STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495282	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

(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 Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification on 04/19/21 through 04/22/21. The facility was found not to be in compliance with 42 CFR 483.73.	E 000		
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the	E 030		4/22/21

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

Electronically Signed | 05/13/2021

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E 030	Continued From page 1	E 030		

following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [hospitals and CAHs].
(v) Volunteers.

*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Next of kin, guardian, or custodian.
(iv) Other RNHCIs.
(v) Volunteers.

*[For ASCs at §416.45(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Volunteers.

*[For Hospices at §418.113(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Hospice employees.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Other hospices.

*[For HHAs at §484.102(c):] The communication

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E 030	Continued From page 2 plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's "Emergency Preparedness Plan (EPP)," the facility failed to ensure the emergency preparedness communication plan included the names and contact information for all staff and entities providing services under arrangement. This failure had the potential to affect 65 residents and hindered the facility's ability to prepare for potential emergency situations and keep patients safe during an emergency event. Findings include: Review of the facility's "Emergency Preparedness Plan" updated 02/24/21 revealed a communication plan. Within the communication an "Emergency Call List" was reviewed. The Emergency Call List did not contain any phone numbers for all staff or any entities providing	E 030	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 deficiencies cited have been or will be corrected by the date or dates indicated. E030 1. The Emergency List was immediately updated with current team, management,	

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E 030	Continued From page 3 services. Further review of the communication plan revealed no contact information for sister facilities that may need to be contacted in the event of an emergency. During an interview on 04/21/21 at 10:00 AM, when the Emergency Preparedness Plan was reviewed with the Maintenance Director, the Maintenance Director stated, "I do not have the full staff listed in here. I only have the Management Team, Medical Director, and our vendors. Our turnover rate is high here and it would be hard to track everyone." When the Maintenance Director was asked if there was contact information for any sister facilities that may need to be contacted in the event of an emergency or evacuation, he stated, "I don't have any information. I have them in my phone with their direct numbers, but I do not have their numbers in our plan. No."	E 030	and sister center information as of 4/21/21. 2. The list will be updated as changes and positions change within the center. 3. Members of the Safety Committee will review on a monthly basis to confirm changes, updates, and additions are made in a timely fashion. 4. The Emergency Preparedness Plan will be reviewed on a quarterly basis by the QA committee. 5. 4/22/21 and ongoing	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:	E 031		4/22/21

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E 031	Continued From page 4 (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's "Emergency Preparedness Plan (EPP)," the facility failed to ensure the emergency preparedness communication plan included all the following: Emergency Officials Contact Information to include the State Licensing and Certification Agency, and the Office of the State Long-Term Care Ombudsman. This failure had the potential to affect 65 residents and hindered the facility's ability to prepare for potential emergency situations and keep patients safe during an emergency event. Findings include: Review of the facility's "Emergency Preparedness	E 031	E031 1. The Emergency Preparedness Plan was immediately updated with the State Licensing and Certification and the Ombudsman contact information on 4/21/21. 2. If there are any communicated changes from those agencies, the list will be updated. 3. Members of the Safety Committee will review on a monthly basis to confirm changes, updates, and additions are made in a timely fashion. 4. The Emergency Preparedness Plan will be reviewed on a quarterly basis by the QA committee.	

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E 031	Continued From page 5 Plan" updated 02/24/21 revealed a communication plan. Within the communication an "Emergency Call List" was reviewed. The Emergency Call List did not contain Emergency Officials Contact Information to include the State Licensing and Certification Agency, and the Office of the State Long-Term Care Ombudsman. During an interview on 04/21/21 at 10:00 AM, when the Emergency Preparedness Plan was reviewed with the Maintenance Director regarding the contact information for emergency officials, the Maintenance Director stated, "I do not see the Ombudsman information listed here and I will have to add that. I don't see the State Licensing Certification Agency listed here either and I will have to add that to our plan."	E 031	5. 4/22/21 and ongoing	
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 04/19/21-04/22/21 Survey Census: 65 Sample Size: 36 Supplemental Residents: 0 No complaints were investigated during the survey.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 557		5/28/21

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F 557	Continued From page 6 §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, the facility failed to ensure one resident (Resident (R) R21) was able to have her desired personal property. R21 was unable to have a television of the size she wanted in her room. This failure effected one of 36 sampled residents. Findings include: During interview on 04/19/21 at 2:48 PM, R21 stated she wanted a 40-inch television in her room but the facility told her she was only allowed to have a 32-inch television. R21 further stated she could not see the 32-inch television very well and thought a larger television would help. R21's television was observed, there was open space around the wall on her side of the room allowing for a larger television. During interview on 04/22/21 at 1:30 PM, the Maintenance Director stated the facility had a policy that residents could only have a 32-inch television or smaller. The Maintenance Director stated R21 had purchased her own television for her room. The Maintenance Director stated the same rules applied if the resident had purchased his/her own television. The Maintenance Director stated that R21 had stated to him that she wanted a 70-inch television and he informed her that she could only have a 32-inch television.	F 557	F557 1. Resident #21 has ordered a 40 inch television, it will be put up once it arrives. 2. Resident #21 has met with the Administrator and has reviewed room setup, ability to store items, and a review of what will fit/not fit within her room. She has also reviewed her Resident Rights and is aware any variance or questions can be directed to the Administrator in the future. 3. Members of the Safety Committee will perform room rounds monthly, and will include a review of Resident #21□s room quarterly to verify safety of items and comfort level of resident. 4. Facility specific requirements/updates to Resident Rights will be communicated timely via the Resident Council on a Monthly basis as there are changes/facility specific updates to be reflected in the minutes. 5. 5-28-2021	

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F 557	Continued From page 7 During interview on 04/22/21 at 2:55 PM, the Maintenance Director stated there was not a written policy regarding television size in resident rooms but it varied by facility and for this facility they have always followed the 32-inch rule. During interview on 04/22/21 at 3:11 PM, Administrator 1 stated in the admission packet it stated that residents were able to have personal property as long as there was space in the room to accommodate the items. During interview on 04/22/21 at 3:50 PM, Administrator 1 stated R66's room would be able to accommodate a larger television. The "Resident Handbook" provided by the facility stated under "Furnishings and Clothing," "Residents are encouraged to bring personal furnishings within the space and safety limits of their room. Portable televisions on a movable stand are permissible. . . To ensure the safety, health, and well-being of all residents, any personal and electrical room furnishings must be approved by the Administrator." The "Admission Packet" provided by the facility stated under "Resident Rights" the right "to retain and use his/her personal clothing and possessions as space permits unless to do so would infringe upon rights of other Residents and unless medically contraindicated as documented by his/her physician in his/her medical record."	F 557		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		5/28/21

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F 656	Continued From page 8 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 9 section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, the facility failed to develop comprehensive and individualized care plans that included person-centered interventions to meet the residents' medical needs for 3 of 17 sampled residents, (Resident (R) 6, R60 and R171). The facility failed to include individualized interventions on the care plan for R60 to prevent falls and potential for injury when the resident had a history of repetitive falls prior to admission. The facility failed to include individualized interventions on the care plans for R6 and R171 of the necessary respiratory care interventions, consistent with physicians' orders and professional standards of practice, for the prevention of respiratory infections resulting from the residents' oxygen tubing resting on the floor. Findings include: Review of the facility's policy and procedure titled, "Care Planning" with an "Effective Date" of 11/01/19, revealed, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient." 1. Review of R60's Electronic Medical Record (EMR) under the "Profile" tab revealed the facility admitted the resident on 03/02/21 from an acute care hospital. Under the "Medical Diagnosis" tab the resident's diagnoses included encephalopathy	F 656	F656 1. Residents #6, #60□s care plans were updated to include person centered interventions to meet the residents□ medical needs. Resident #171 no longer resides in facility. 2. Current residents care plans will be reviewed to ensure they include person centered interventions to meet the residents□ medical needs. Corrections will be made as indicated. 3. Members of the interdisciplinary care plan team will be educated regarding development of care plans with person centered interventions. Nursing leadership will audit 10 resident care plans weekly x 4 weeks to ensure accuracy. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 5-28-2021	

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F 656	Continued From page 10	F 656		

(brain disease, disorder, or damage), generalized muscle weakness, altered mental status, mononeuropathy (damage to a single nerve that can cause a loss of sensation, movement, or function of the affected body part) of both legs, unspecified dementia without behavioral disturbance, unsteadiness on feet, and repeated falls.

Review of R60's "Admission Assessment/Screening V.1.2" under the "Assmnts (Assessments)" tab in the EMR, dated 03/02/21 at 1:52 PM, revealed the resident was alert and oriented to person and situation. The assessment indicated the resident had fallen within the past month.

A "Falls Risk Assessment" also under the "Assmnts" tab completed on 03/02/21 at 1:52 PM revealed the admitting nurse documented that R60's risk factors for falls included impaired vision "with or without glasses" and incontinence. The resident's most recent fall prior to admission occurred on "02/23" (no year documented).

Review of the resident's "Order Summary Report" under the "Orders" tab for the dates 03/01/21 through 04/30/21 revealed no orders pertinent to the resident's risk for falls.

Review of the resident's "Admission Minimum Data Set (MDS)," with an "Assessment Reference Date (ARD)" of 03/08/21, in the EMR under the "MDS" tab, revealed the answer codes for the "Brief Interview for Mental Status (BIMS)" assessment and summary score, and the staff assessment of the resident's mental status were all populated with dashes. The MDS assessment indicated that R60 had no behavioral symptoms,

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F 656	Continued From page 11	F 656		

did not reject care, and did not exhibit wandering behavior. R60 was able to walk in her room with limited assistance of one person, was unsteady on her feet but able to stabilize herself without staff assistance but sustained a fall in the last month prior to her admission.

Review of R60's care plan, dated 03/09/21, revealed a "Focus" or problem area created on 03/02/21 related to her fall risk that read, "The resident is at risk for falls r/t [related to] confusion, deconditioning, gait/balance problems, diuretic therapy, hyperlipidemia, HTN [high blood pressure], [and] major depressive disorder. The staff documented the "Goal" for the resident's fall risk as, "The resident will be free of falls through the review date [05/31/21]." The interventions developed by the staff to prevent R60 from future falls included only three preventative measures: "Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Keep environment free of trip hazards."

The three interventions on R60's care plan for fall prevention were not person-centered and did not include the resident's fall history, impaired vision with or without glasses, and incontinence status.

2. Review of R171's EMR under the "Profile" tab revealed the facility admitted the resident on 04/09/21. Review of the resident's diagnoses under the "Medical Diagnosis" tab in the EMR revealed R171 was admitted with diagnoses that included acute respiratory failure with hypoxia (low oxygen level in the blood), exacerbation (an increase in symptoms) of chronic obstructive pulmonary disease (COPD), and dependence on supplemental oxygen.

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Review of R171's April 2021 "Order Summary Report" found under the "Orders" tab in the EMR revealed physician's orders for:
"Oxygen Therapy - Oxygen 3 liters per minute [3L/min] via nasal cannula [for] COPD" with an order date of 04/12/21; and
"Oxygen tubing and humidifier change weekly on Thursdays every night shift every 7 day(s)" with an order date of 04/12/21.

Review of R171's "Admission MDS" with an "ARD" of 04/15/21 found under the "MDS" tab in the EMR revealed the resident had a "BIMS" score of 13 out of 15, which indicated the resident was cognitively intact. The assessment revealed R171 experienced shortness of breath or trouble breathing with exertion and when lying flat.

Observation on 04/19/21 at 11:45 AM revealed R171 received oxygen at 3L/min delivered via clear tubing applied to his nose and supplied by an oxygen concentrator at bedside. Additional observation revealed R171's oxygen tubing trailed off the left side of the resident's bed to the floor and continued along the contaminated floor approximately 2 feet to the oxygen concentrator where it joined to an empty humidifier bottle. Neither the oxygen tubing nor the humidifier bottle where initialed and dated with the last change of the respiratory equipment. During an interview on 04/19/21 at 11:45 AM, R171 stated the staff applied his oxygen tubing on admission and added the humidifier bottle, ". . . the day after I got here and have not changed it out for a full bottle since then."

Review of the resident's undated active "Care Plan" found under the "Care Plan" tab in the EMR

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revealed the staff did not include interventions for changing the resident's oxygen tubing and humidifier every seven days, for initialing and dating the oxygen tubing and the humidifier bottle when changed, or to ensure that the resident's oxygen tubing did not come into contact with the contaminated floor.

3. Review of R6's EMR "Profile" tab revealed the facility admitted the resident on 01/06/21. The resident's diagnoses under the "Medical Diagnosis" tab revealed the resident was admitted with diagnoses that included other cerebrovascular disease, acute embolism and thrombosis of left femoral vein, and simple chronic bronchitis.

Review of R6's "Significant Change in Status Assessment MDS" with an "ARD" of 01/14/21 revealed the resident had a "BIMS" score of 13 out of 15, which indicated the resident was cognitively intact.

Review of R6's April 2021 "Order Summary Report" found under the "Orders" tab in the EMR revealed physician's orders for: "Oxygen Therapy - Oxygen at 2 liters per minute via nasal cannula" (order date: 03/03/21); and "Oxygen tubing change weekly on Sunday, 7p-7a shift every night shift every Sun" (order date: 03/03/21).

Observation on 04/19/21 at 11:24 AM revealed R6 rested in bed and received oxygen at 2L/min delivered via clear tubing applied to his nose and supplied by an oxygen concentrator at bedside. Additional observation revealed R6's oxygen tubing trailed off the left side of the resident's bed to the floor and continued along the contaminated floor approximately 2.5 feet to the oxygen

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F 656	Continued From page 14 concentrator where it joined to a humidifier bottle with approximately 1/4 cup of fluid remaining in the bottle. Neither the oxygen tubing nor the humidifier bottle were initialed and/or dated with the last change of the respiratory equipment. Review of the resident's undated active "Care Plan" found under the "Care Plan" tab in the EMR revealed the staff did not include interventions for changing the resident's oxygen tubing and humidifier every seven days, to initial and date the oxygen tubing and humidifier when changed, or to ensure the resident's oxygen tubing did not come into contact with the contaminated floor. During an interview on 04/22/21 at 3:15 PM, the Director of Nursing (DON) stated that she expected the admitting nurse to begin the initial care plan for new admissions and is to include pertinent interventions according to the resident's specific risk factors and care needs.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		5/28/21

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F 657	Continued From page 15 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 observation, interview, record review, and review of facility policies, the facility failed to update the comprehensive care plan with person-centered interventions to prevent additional falls for 1of 17 sampled residents, (Resident (R) 60), who had a history of falls prior to admission and subsequently sustained a fall after admission to the facility. Findings include: Review of the facility policy titled, "Falls Management Program," with an "Effective Date" of 11/01/19, revealed: "The Center considers all patients to be at risk for falls and provides an environment as safe as practicable for all patients. The center utilizes a systems approach to a Falls Management Program that conducts multi-faceted, interdisciplinary assessments with evidence based [sic] interventions to develop individual care strategies. . . . 2. Complete the Post-Fall Assessment to determine, to the extent possible, the cause of a patient fall. . . . Follow-Up Responsibilities: 1. The Unit Manager will review	F 657	F657 1. Resident #60□s care plan was updated with interventions to prevent additional falls. 2. The care plans of residents who have fallen in the past 14 days will be reviewed to ensure interventions are in place to prevent additional falls. Corrections will be made as indicated. 3. Current licensed nurses will be educated regarding the need to update care plans with fall specific interventions as indicated. Nursing leadership will review to verify completion during weekly fall committee meeting x 4 weeks. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 5-28-2021	

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the Incident Report and any post fall follow-up and communicate any necessary fall management interventions to direct caregivers. . . Falls Committee: . . . 2. Each fall will be reviewed for causative factors utilizing the Post Fall Assessment, Device Assessment, and Incident Report. 3.The committee will evaluate and recommend additional fall management strategies as indicated . . . 5. The Unit Manager verifies care plan revisions, patient monitoring, appropriate referrals, and communication to staff for all recommendations. . . . "

Review of R60's Electronic Medical Record (EMR) under the "Profile" tab revealed the facility admitted the resident on 03/02/21 from an acute care hospital. Under the "Medical Diagnosis" tab the resident's diagnoses included encephalopathy (brain disease, disorder, or damage), generalized muscle weakness, altered mental status, mononeuropathy (damage to a single nerve that can cause a loss of sensation, movement, or function of the affected body part) of both legs, unspecified dementia without behavioral disturbance, unsteadiness on feet, and repeated falls.

Review of R60's "Admission Assessment/Screening V.1.2" under the "Assmnts (Assessments)" tab in the EMR, dated 03/02/21 at 1:52 PM, revealed the resident was alert and oriented to person and situation. The assessment indicated the resident had fallen within the past month. A "Falls Risk Assessment" also under the "Assmnts" tab completed on 03/02/21 at 1:52 PM revealed the admitting nurse documented that R60's risk factors for falls included impaired vision "with or without glasses" and incontinence. The resident's most recent fall

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prior to admission occurred on "02/23" (no year documented).

Review of the resident's "Order Summary Report" under the "Orders" tab for the dates 03/01/21 through 04/30/21 revealed no orders pertinent to the resident's risk for falls.

Review of the resident's "Admission Minimum Data Set (MDS)," with an "Assessment Reference Date (ARD)" of 03/08/21, revealed the answer codes for the "Brief Interview for Mental Status (BIMS)" assessment and summary score, and the staff assessment of the resident's mental status were all populated with dashes. The "MDS" assessment indicated that R60 had no behavioral symptoms, did not reject care, and did not exhibit wandering behavior. R60 was able to walk in her room with limited assistance of one person, was unsteady on her feet but able to stabilize herself without staff assistance but sustained a fall in the last month prior to her admission.

Review of R60's multidisciplinary "Progress Notes" under the "Progress Notes" tab dated from 03/02/21 at 1:52 PM through 04/20/21 at 4:05 PM, a "Fall Risk Assessment" under the "Assmnts" tab dated 03/24/21 at 4:52 AM, and "Post Fall Documentation" notes also under the "Assmnts" tab from 03/24/21 at 12:28 PM through 03/29/21 at 4:28 AM, revealed that on 03/24/21 at 4:45 AM, the nurse documented the resident, ". . . had to stay at the nursing station most of the night, until sleepy. [The] resident had a fall this shift at 0410 [4:10 AM] . . . Neuro checks were completed and skin check [sic]. Resident has not complained of any pain."

Review of a "Post Fall Documentation" note,"

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dated 03/24/21 at 12:28 PM, revealed the resident had an unwitnessed fall in her room during the prior shift. The nurse documented the resident, ". . . has a hx [history] of falls, confusion, and ambulating w/o [without] calling for assistance. [A] bruise [is] noted to resident's right temple next to [her] eye. [The] resident denies any pain r/t fall. Scattered bruising noted to BLUE [bilateral (both) upper extremities], and BLLE [bilateral lower extremities]. Vitals [vital signs] WNL [within normal limits]. No s/s [signs of symptoms] of distress or SOB [shortness of breath] noted. Resident does not indicate when transferring that she has pain, no facial grimacing or wincing, does not say "ow or that hurts." Recommendations: Continue with current plan of care as it remains appropriate. Resident located in highly visible area to ensure residents safety at this time."

Review of R60's "Care Plan", dated 03/09/21, found under the "Care Plan" tab in the EMR revealed a "Focus" or problem area created on 03/02/21 related to her fall risk that read, "The resident is at risk for falls r/t [related to] confusion, deconditioning, gait/balance problems, diuretic therapy, hyperlipidemia, HTN [high blood pressure], [and] major depressive disorder. The staff documented the "Goal" for the resident's fall risk as, "The resident will be free of falls through the review date [05/31/21]." The interventions developed by the staff to prevent R60 from future falls included only three preventative measures: "Anticipate and meet the resident's needs." Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Keep environment free of trip hazards."

R60's care plan was not updated with new or

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revised person-centered interventions following the resident's fall on 03/24/21.

Review of an "Incident Note" under the "Progress Notes" tab in the EMR, which was completed on 03/24/21 at 3:44 PM by the facility's Certified Infection Preventionist and Unit Manager, Licensed Practical Nurse (LPN) 4 revealed, "[The] resident was observed on floor next to her bed by staff wrapped in her blankets . . . Hx of falls, dementia [diagnosis] . . . Recommendations: Will place fall mats next to bed."

Subsequent "Post Fall Documentation" notes under the "Assmnts" tab dated from 03/24/21 at 12:28 PM through 03/29/21 at 4:28 AM reflected the "Recommendations" to prevent further falls included: Continue with current plan of care as it remains appropriate; frequent reminders, frequent checks, when awake is given activities to do in eye view of staff or has been talking with other residents in the hall; and "Continue POC [Plan of Care].

During an interview on 04/21/21 at 1:05 PM, the facility's Certified Infection Preventionist and Unit Manager, Licensed Practical Nurse (LPN) 4 stated that she talks with the resident and the staff to try and determine the reason the resident's fall. The resident's fall is then reviewed at least weekly by the "Falls Management/Committee Meeting" during which the team conducts a root-cause analysis of the resident's fall to determine the appropriate fall-prevention interventions to add to the resident's care plan.

During an interview on 04/22/21 at 3:15 PM, the

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F 657	Continued From page 20 Director of Nursing (DON) provided a copy of a "Falls Management/Committee Meeting Minutes" form for R60's fall that occurred on 03/24/21. The DON stated that the Falls Management/Committee team is to meet weekly after a resident falls to review the factors involved in the fall and update the resident's care plan with appropriate interventions to help prevent future falls. Review of the form's instructions for completion revealed the team is to, ". . . Complete [the form] at least weekly during falls committee meeting. Minutes are to be completed anytime falls are discussed." The form included six sections for the team to complete: "Medications," "Orthostatic hypotension," 'Vision," "Mobility, "Unsafe Behavior," and "Other." Further review of the 03/24/21 "Falls Management/Committee Meeting Minutes" form completed in response to R60's fall revealed the Falls Management/Committee competed only one of the six sections, "Unsafe Behavior," which reflected only that the resident, "Fell out of bed wrapped in blankets. Fall mats next to bed." The DON then stated that the 03/24/21 "Falls Management/ Committee Meeting Minutes" form for R60's fall was the only documentation the facility had for her fall. Review of the meeting minutes provided no documentation reflective of a root-cause analysis by the committee of the resident's 03/24/21 fall and/or of her history of falls prior to admission to determine any common causes. Review of R60's care plan for fall risk revealed the care plan was not updated after the committee's meeting to reflect the addition of fall mats next to the resident's bed or other person-centered interventions.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		5/28/21

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F 689	Continued From page 21 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: Based on interviews, record review, and facility policy review, the facility failed to conduct an effective post-fall root-cause analysis per facility policy to develop appropriate person-centered fall prevention measures for one resident (Resident (R) 60) with repeated falls out of a sample of 17 residents. The failed practice put R60 at risk for further falls and injury. Findings include: 1. Review of R60's EMR under the "Profile" tab revealed the facility admitted the resident on 03/02/21 from an acute care hospital. Under the "Medical Diagnosis" tab the resident's diagnoses included encephalopathy (brain disease, disorder, or damage), generalized muscle weakness, altered mental status, mononeuropathy (damage to a single nerve that can cause a loss of sensation, movement, or function of the affected body part) of both legs, unspecified dementia without behavioral disturbance, unsteadiness on feet, and repeated falls. Review of R60's "Admission Assessment/Screening V.1.2" under the "Assmnts (Assessments)" tab, dated 03/02/21 at	F 689	F689 1. A root cause analysis will be complete for resident #60s repeated falls, interventions will be implemented as indicated. 2. Current residents who have fallen in the past 14 days will be reviewed to determine if repetitive falls have occurred. If identified, the fall committee will complete a root cause analysis and implement interventions to decrease the risk of additional falls occurring immediately at the time of identification. 3. The Falls Committee will be educated regarding the need to ensure appropriate person-centered fall prevention measures are implemented as indicated. The Falls Committee will meet weekly and analyze falls per policy. Nursing leadership will verify implementation during fall committee meeting weekly x 4 weeks. Issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 5-28-2021	

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1:52 PM, revealed the resident was alert and oriented to person and situation. The assessment indicated the resident had fallen within the past month. A "Falls Risk Assessment" also under the "Assmnts" tab completed on 03/02/21 at 1:52 PM revealed the admitting nurse documented that R60's risk factors for falls included impaired vision "with or without glasses" and incontinence. The resident's most recent fall prior to admission occurred on "02/23" (no year documented).

Review of the resident's "Order Summary Report" under the "Orders" tab in the EMR for the dates 03/01/21 through 04/30/21 revealed no physician orders pertinent to the resident's risk for falls.

Review of the resident's Admission "Minimum Data Set (MDS)," with an "Assessment Reference Date (ARD)" of 03/08/21, found under the "MDS" tab in the EMR revealed the answer codes for the "Brief Interview for Mental Status (BIMS)" assessment and summary score, and the staff assessment of the resident's mental status were all populated with dashes. The "MDS" assessment indicated that R60 had no behavioral symptoms, did not reject care, and did not exhibit wandering behavior. R60 was able to walk in her room with limited assistance of one person, was unsteady on her feet but able to stabilize herself without staff assistance but had sustained a fall in the last month prior to her admission.

Review of R60's "Care Plan", dated 03/09/21, found under the "Care Plan" tab in the EMR revealed a "Focus" or problem area created on 03/02/21 related to her fall risk that read, "The resident is at risk for falls r/t [related to] confusion, deconditioning, gait/balance problems, diuretic therapy, hyperlipidemia, HTN [high blood

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pressure], [and] major depressive disorder. The staff documented the "Goal" for the resident's fall risk as, "The resident will be free of falls through the review date [05/31/21]." The interventions developed by the staff to prevent R60 from future falls included only three preventative measures: "Anticipate and meet the resident's needs." "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed." "Keep environment free of trip hazards."

Review of R60's multidisciplinary "Progress Notes" under the "Progress Notes" tab in the EMR dated from 03/02/21 at 1:52 PM through 04/20/21 at 4:05 PM, a "Falls Risk Assessment" under the "Assmnts" tab dated 03/24/21 at 4:52 AM, and "Post Fall Documentation" notes also under the "Assmnts" tab from 03/24/21 at 12:28 PM through 03/29/21 at 4:28 AM, revealed that on 03/24/21 at 4:45 AM, the nurse documented the resident, ". . . had to stay at the nursing station most of the night, until sleepy. [The] resident had a fall this shift at 0410 [4:10 AM] . . . Neuro checks were completed and skin check [sic]. Resident has not complained of any pain."

Review of a "Post Fall Documentation Note," dated 03/24/21 at 12:28 PM, revealed the resident had an unwitnessed fall in her room during the prior shift. The nurse documented the resident, ". . . has a hx [history] of falls, confusion, and ambulating w/o [without] calling for assistance. [A] bruise [is] noted to resident's right temple next to [her] eye. [The] resident denies any pain r/t fall. Scattered bruising noted to BLUE [bilateral (both) upper extremities], and BLLE [bilateral lower extremities]. Vitals [vital signs] WNL [within normal limits]. No s/s [signs of symptoms] of distress or SOB [shortness of

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breath] noted. Resident does not indicate when transferring that she has pain, no facial grimacing or wincing, does not say "ow or that hurts." Recommendations: Continue with current plan of care as it remains appropriate. Resident located in highly visible area to ensure residents safety at this time."

Review of an "Incident Note" under the "Progress Notes" tab, which was completed on 03/24/21 at 3:44 PM by the facility's Certified Infection Preventionist and Unit Manager, Licensed Practical Nurse (LPN) 4 revealed, "[The] resident was observed on floor next to her bed by staff wrapped in her blankets . . . Hx of falls, dementia [diagnosis] . . . Recommendations: Will place fall mats next to bed."

Subsequent "Post Fall Documentation" notes under the "Assmnts" tab dated from 03/24/21 through 04/20/21 reflected the "Recommendations" included: Continue with current plan of care as it remains appropriate; frequent reminders, frequent checks, when awake is given activities to do in eye view of staff or has been talking with other residents in the hall; and "Continue POC [Plan of Care].

During an interview on 04/21/21 at 1:05 PM, the facility's Certified Infection Preventionist and Unit Manager Licensed Practical Nurse (LPN) 4 stated that when a resident falls, the nurse performs a full head-to-toe assessment to determine if the resident has any injuries or is experiencing pain. LPN4 stated that she talks with the resident and the staff to try and determine the reason the resident fell. The resident's fall is then reviewed at least weekly by the "Falls Management/Committee Meeting" during which

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the team conducts a root-cause analysis if the resident's fall to determine and implement appropriate fall-prevention interventions.

During an interview on 04/22/21 at 3:15 PM, the Director of Nursing (DON) provided a copy of a "Falls Management/Committee Meeting Minutes" form for R60's fall that occurred on 03/24/21. Review of the form's instructions for completion revealed the team is to, ". . . Complete at least weekly during falls committee meeting. Minutes are to be completed anytime falls are discussed." The form included six sections for the team to complete: "Medications," "Orthostatic hypotension," 'Vision," "Mobility, "Unsafe Behavior," and "Other." Further review of the form completed in response to R60's fall on 03/24/21 revealed the Falls Management/Committee completed only one of the six sections, "Unsafe Behavior," which reflected only that the resident, "Fell out of bed wrapped in blankets. Fall mats next to bed." The DON stated that the Falls Management/Committee team is to meet weekly after a resident falls to review the factors involved in the fall and update the resident's care plan with appropriate interventions to help prevent future falls. The DON then stated that the 03/24/21 "Falls Management/Committee Meeting Minutes" form for R60's fall was the only documentation the facility had for her fall. Further review of the meeting minutes provided no documentation reflective of a root-cause analysis by the committee of the resident's 03/24/21 fall and/or of her history of falls prior to admission to determine any common causes. Review of R60's care plan for fall risk revealed the care plan was not updated after the committee's meeting to reflect the addition of fall mats next to the resident's bed.

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F 689	Continued From page 26 Review of the facility policy titled, "Falls Management Program," with an "Effective Date" of 11/01/19, revealed: "The Center considers all patients to be at risk for falls and provides an environment as safe as practicable for all patients. The center utilizes a systems approach to a Falls Management Program that conducts multi-faceted, interdisciplinary assessments with evidence based [sic] interventions to develop individual care strategies. . . . 2. Complete the Post-Fall Assessment to determine, to the extent possible, the cause of a patient fall. . . . Follow-Up Responsibilities: 1. The Unit Manager will review the Incident Report and any post fall follow-up and communicate any necessary fall management interventions to direct caregivers . . . Falls Committee: . . . 2. Each fall will be reviewed for causative factors utilizing the Post Fall Assessment, Device Assessment, and Incident Report. 3.The committee will evaluate and recommend additional fall management strategies as indicated. . . . 5. The Unit Manager verifies care plan revisions, patient monitoring, appropriate referrals, and communication to staff for all recommendations. . . . "	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	F 695		5/28/21

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F 695	Continued From page 27 by: Based on observation, interview, record review, and review of facility policy, the facility failed to provide necessary respiratory care consistent with the physicians' orders, professional standards of practice, and the residents' care plans for two of two residents observed for oxygen use, (Resident (R) 6 and R171). The staff failed to date and initial R6's and R171's oxygen tubing and humidifiers, failed to ensure the residents' oxygen tubing did not come into contact with the contaminated floor, and failed to ensure that R171's humidifier bottle was replaced when empty. Findings include: Review of the facility's policy and procedure titled, "Respiratory/Oxygen Equipment," with an "Effective Date" of 11/01/19, revealed that, "Licensed staff will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per physician's order and in accordance with standards of practice . . . 6. Nasal cannulas, Simple masks, Venturi mask, and Oximizer must be changed every week, dated and initialed. 7. If [the] flow rate [of oxygen] is greater than 4 liters/minute, a pre-filled disposable humidifier bottle must be used. Humidifier bottles are to be dated and changed every 7 days." The policy and procedure failed to address that staff ensure oxygen tubing be kept off the floor. 1. Observation on 04/19/21 at 11:45 AM revealed R171 rested in bed and received oxygen at 3L/min delivered via clear tubing applied to his nose and supplied by an oxygen concentrator at bedside. Additional observation revealed R171's	F 695	F695 1. Resident #6 and resident #171□s oxygen tubing was dated and removed from the floor. Resident#6□s humidifier bottle was dated. Resident #171□s humidifier bottle was replaced and dated. Resident #171 no longer resides in the center. 2. Current residents receiving oxygen will be observed to ensure tubing and humidifier bottle are dated, and not in contact with the floor. Current residents with humidified oxygen will be observed to ensure bottles are not empty. Corrections will be made as indicated. 3. Current licensed nursing staff and department heads will be educated regarding monitoring respiratory care equipment during rounds. Oxygen tubing and humidifier bottles will be changed and dated based on physician order by licensed nurses. Nursing leadership will verify on rounds 3x weekly x 4 weeks. Any issues will be corrected immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 5-28-2021.	

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oxygen tubing trailed off the left side of the resident's bed to the floor and continued along the floor approximately 2 feet to the oxygen concentrator where it joined to an empty humidifier bottle. Neither the oxygen tubing nor the humidifier bottle were initialed and dated with the last change of the respiratory equipment.

During an interview on 04/19/21 at 11:45 AM, R171 stated he was admitted to the facility ". . . a week ago" due to a worsening of his COPD and an increase in edema (fluid retention) to both of his feet. When asked when the staff most recently changed his oxygen tubing and replaced his humidifier bottle, the resident stated the staff applied his oxygen tubing on admission and added the humidifier bottle, ". . . the day after I got here and have not changed it out for a full bottle since then."

Review of R171's Electronic Medical Record (EMR) under the "Profile" tab revealed the facility admitted the resident on 04/09/21. Review of the "Med Diag [Medical Diagnosis]" tab in the EMR revealed R171 was admitted with diagnoses that included acute respiratory failure with hypoxia (low oxygen level in the blood), exacerbation (an increase in symptoms) of chronic obstructive pulmonary disease (COPD), and dependence on supplemental oxygen.

Review of R171's April 2021 "Order Summary Report" found under the "Orders" tab in the EMR revealed physician's orders for: "Oxygen Therapy - Oxygen 3 liters per minute [3L/min] via nasal cannula [for] COPD" with an order date of 04/12/21; and "Oxygen tubing and humidifier change weekly on Thursdays every night shift every 7 day(s)" with an order date of 04/12/21.

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Review of the R171's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/15/21 found under the "MDS" tab in the EMR revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, which indicated the resident was cognitively intact. The assessment revealed R171 experienced shortness of breath or trouble breathing with exertion and when lying flat.

Review of the resident's undated active "Care Plan" found under the "Care Plan" tab in the EMR revealed it did not include interventions for changing the resident's oxygen tubing and humidifier every 7 days, to initial and date the oxygen tubing and humidifier when changed, nor to ensure the resident's oxygen tubing did not come into contact with the contaminated floor (Cross-reference F656 - Comprehensive Care Plans).

Review of the resident's April 2021 "Treatment Administration Record (TAR)" found under the "Orders" tab in the EMR revealed an entry for: "Oxygen tubing and humidifier change weekly on Thursdays every night shift every 7 day(s)" with an order date of 04/12/21. Further review of the April 2021 "TAR" revealed the staff documented this task was most recently completed by the night shift staff on Monday, 04/19/21. However, the "TAR" entry did not include instructions for the staff to initial and date the respiratory equipment when changed and did not include an entry for the staff to ensure the resident's oxygen tubing did not come into contact with the contaminated floor.

2. Observation on 04/19/21 at 11:24 AM revealed

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R6 rested in bed and received oxygen at 2L/min delivered via clear tubing applied to his nose and supplied by an oxygen concentrator at bedside. Additional observation revealed R6's oxygen tubing trailed off the left side of the resident's bed to the floor and continued along the contaminated floor approximately 2.5 feet to the oxygen concentrator where it joined to a humidifier bottle with approximately 1/4 cup of fluid remaining in the bottle. Neither the oxygen tubing nor the humidifier bottle were initialed and dated with the last change of the respiratory equipment.

Review of R6's EMR "Profile" tab revealed the facility admitted the resident on 01/06/21. Review of the "Med Diag [Medical Diagnosis]" tab in the EMR revealed the resident was admitted with diagnoses that included other cerebrovascular disease, acute embolism and thrombosis of left femoral vein, and simple chronic bronchitis.

Review of R6's April 2021 "Order Summary Report" found under the "Orders" tab in the EMR revealed physician's orders for: "Oxygen Therapy - Oxygen at 2 liters per minute via nasal cannula" (order date: 03/03/21); and "Oxygen tubing change weekly on Sunday, 7p-7a shift every night shift every Sun" (order date: 03/03/21).

Review of R6's significant change in status assessment "MDS" with an ARD of 01/14/21 revealed the resident had a "BIMS" score of 13 out of 15, which indicated the resident was cognitively intact.

Review of the resident's undated active "Care Plan" found under the "Care Plan" tab in the EMR revealed it did not include interventions for changing the resident's oxygen tubing and

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humidifier every 7 days, to initial and date the oxygen tubing and humidifier when changed, nor to ensure the resident's oxygen tubing did not come into contact with the contaminated floor (Cross-reference F656 - Comprehensive Care Plans).

Review of the resident's April 2021 "TAR" found under the "Orders" tab in the EMR revealed an entry for: "Oxygen tubing change weekly on Sunday, 7p-7a shift every night shift every Sun[day]" with an order date of 03/03/21 and a discontinue date of 04/09/21. The April 2021 TAR revealed the staff documented this task was most recently completed by the night shift staff on Sunday, 04/04/21. Further review of the "TAR" revealed that although the resident had active physician's orders for oxygen use and for weekly changes of the oxygen tubing, the "TAR" had no subsequent entries for R6's oxygen order, interventions for the maintenance and labeling of the resident's respiratory equipment, or for ensuring the resident's oxygen tubing did not come into contact with the contaminated floor.

During an interview on 04/21/21 at 1:05 PM, the facility's Certified Infection Preventionist, Licensed Practical Nurse (LPN) 4 stated that oxygen tubing should never be allowed to touch the floor due to infection prevention and control concerns. LPN4 stated that all staff were responsible for checking oxygen tubing placement and the water level in the humidifier bottles. All respiratory equipment should be changed every 7 days and labeled with the date of the change and initialed by the staff member who provided the change in the respiratory equipment.

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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		5/28/21

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F 880	Continued From page 33 (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 observation, interview, record review, review of facility policy, and review of disinfectant instructions for use, the facility failed to ensure the staff appropriately disinfected blood glucose (sugar) monitors between resident use for one of two residents (Resident (R) 38), and failed to prevent the potential for cross-contamination for two of two residents (R38 and R12) when the staff placed wax paper barriers on the potentially	F 880	F880 (will also have associated dPOC) 1. Resident #38 and resident #12 are currently receiving blood glucose monitoring according to appropriate infection control practices. 2. Current residents receiving blood glucose monitors will be observed to ensure appropriate infection control practices are being followed. Corrections	

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F 880	Continued From page 34 contaminated surfaces of two medication carts and on surfaces in resident rooms. The facility had 18 residents who received blood glucose monitoring. Findings include: Review of the facility's policy and procedure titled, "Blood Test Monitoring," dated 11/01/19, revealed, "Procedure: . . . 2. Manufacturer's guidelines will be followed for monitoring device preparation . . . 6. Device must be cleaned and disinfected between patients." Review of a document titled, "Cleaning and Disinfecting the Assure Platinum Blood Glucose Monitoring System," revised "12/17" revealed, "The meter should be cleaned and disinfected after use on each patient . . . [An] Environmental Protection Agency (EPA) registered disinfectant product may be used to clean and disinfect the blood glucose meter." Review of the "Product Literature Sheet," dated 2021, for "PDI (Professional Disposables International, Inc.) Sani-Cloth Bleach Germicidal Disposable Wipe," retrieved online on 04/21/2021 at: https://pdihc.com/wp-content/uploads/2018/08/PDI-Sani-Cloth-Bleach-Clinical-Wipe-Sell-Sheet_12207201.pdf, revealed the "Sani-Cloth Bleach Wipe Benefits" included that the product was, "Effective against SARS-CoV-2 (Coronavirus), the virus that causes COVID-19." Review of the PDI Sani-Cloth Bleach Germicidal Disposable Wipe" "Wall Chart" titled, "General Guidelines for Use," dated 2019, retrieved online 04/21/2021 at: https://pdihc.com/wp-content/uploads/2019/08/SaniClothBleachIFUCanisterWa	F 880	will be made as indicated. 3. Current licensed nurses will be educated regarding the need to clean and disinfect the machine between residents per manufacturers guideline. Blood glucose monitoring will be observed by nursing leadership 3x weekly x 4 weeks to ensure appropriate infection control practices are being followed. Any issues will be corrected immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 5-28-2021.	

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llchart 05168534.pdf revealed, ". . . 4. Treated surface must remain visibly wet for a full four (4) minutes. Use additional wipe(s) if needed to assure continuous 4 minute [sic] wet contact time."

1. a. Observation on 04/21/2021 at 11:55 AM revealed Licensed Practical Nurse (LPN) 2 stood at her medication cart wiping all surfaces of glucometer #2 (a device used to measure the blood sugar levels) with a disposable wipe. The LPN identified the wipe as a "PDI Sani-Cloth Bleach Germicidal Disposable Wipe." After wiping the device with the germicidal wipe, the LPN placed the glucometer on a piece of wax paper on the medication cart. Further observation revealed a second glucometer (glucometer #1) sat on a separate piece of wax paper uncovered and dry. LPN2 stated that she had also cleaned the glucometer #1 with a "PDI Sani-Cloth Bleach Germicidal Disposable Wipe."

Continued observation revealed at 12:03 PM, the LPN used glucometer #2, which she had wiped with the "PDI Sani-Cloth Bleach Germicidal Disposable Wipe" seven minutes prior, to complete a blood sugar test for R38. After completion of the test, LPN2 took the potentially contaminated glucometer back to the medication cart and used two "PDI Sani-Cloth Bleach Germicidal Wipes" to clean the glucometer. The LPN disposed of both wipes in the trash and placed the glucometer on a new piece of wax paper on the top of the medication cart. LPN2 stated, "It [the glucometer] has to sit for four minutes before it can be used again to make sure it's disinfected." When asked about the "PDI Sani-Cloth Bleach Germicidal Wipes" instructions for use for cleaning and disinfecting glucometers

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after use, the LPN stated, "I was told they [the glucometers] were supposed to dry for four minutes while the disinfectant worked." The LPN stated that she was unaware the glucometers needed to remain visibly wet with the germicide for at least four minutes in order to appropriately disinfect the devices. LPN2 did not recall who instructed her to allow the glucometers to air dry, nor when she received inservice training in infection control as it related to the disinfection of glucometers.

b. Observation on 04/21/2021 at 11:55 AM revealed after LPN2 finished wiping the surface of glucometer #2 with "PDI Sani-Cloth Bleach Germicidal Wipes," she placed the glucometer on a piece of wax paper that was in direct contact with the potentially contaminated top of the medication cart. At 12:03 PM, the LPN assembled additional blood sugar testing supplies, picked up glucometer #2 along with the wax paper underneath the device, entered R38's room, and placed the wax paper holding the glucometer on the potentially contaminated countertop of the resident's sink while she washed and dried her hands and applied gloves. LPN2 then placed the wax paper and glucometer on the resident's potentially contaminated bedside table. After completing the resident's blood sugar test, the LPN picked up glucometer #2 along with the wax paper underneath the device and placed the wax paper underneath the glucometer directly on the top of the medication cart potentially contaminating the cart top. When asked about the potential for cross-contamination of both the resident's room items and top of the medication cart, the LPN stated that she had not considered that possibility.

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2. Observation on 04/21/2021 at 11:37 AM revealed LPN1 stood at her medication cart and placed a section of wax paper on the surface of the medication cart without first cleaning and disinfecting the cart top. LPN1 then retrieved a glucometer from a plastic bag storage and placed it and other supplies on the wax paper. LPN1 picked up the glucometer along with the wax paper underneath the device, entered R12's room, and placed the wax paper holding the glucometer on top of the potentially contaminated countertop of the resident's sink while she washed and dried her hands and applied gloves. LPN1 then placed the wax paper and glucometer on the resident's potentially contaminated bedside table. After completing the resident's blood sugar test, the LPN picked up the glucometer along with the wax paper underneath the device and returned to the medication cart. The LPN then disposed of the wax paper and without first cleaning and disinfecting the cart top, placed a new section of wax paper directly on the top. When asked about the potential for cross-contamination of both the resident's room items and top of the medication cart, the LPN stated that she had not considered that possibility.

Review of an "Inservice/Education Sign in Sheet," dated "2/27/20," revealed the training information presented related to cleaning of glucometers. The inservice "Sign in Sheet" revealed both LPN1 and LPN2 attended the training, which instructed the staff to keep, "2 [sic] glucometers on each [medication] cart top when one is in use the other is being cleaned. . ." The attachment titled, "Cleaning and Disinfecting the Assure Platinum Blood Glucose Monitoring System," revised "12/17" revealed, "The meter should be cleaned

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and disinfected after use on each patient. . . . [An] Environmental Protection Agency (EPA) registered disinfectant product may be used to clean and disinfect the blood glucose meter." The training did not address that use of the "PDI Sani-Cloth Bleach Germicidal Wipes" required the glucometer to remain visibly wet with the germicidal agent for at least four minutes for adequate disinfection, nor did it address how to avoid sources of potential cross-contamination.

During an interview on 04/21/2021 at 1:05 PM, LPN4, the facility's Certified Infection Preventionist, stated that the facility had no residents with diagnoses that included blood-borne pathogens. LPN4 stated that she expected the staff to, ". . . follow protocol, standards of practice, and the facility's policies and procedures when performing blood sugar testing and for disinfecting the medication carts. This included cleaning and disinfecting the tops of the medication carts in between medication passes, cleaning and disinfecting the glucometers after each use as specified by the device's directions for use, and to use a protective barrier when using the glucometer, but to use a separate wax paper barrier in the resident's room, which is disposed of prior to leaving the resident's room to avoid possible cross-contamination."

During an interview on 04/22/2021 at 12:15 PM the Director of Nursing and the Registered Nurse (RN) Consultant stated the staff were to follow the facility's policies and procedures and standards of clinical practice when performing blood sugar testing and for disinfecting the glucometers and medication carts.

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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 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;	F 883		5/28/21

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F 883	Continued From page 40 (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 interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to obtain physician orders for and offer two of five residents (Resident (R) 66 and R169) and/or their representative, reviewed for influenza/pneumonia vaccinations, the opportunity for the resident to be vaccinated in accordance with nationally recognized standards. The facility failed to offer R169 the opportunity to be vaccinated with PCV13 (pneumococcal vaccine) in accordance with CDC guidelines and failed to obtain a physician order for or offer the resident the influenza vaccine in accordance with the facility policy. The facility also failed to obtain a physician order for or offer R66 the opportunity to be vaccinated with the influenza vaccination in accordance with the facility policy. The resident and/or their representative were unable to share in clinical decision making with the medical	F 883	F883 1. Resident #66 will be offered the influenza and pneumonia vaccinations per CDC guidelines. Resident #169 no longer resides in facility. 2. Current resident□s influenza and pneumococcal immunization status will be reviewed to ensure influenza and pneumococcal vaccines have been offered per CDC recommendations. Corrections will be made as indicated. 3. Current licensed nurses will be educated regarding offering the influenza and pneumococcal vaccines on admission per CDC guidelines and documentation in the medical record. Nursing leadership will review all new admissions weekly x 4 weeks to ensure documentation is in place. Any issues will be corrected immediately at the time of	

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F 883	Continued From page 41 provider as they were not given information or offered the vaccinations. The failed practice had the potential to increase the risk for influenza and/or pneumonia for the two residents. Findings include: Review of the Centers for Disease Control and Prevention (CDC) website titled, "Pneumococcal Vaccine Recommendations" revealed, "For adults 65 years or older who do not have an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant and want to receive PCV13 (Prevnar13®), AND PPSV23 (Pneumovax23®) . . . Administer 1 dose of PCV13 first then give 1 dose of PPSV23 at least 1 year later. If the patient already received PPSV23, give the dose of PCV13 at least 1 year after they received the most recent dose of PPSV23. Anyone who received any doses of PPSV23 before age 65 should receive 1 final dose of the vaccine at age 65 or older." Retrieved online, 04/22/21, at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html Review of the facility policy "Vaccinations and PPDs" with an effective date of 11/01/19, read in part, "Policy: After receiving a physician's order a licensed nurse will administer routine or standard vaccination to each patient unless medically contraindicated and will document accordingly." "Procedure: 1. Annual flu vaccine will be administered to all patients by physician order. 2. A copy of vaccine related information/education that was provided to the patient of [sic] responsible party in the form of CDC Vaccination Information Statement will be placed in the patient's medical record. 3. . . Pneumovax ... will	F 883	identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 5-28-2021.	

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be administered as physician ordered. . . 5. Documentation of all vaccinations is to be documented on the Immunization Report. . ."

1. Review of R66's Electronic Medical Record (EMR) under the "Profile" tab revealed the facility admitted the resident on 09/30/20 with diagnoses that included dementia, chronic obstructive pulmonary disease, and history of urinary tract infection.

Review of the resident's Admission "Minimum Data Set (MDS)", with an "Assessment Reference Date (ARD)" of 10/06/20, revealed the resident did not receive the influenza vaccine at the facility for the 2020 influenza season and that the facility did not offer the influenza vaccine to the resident.

Review of the resident's Quarterly "MDS" assessments, with "ARDs" of 01/05/21 and 04/05/21 respectively, revealed the resident did not receive the influenza vaccine at the facility for the 2020 influenza season and that the facility did not offer the influenza vaccine to the resident.

Review of R66's "Physician Orders" for April 2021, found under the "Orders" tab in the EMR, failed to contain an order to administer the influenza vaccine.

Review of R66's EMR under the "Immunizations" tab revealed no documentation to indicate the resident received or was offered the influenza vaccine or did not receive the vaccines due to medical contraindications, previous vaccination, or refusal.

2. Review of R169's EMR under the "Profile" tab

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revealed the facility admitted the resident on 04/08/21 with a primary diagnosis of small bowel perforation. The resident was greater than 65 years of age at the time of admission.

Review of the resident's Admission "MDS" with an "ARD" of 04/14/21, revealed the section for "Influenza Vaccine," was blank. The section for "Pneumococcal Vaccine" indicated the resident's pneumococcal vaccination was not up to date but provided no reason why the resident did not receive the pneumococcal vaccine.

Review of R169's "Physician Orders" for April 2021, found under the "Orders" tab in the EMR failed to contain an order to administer the influenza or pneumococcal vaccines.

Review of R169's EMR under the "Immunizations" tab revealed no documentation to indicate the resident was offered or received the Prevnar 13 pneumococcal vaccine, the Pneumovax 23 vaccine, or the influenza vaccine, or did not receive the vaccines due to medical contraindications, previous vaccination, or refusal.

During an interview on 04/22/21 at 12:15 PM, the Director of Nursing (DON) and the Registered Nurse (RN) Consultant, the DON confirmed the facility had no documentation related to the influenza vaccination for R66 and had no documentation related to R169's influenza, Prevnar 13, or Pneumovax 23 vaccinations or documentation of previous administration.