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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/17/2021 through 02/19/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/17/2021 through 02/19/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 60 certified bed facility was 42 at the time of the survey. The survey sample consisted of 21 current Resident reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578		3/19/21

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

Electronically Signed | 02/26/2021

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F 578	Continued From page 1 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interviews, and facility document review, it was determined that the facility staff failed to ensure 4 out of 21 residents (#131, #19, #8 and #1) in the survey sample had an opportunity to formulate and Advance Directive. The findings include:	F 578	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	

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F 578	Continued From page 2 1. Resident #131 was admitted to the nursing facility on 2/11/21 with diagnoses that included chronic obstructive pulmonary disease (COPD), acute cystitis with hematuria (blood), muscle weakness and repeated falls. The Admission Minimum Data Set (MDS) assessment dated 2/16/21 coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had intact cognitive skills for daily decision making. On 2/17/21 at 1:00 p.m., during an interview with Resident #131, she stated she did not have an Advance Directive and had not been approached by any facility personnel about developing one. She stated she did not have a living will and wanted everything to be done for her if she had a medical emergency. On 2/18/21 at 2:00 p.m., a request was made of the Admission's Director as to whether the resident had an Advance Directive, or that information was presented to give the resident an opportunity to formulate one. On 2/18/21 at 3:15 p.m., the Admission's Director presented a document titled (Company name) Policies Governing the Implementation of Self-Determination Rights. The resident's signature was in place along with the Admission Director's signature. There was no date as to when the signatures were obtained, thus the document was undated. The document gave an opportunity to have the resident receive information regarding advance directives in order to formulate one or opt out. None of the questions were filled out, all were blank. When asked when	F 578	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. F578 1. Resident #131 has been given the opportunity to formulate an advanced directive. Resident #19 discharged from the facility on 2/20/21. Resident #1 discharged from the facility on 2/24/21. Resident #8□s representative has been given the opportunity to formulate an advanced directive. 2. All current residents were reviewed to ensure that documentation of the opportunity to formulate an advanced directive was completed and documentation is present in the medical record. 3. The Admissions Department was educated on completion of the Self-Determination of Rights and communication of resident advanced directives. Charge Nurses were educated on ensuring that resident advance directives are acknowledged. 4. A Nurse will complete a random weekly review of newly admitted residents to ensure that the residents were given the opportunity to formulate an advanced directive. 5. Issues noted during the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 19, 2021	

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F 578	Continued From page 3	F 578		

she had the resident sign the document, she stated, "A few minutes ago." Further, the Admission's Director was not able to share if she explained the content of the document to the resident, nor was she able to explain the document to this surveyor. The Admission's Director stated, "No one has instructed me on how to fill out this document or help the resident with the document. We ask the resident or the family about a living will or Advance Directive and many come from the hospital with one. We upload the document in the electronic record, but if they don't have one, there is nothing else I know to do."

On 2/18/21 at 3:30 p.m., Resident #131 stated the Admission's Director told her she needed to sign more admission paperwork for treatment, but nothing else was explained to her about the content of the paperwork.

On 2/19/21 at 12:13 p.m., via phone interview, the Administrator validated what the Admission's Director said regarding residents admitted with either a living will or advanced directives and they are placed in the clinical record. She stated she was not familiar with the process of reviewing a document that addressed Advance Directive options with residents for the opportunity to formulate one, but would check further and return with more information.

On 2/19/21 at 2:09 p.m., via phone interview, the Administrator stated the facility staff (Admission's office or Nursing staff) was not ensuring all residents were presented with information to be able to create an Advance Directive if they desired.

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F 578	Continued From page 4	F 578		

The policy and Procedures titled, Nursing Policies and Procedures/Advance Directives dated 3/24/20 indicated the following:
"A copy of the Center's policies governing the implementation of self-determination of rights is presented upon admission by the Admissions Office and the Notification/Acknowledgment Form verify all communication regarding advance directives is to be placed in the medical record at the time of admission."

2. Resident #19 was admitted to the nursing facility on 1/27/21 with a diagnoses of COVID-19.

The Admission Minimum Data Set (MDS) assessment dated 2/1/21 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had intact cognitive skills for daily decision making.

On 2/18/21 at 2:00 p.m., a request was made of the Admission's Director as to whether the resident had an Advance Directive, or that information was presented to give the resident an opportunity to formulate one.

On 2/18/21 at 3:15 p.m., the Assistant Admission's Director presented a document titled (Company name) Policies Governing the Implementation of Self-Determination Rights. There was an electronic signature dated 2/2/21 for both the resident and the Assistant Admission's Director. The document gave an opportunity to have the resident receive information regarding advance directives in order to formulate one or opt out. None of the questions were filled out, all were blank. The Assistant

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F 578	Continued From page 5	F 578		

Admission's Director was not able to share if she explained the content of the document to the resident, nor was she able to explain the document to this surveyor. The Admission's Director stated, "No one has instructed me on how to fill out this document or help the resident with the document. We ask the resident or the family about a living will or Advance Directive and many come from the hospital with one. We upload the document in the electronic record, but if they don't have one, there is nothing else I know to do."

On 2/18/21 at 3:45 p.m., Resident #19 was shown the electronically signed document and replied, "I have never seen that and I don't know what that is, but I am getting better and plan to go home very soon." The Admission History and Physical indicated the resident was a full code.

On 2/19/21 at 12:13 p.m., via phone interview, the Administrator validated what the Admission's Director said regarding residents admitted with either a living will or advanced directives and they are placed in the clinical record. She stated she was not familiar with the process of reviewing a document that addressed Advance Directive options with residents for the opportunity to formulate one, but would check further and return with more information.

On 2/19/21 at 2:09 p.m., via phone interview, the Administrator stated the facility staff (Admission's office or Nursing staff) was not ensuring all residents were presented with information to be able to create an Advance Directive if they desired.

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F 578	Continued From page 6	F 578		

5. Facility staff failed to ensure Resident #1 and/or her representative was given the opportunity to formulate an advanced directive.

The findings included:

Resident #1 was admitted to the facility on 10/28/19 with diagnoses that included but were not limited to debility, cardio-respiratory conditions, anemia, heart failure, high blood pressure, and diabetes. Resident #1's most recent MDS (minimum data assessment) was an annual assessment with an ARD (assessment reference date) of 11/7/20. Resident #1 was coded as being intact in cognitive function scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #1's clinical record revealed a DNR (Do not Resuscitate) order dated 10/25/19 that documented the following: "The patient is incapable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make evaluation of the risks and benefits of alternatives to that decision...While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life prolonging procedures be withheld or withdrawn."

Review of Resident #1's "Virginia Advance Medical Directive" pages 4 through 4 were blank.

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On 2/18/21 at 12:44 p.m., ASM (Administrative Staff Member) #1, the Administrator was made aware of the above concerns.

Review of facility policy titled, "Advanced Directives," documents in part the following:
"Documents of declaration for advanced directives that are approved by state law (i.e. living wills, Durable power of Attorney and/or Agents for Healthcare Decisions/Healthcare Power of Attorney, appointments for anatomical gifts/organ donations) will be placed in the medical record as provided by the patient or legally designated agent/representative.
1. A copy of the Center's policies governing the implementation of self- determination of rights is presented upon admission by the Admissions Office and the Notification/Acknowledgement Form verifying all communication regarding advanced directives is to be placed in the Medical Record at the time of admission.
2. If the patient chooses to provide advanced directive documents, these documents must be verified as original documents and will be placed in the medical record.
3. An advanced directive is separate from a DNR order; however, a Living Will or other Advance Directive document may actually specify the withholding of CPR which does necessitate the proper securing of a valid DNR order if a DDNR state form, DNR jewelry, or POST form has not accompanied the patient upon admission.
4. Upon admission a licensed nurse must immediately review the advance medical directive documents provided. If the Living Will specifies or declares the withholding of CPR or specifies that they do not want to be resuscitated, a licensed nurse must immediately notify the attending

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physician and secure a valid DNR order. A valid DNR order is an original order initiated by the physician, an original Virginia Department of Health Durable Do No (sic) Resuscitate Order Form, legible photocopy of the DDNR, DNR jewelry, or POST form. If a valid DNR order is received, a licensed nurse enter the order in the electronic record."

No further information was presented prior to exit.

3. The facility staff failed to execute the opportunity to provide an advance directive for Resident #8.

The findings include:

3. Resident #8 was admitted to the facility on 12/23/2009 and readmitted to the facility on 12/29/2020 with a past medical history that included Essential Hypertension, Pressure Ulcer of the Sacral Region and Feeding difficulties.

The current Minimum Data Set (MDS) a quarterly revision with an Assessment Reference Date (ARD) of 01/15/2021 coded the resident as having long and short-term memory problems.

A review of the clinical record on 2/18/21 at 3:02 PM revealed there was no advance directive in the clinical record.

During an interview with the Admissions Director on 2/18/21 at approximately 3:40 p.m., concerning Resident #8's Advanced Directive she

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F 578	Continued From page 9 stated, "I don't have records on Resident #8, they are stored offsite at Iron Mountain Storage." The Policy "Advance Directives" Effective 03/24/20 Reads: Documents of declaration for advance directives that are approved by state law will be placed in the medical record as provided by the patient or legally designated agent/representative. The Procedure: A copy of the Center's policies governing the implementation of self-determination of rights is presented upon admission by the Admissions Office and the Notification/Acknowledgment form verifying all communication regarding advance directives to be placed in the Medical Record at the time of admission. On 2/19/21 at 3:30 p.m. an Interview was conducted via telephone with the Administrator concerning the above issue with the Advance Directive not being located in the residents chart. She stated, "We would usually get the POA (Power of Attorney) involved." (If further information is needed involving the Resident).	F 578		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		3/19/21

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F 689	Continued From page 10 Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to ensure a safe Hoyer lift transfer which resulted in a fall for one out of 21 sampled residents; Resident #1. The findings included: Resident #1 was admitted to the facility on 10/28/19 with diagnoses that included but were not limited to debility, cardio-respiratory conditions, anemia, heart failure, high blood pressure, and diabetes. Resident #1's most recent MDS (minimum data assessment) was an annual assessment with an ARD (assessment reference date) of 11/7/20. Resident #1 was coded as being intact in cognitive function scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #1's clinical record revealed that she had experienced a fall on 12/19/20. The following nursing note was documented: "Patient was being Hoyer lifted from bed to WC (wheelchair). When lowering to WC patient was on the edge and unable to get back in the chair. Went to readjust patient with Hoyer and while doing so, she slipped out of the vest in very slow motion to the floor. This was a monitored slide/fall by a CNA (Certified Nursing Assistant) and myself. Assessed patient head to toe and all seemed WNL (within normal limits) with the exception of her BP: 180/80 and continued to monitor that. The last BP was 170/78. She says her back is achy in which case @ (at) Tylenol were given to patient to help with the pain." Review of a fall incident report dated 12/19/20 documented the following: "Pt (patient) was being	F 689	F689 1. Resident #1 discharged from the facility on 2/24/21. 2. All residents using a Hoyer lift for transfer will be transferred in a safe manner, using two staff members for the transfer. 3. Nursing staff were educated on safe transfer technique for using a Hoyer lift to include two-person assist. 4. A Nurse will complete random weekly observation of staff using a Hoyer lift for a transfer to ensure that the proper steps are followed. 5. Issues noted during the observations will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 19, 2021	

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Hoyer lifted to her chair. Was sitting on edge of the wheelchair and when attempting to reposition patient into chair she slipped out of vest in slow motion onto the floor...assessed patient from head to toe with no wounds, bleeding, or injuries noted...Got the assistance from the charge nurse and other CNAs to reposition patient into another Hoyer lift and put her right back into bed..."

Review of Resident #1's care plan dated 10/20/17 and canceled on 2/11/21 documented the following: "The resident has an ADL self-care performance deficit r/t (related to) Activity Intolerance. Hands remain swollen. Is unable to move w/c (wheelchair) with hands and feet...Interventions: Assist of 2 staff for transfers and mechanical lift."

On 2/18/21 at 2:17 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the nurse present during the fall. When asked what had happened at the time of the fall on 12/19/20, LPN #1 stated that the CNA (Certified Nursing Assistant) was using the sit to stand lift and was lowering the resident to the wheelchair but that she did not put the resident far back enough in the wheelchair. LPN #1 stated that the CNA unhooked the straps before repositioning the resident, and the resident slid out of the wheelchair as soon as the straps were unhooked. When asked if she had witnessed the fall, LPN #1 stated that the CNA was using the Hoyer lift by herself and that she was called in when the resident was sitting on the edge of the wheelchair. When asked if staff should be utilizing the Hoyer lift or sit to stand lift with just one staff member, LPN #1 stated that they were supposed to use two staff with the sit to stand, especially with the resident being on the heavier

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F 689	Continued From page 12 side. LPN #1 stated that she had not seen the nursing aide in a while and was not sure if she still worked at the facility. On 2/18/21 at approximately 12:30 p.m., an interview with the CNA who transferred Resident #1 was attempted for an interview. She could not be reached prior to exit. On 2/18/21 at 12:44 p.m., ASM (Administrative Staff Member) #1, the Administrator was made aware of the above concerns. Facility policy titled, "Mechanical Lift" documents in part, the following: "Two nursing staff must assist with mechanical lift and transfer...position chair and lock brakes...move patient over chair and lower into chair. Base of lifter around chair. Detach hooks from seat/sling..." No further information was presented prior to exit.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that facility staff failed to obtain a physician's order for the	F 695	F695 1. Resident #279 is receiving oxygen as	3/19/21

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F 695	Continued From page 13 use of oxygen for one of 21 residents in the survey sample; Resident #279. The findings included: Resident #279 was admitted to facility on 2/10/21 with diagnoses that included but were not limited to COVID-19, sepsis, and acute respiratory failure. Resident #279's most recent MDS (minimum data set) assessment was an entry assessment with an ARD (assessment reference date) of 2/10/21. Resident #279 did not have a completed MDS assessment. On 2/17/21 at 12:18 p.m., an observation was made of Resident #279. She was sitting up in her wheelchair wearing a nasal cannula that was hooked up to an oxygen (02) concentrator. The 02 concentrator was turned on and at 2 liters of oxygen. On 2/18/21 at 11:15 a.m., a second observation was conducted of Resident #279. She was lying in bed with her nasal cannula in place. When asked how many liters she was receiving, Resident #279 stated that she has always been on 2 liters of oxygen. Review of Resident #279's current POS (Physician Order Summary) failed to evidence an order for oxygen. Review of Resident #279's care plan dated 2/15/21 documented the following: "The resident has oxygen therapy r/t (related to) CHF (Congestive Heart Failure)...The resident will have no s/sx (signs/symptoms) of poor oxygen absorption through next review date...Oxygen Settings: 02 via nasal cannula as ordered."	F 695	ordered by the physician. 2. Residents using oxygen were reviewed to ensure that an order for the oxygen was present. 3. Charge Nurses were educated on obtaining physician order for use of oxygen. 4. A Nurse will complete a random weekly observation of residents using oxygen to ensure that an order for the oxygen is present. 5. Issues noted during the observation will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 19, 2021	

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F 695	Continued From page 14 On 2/19/21 at 10:47 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, Resident #279's assigned nurse. When asked if there should be an order for the use of oxygen, LPN #1 stated that she would expect an order. When asked why there should be an order for the use of oxygen, LPN #1 stated that she expected an order so that all nursing staff were aware to check on her 02 levels and for any episodes of shortness of breath. When asked if oxygen was also considered a medication, LPN #1 stated that it was. When asked if Resident #279 had an order for the use of her oxygen, LPN #1 stated that she would have to look into that. On 2/19/21 at 12:31 p.m., ASM (Administrative Staff Member) #1, the Administrator sent this writer via email, evidence that a nurse had recently put an order in place for the use of Resident #279's oxygen. The order documented in part, the following: "2/19/21 at 10:52 (a.m.) May use oxygen at 2 liters as needed for comfort. Monitor 02 sats (saturation) once a shift. Keep 02 sats above 92 % (percent). Every shift." On 2/18/21 at 12:44 p.m., ASM (Administrative Staff Member) #1, the Administrator was made aware of the above concerns. Facility policy titled, "Respiratory Care" documents in part, the following: "Licensed staff will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per physician's order and in accordance with standards of practice."	F 695		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)	F 727		3/19/21

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F 727	Continued From page 15 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interviews the facility staff failed to ensure the services of a registered nurse for at least 8 consecutive hours on Saturday 1/30/21 and Sunday 1/31/21. The findings included: The facility's as worked schedules from January 18, 2021 through February 17, 2021 were reviewed for RN (registered nurse) coverage for at least 8 consecutive hours a day, 7 days a week. On Saturday 1/30/21 and Sunday 1/31/21 there was no RN coverage identified on the facility's as worked schedules. On 2/18/21 at 1:30 P.M. a phone interview was conducted with the facility's Scheduler. The Scheduler was asked about RN coverage for Saturday 1/30/21 and Sunday 1/31/21. The Scheduler stated, "I don't see where there was an RN for that weekend. The Director of Nursing is	F 727	F727 1. A registered nurse is providing services for 8 consecutive hours daily. 2. The facility Scheduler will ensure that an RN is scheduled for 8 consecutive hours daily. If the RN is not able to work the scheduled hours, an RN from the Nursing Management Team will provide the 8 consecutive hours of coverage. 3. The facility Scheduler will be educated on ensuring that an RN is scheduled for 8 consecutive hours of daily coverage. 4. The Administrator will review daily RN coverage to ensure that 8 consecutive hours are provided daily. 5. Issues noted during the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 19, 2021	

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F 727	Continued From page 16 the RN coverage during the week." On 2/18/21 at 2:30 P.M. a phone interview was conducted with the facility's Administrator regarding RN coverage on Saturday 1/30/21 and Sunday 1/31/21. The Administrator stated, "There was no RN coverage for that weekend. The Unit Manager was out with COVID, our Staff Development Coordinator quit without notice and my Director of Nursing had already worked the previous weekend. We had an agency nurse scheduled but she backed out at the last minute." The Administrator also stated that there was no facility policy for RN coverage. On 2/19/21 at approximately 4:50 P.M. a pre-exit debriefing was held with the Administrator where the above information was shared. Prior to exit no further information was provided.	F 727		
F 883 SS=E	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 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	F 883		3/19/21

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F 883	Continued From page 17 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 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility	F 883	F883	

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F 883	Continued From page 18 documentation, the facility staff failed to give 2 out of 5 residents in the survey sample (Resident #4 and Resident #12) the opportunity to receive the pneumococcal vaccination. The findings included: 1. Resident #4 was admitted to the nursing facility on 09/30/20. Diagnosis for Resident #4 included but not limited to Hypertension and Cerebral Infarction. The most recent Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 01/04/21 coded Resident #4 with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #4 under section "O" Special Treatments and Programs (O0300) section (A) asked if the residents Pneumococcal vaccination was up to date; was coded "No." In addition, the MDS under section (B) asked if Pneumococcal vaccine not received, state reason; was coded "Not offered." Review of Resident #4's immunization record did not display the pneumococcal vaccine was either offered or declined. A phone interview was conducted with the Director of Nursing/Infection Preventionist (DON/IP) and Cooperate on 02/18/21 at approximately 1:15 p.m. When asked if Resident #4 was offered the pneumococcal vaccine, they replied, "No, nothing is documented." The DON/IP said the pneumococcal vaccination should have been offered on admission." The DON/IP stated, "If the resident refused the vaccination, the refusal should have document."	F 883	1. Resident #4 has been given the opportunity to receive the pneumococcal vaccination. Resident #12 has been given the opportunity to receive the pneumococcal vaccination. 2. Current Residents were reviewed to ensure that they were given the opportunity to receive the pneumococcal vaccination. 3. Charge Nurses were educated on offering the pneumococcal vaccination at time of admission and documenting the Resident□s response. 4. An RN will review documentation of Resident response to the offer of pneumococcal vaccination to ensure that Residents receive the offer at time of admission. 5. Issues noted during the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: March 19, 2021	

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When asked, "What is the purpose of the pneumococcal vaccination" the DON replied, "To stop the resident from getting sick; it helps to prevent pneumonia."

2. Resident #12 was admitted to the nursing facility on 12/30/19. Diagnosis for Resident #12 included but not limited to Chronic Obstructive Pulmonary Disease (COPD.) The most recent Minimum Data Set (MDS) an annual assessment with an Assessment Reference Date (ARD) of 12/19/20 coded Resident #12 with a 08 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #4 under section "O" under Special Treatments and Programs (O0300) section (A) asked if the residents Pneumococcal vaccination was up to date; was coded "No." In addition, the MDS under section (B) asked if Pneumococcal vaccine not received, state reason; was coded "Not offered."

Review of Resident #12's immunization record did not display the pneumococcal vaccine was either offered or declined.

A phone interview was conducted with the Director of Nursing/Infection Preventionist (DON/IP) and Cooperate on 02/18/21 at approximately 1:15 p.m. When asked if Resident #4 was offered the pneumococcal vaccine, they replied, "No, nothing is documented." The DON/IP said the pneumococcal vaccination should have been offered on admission." The DON/IP stated, "If the resident refused the vaccination, the refusal should have document." When asked, "What is the purpose of the pneumococcal vaccination" the DON replied, "To

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stop the resident from getting sick; it helps to prevent pneumonia."

The above information was shared with Administrator during a debriefing on 2/19/21 at approximately 2:56 p.m. No additional information was provided.

The facility's policy titled Admitting (Physician Orders) effective date: 03/24/20.
-Policy: Admission Physician Orders must be provided for every patient at the time of admission or readmission to activate a medical plan of care.

Procedure - read in part:
1. Upon every patient's admission or readmission or re-entry to the Center, a license nurse will notify the physician requesting and/or verifying physician's orders.

2. Upon receiving admission physician's orders from the physician, the nurse will record the order to include:
B. Admission orders read in part: Pneumococcal vaccine unless contraindicated.