits and potential side effects of influenza and pneumococcal immunization for 3 of 5 residents in the survey sample, (Resident #3, #4, #5). The findings included: 1. Resident #3 was admitted to the facility on 02/23/2021 and discharged on 03/21/2021. Diagnosis included but were not limited to, Chronic Systolic (Congestive) Heart Failure and Type 2 Diabetes Mellitus Without Complications. Resident #3's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 03/01/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. 2. Resident #4 was admitted to the facility on 02/10/2021. Diagnosis included but were not limited to, COVID-19 and Essential Hypertension. Resident #4's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 03/17/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. 3. Resident #5 was admitted to the facility on 02/19/2021. Diagnosis included but were not	F 883	F883 1- Resident #3 was discharged from the facility on 3/21/21. Resident #4 and #5 have been provided education regarding the benefits and potential side effects of influenza and pneumococcal immunizations as evidenced by documentation on the resident immunization record. 2-The Unit Manager or designee will review current residents to ensure that education regarding the benefits and potential side effects of influenza and pneumococcal immunizations are provided and documented on the resident record. 3- The Staff Development Coordinator educated all licensed Nursing staff on providing information regarding the benefits and potential side effects of influenza and pneumococcal immunizations and documenting this education on the resident record. 4-The Unit Manager or designee will audit resident immunization records on a weekly basis to ensure that the benefits and potential side effects of influenza and pneumococcal immunizations are provided and documented on the resident record 3x/week x 4, weekly x2, monthly x1. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation. 5-Completion date 04/27/21.	

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F 883	Continued From page 18 limited to, Multiple Fractures of Pelvis with Stable Disruption Of Pelvic Ring, Subsequent Encounter For Fracture With Routine Healing and muscle Weakness (Generalized). Resident #5's Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date Date of 02/25/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. On 03/23/2021 received copy of Influenza and Pneumococcal Vaccinations Policy and Procedure. On 03/25/2021 at approximately 4:30 p.m., this surveyor requested documentation evidencing that Resident #3 and / or the representative, Resident #4 and / or the representative and Resident #5 and / or the representative was provided education regarding the benefits and potential side effects of the influenza and pneumococcal immunizations. An interview was conducted with the Director of Nursing on 03/25/2021 at approximately 5:30 p.m. The Director of Nursing provided Vaccine Information Statement sheets and stated, "The staff review these with the residents on admission." Review of the Vaccine Information Statement sheet revealed the following: VACCINE INFORMATION STATEMENT Influenza (Flu) Vaccine (Inactivated or Recombinant): What you need to know 1. Why get vaccinated? 2. Inactivated and recombinant flu vaccines 3. Some people should not get this vaccine 4. Risks of a vaccine reaction 5. What if there is a serious reaction 6. The National Vaccine Injury Compensation Program; VACCINE INFORMATION STATEMENT Pneumococcal Conjugate Vaccine (PCV13):	F 883		

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F 883	Continued From page 19	F 883		

What You Need To Know 1. Why get vaccinated? 2. PCV 13 3. Talk with your health care provider 4. Risks of a vaccine reaction 5. What if there is a serious problem? 6. The National Injury Compensation Program 7. How can I learn more?; VACCINE INFORMATION STATEMENT Pneumococcal Polysaccharide Vaccine What You Need To Know 1. Why get vaccinated? 2. Pneumococcal polysaccharide vaccine (PPSV23) 3. Some people should not get this vaccine 4. Risk of a vaccine reaction 5. What if there is a serious reaction 6. How can I learn more?; VACCINE INFORMATION STATEMENT Pneumococcal Polysaccharide Vaccine (PPSV23): What You Need To Know 1. Why get vaccinated? 2. PPSV23 3. Talk with your health care provider 4. Risks of a vaccine reaction 5. What if there is a serious problem? 6. How can I learn more? When asked for documented evidence that the Vaccine Information Statement was reviewed with the residents and / or resident representative regarding the benefits and potential side effects of the influenza and pneumococcal immunizations, Director of Nursing stated, "Staff go over the Vaccine Information Statements with residents on Admission but they do not document in the medical record going over it with the resident."

The Administrator, Assistant Administrator, Director of Nursing and Corporate Nurse was made aware of the findings at the pre-exit meeting on 03/25/2021 at approximately 6:00 p.m. No further information was provided about the findings.

Policy Name: Influenza & Pneumococcal

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F 883	Continued From page 20 Vaccinations Policy Number: 1701 Effective Date: 02/06/20 Policy: Vaccination against influenza will be offered to Center patients and staff annually. Vaccination against pneumonia will be offered to Center patients as indicated. Procedure: g. 2) Provide Vaccination Information Sheet (VIS) for influenza vaccine to patient and/or responsible party. Copy of VIS will be maintained with Patient Influenza Vaccine Tracking/Surveillance Log(s) and a copy will be placed in the patient's record as proof of education; include the date on the first page of the Vaccination Information Sheet (VIS).	F 883		